

**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:

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.

Indicate the number of day intervals for the Medicare-covered stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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:

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:

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

**SECTION B – 1A – INPATIENT HOSPITAL ACUTE – 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 – 1A – INPATIENT HOSPITAL ACUTE – 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:

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

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

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

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



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

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:

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Is a referral required for Inpatient Hospital - Acute Services? Inpatient Hospital - Acute Notes

Yes

No

Notes (Optional):

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

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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

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

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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

PBP Data Entry System - Section B-1, 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 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):

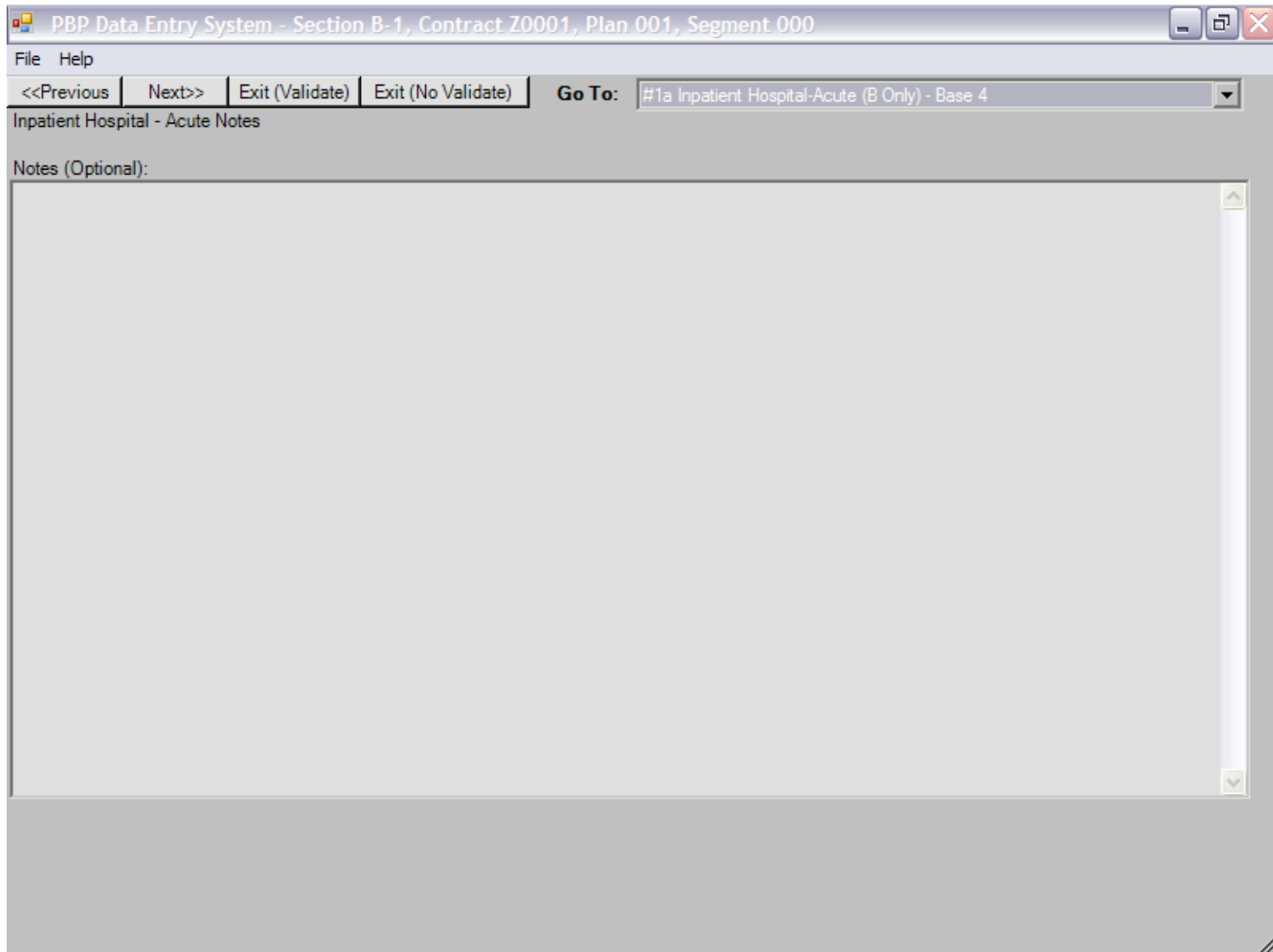
Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
[ ]	[ ]	[ ]
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
[ ]	[ ]	[ ]
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
[ ]	[ ]	[ ]

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**



**SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – 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

Maximum Plan Benefit Coverage is not applicable for this Service Category

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

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

Yes  
 No

Select enhanced benefit:

Additional Days  
 Non-Medicare-covered Stay

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

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

Select type of benefit for Additional Days:

Mandatory  
 Optional

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

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

Indicate number of Additional Days per benefit period:

Select type of benefit for Non-Medicare-covered stay:

Mandatory  
 Optional





**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

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:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

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

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

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

**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):



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

Indicate number of days per period:

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

Select type of benefit for Inpatient Psychiatric Hospital Services:  
 Mandatory  
 Optional

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

Select the Maximum Plan Benefit Coverage type:  
 Covered under Inpatient Hospital Services Category 1a  
 Plan-specified amount per period

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

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

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

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:  
[ ] [ ] [ ]

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

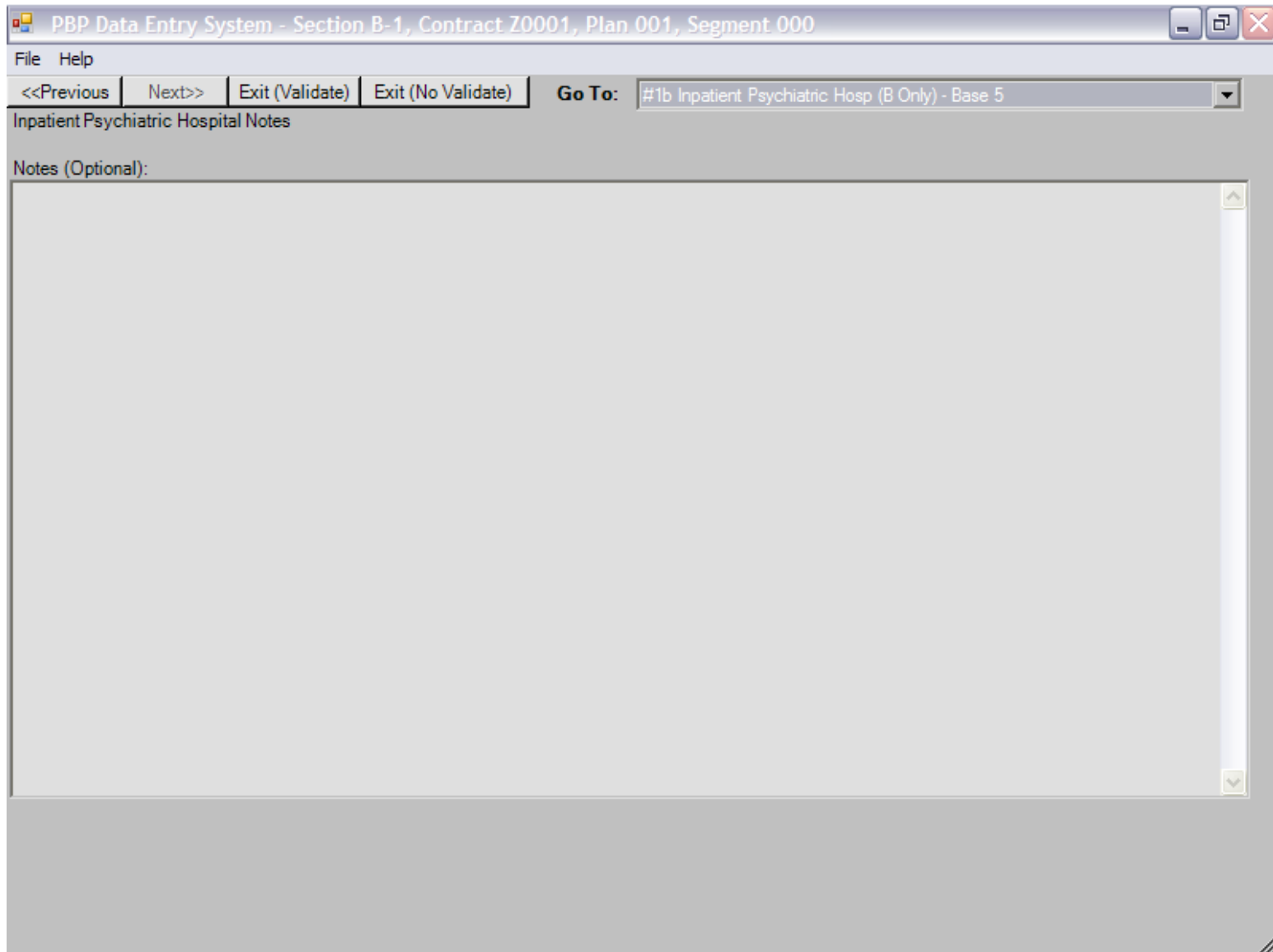
Indicate Copayment amount per stay:  
[ ]

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

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**



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

SECTION B – 2 – SNF – BASE 3 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 3

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

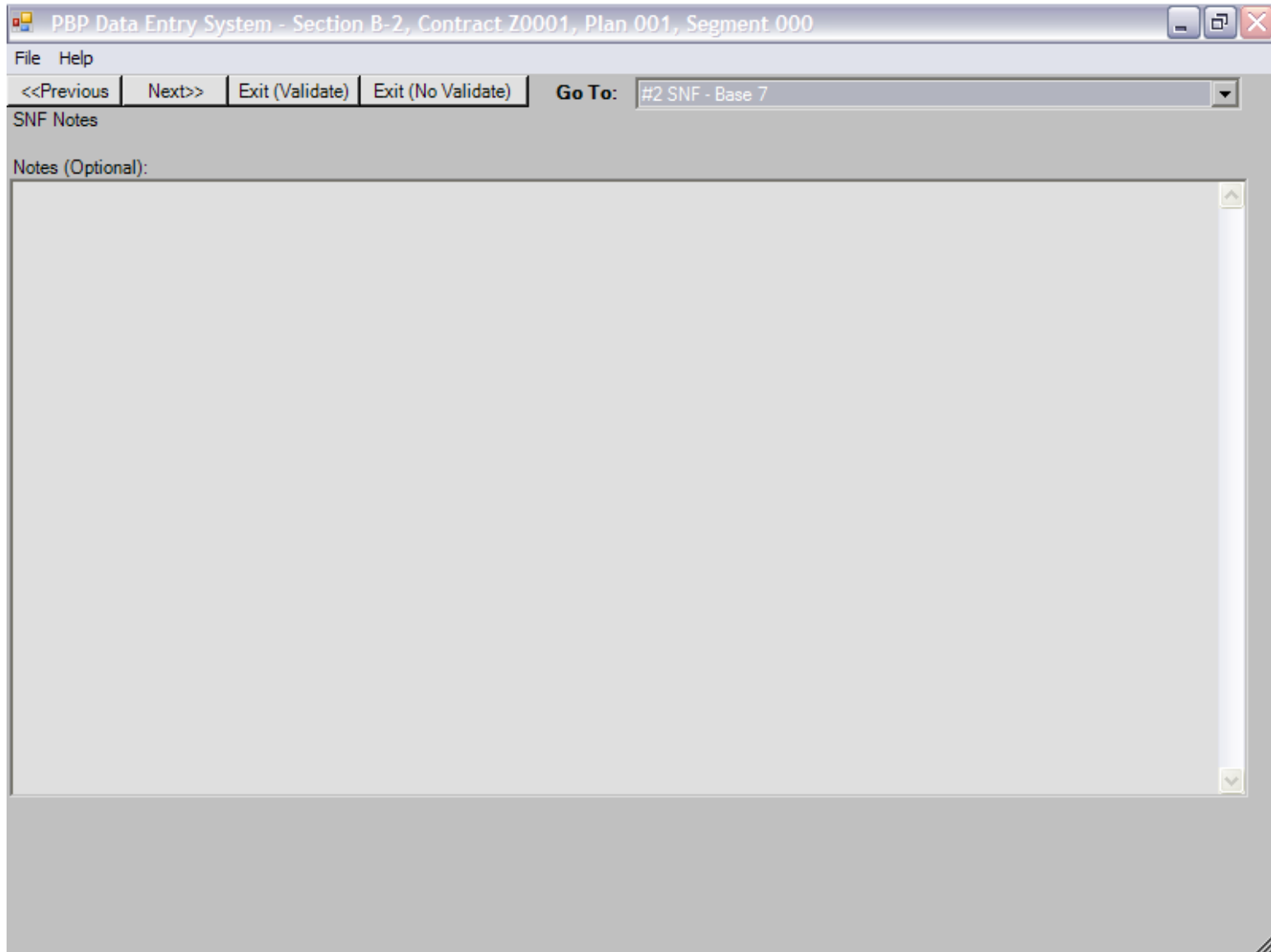
ESRD I Plans Only (Optional): If the beneficiary does not notify the plan of a planned inpatient admission, indicate the additional copayment amount per day:

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

File Help

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

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

File Help

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

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) 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:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

**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):

[Large empty text area for notes]



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:  
\_\_\_\_\_

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:  
\_\_\_\_\_

Select the Maximum Plan Benefit Coverage periodicity:

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

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

PBP 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 Copayment amount for Worldwide Coverage:

Indicate Minimum Copayment amount for Medicare-covered Benefits:

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

Indicate Maximum Copayment amount for Medicare-covered Benefits:

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

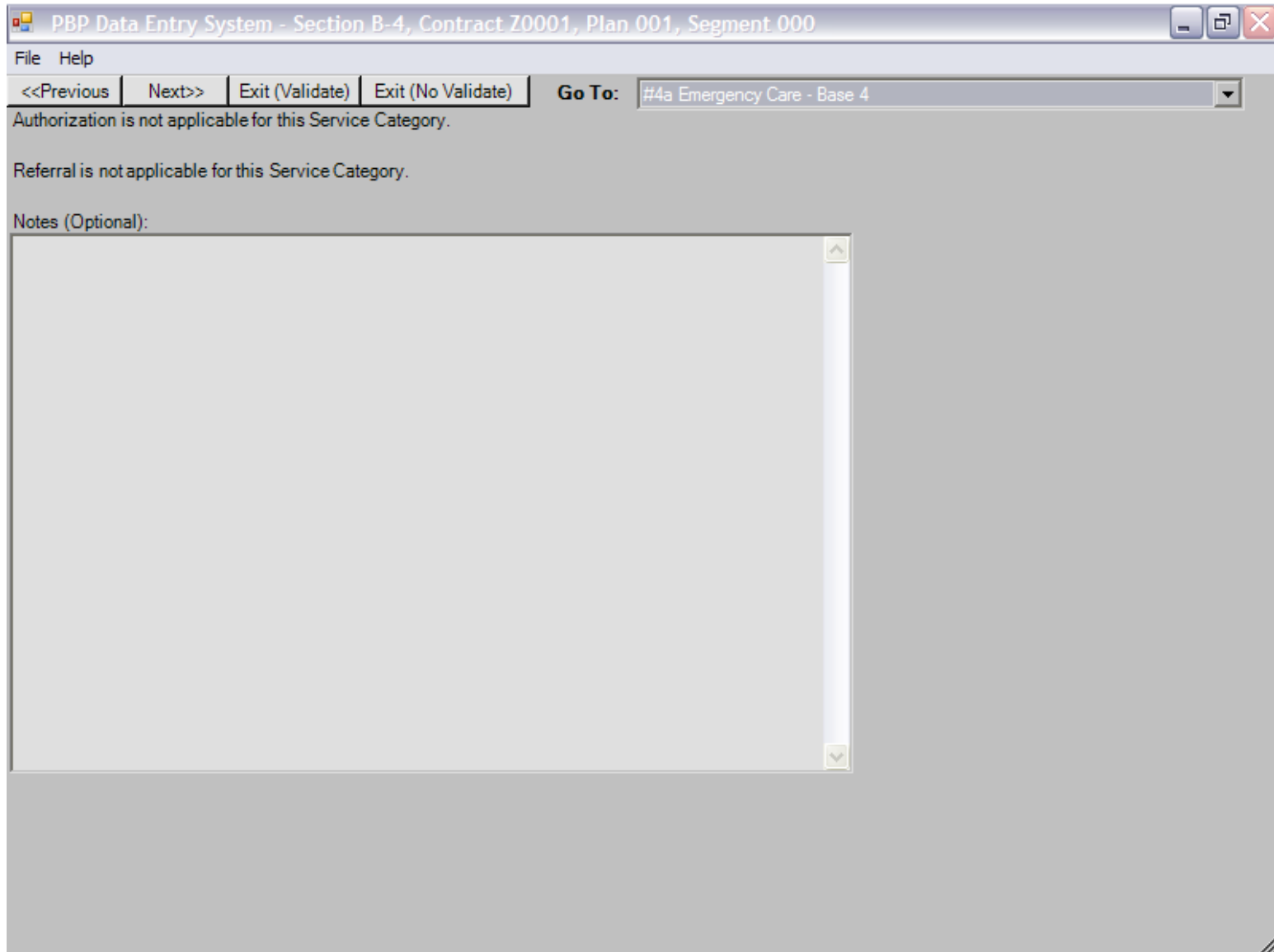
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?  
 Yes  
 No

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

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

Enter number of Days or Hours:

**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

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4b Urgently Needed Services - Base 1

**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.

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 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

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

File Help

<<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:

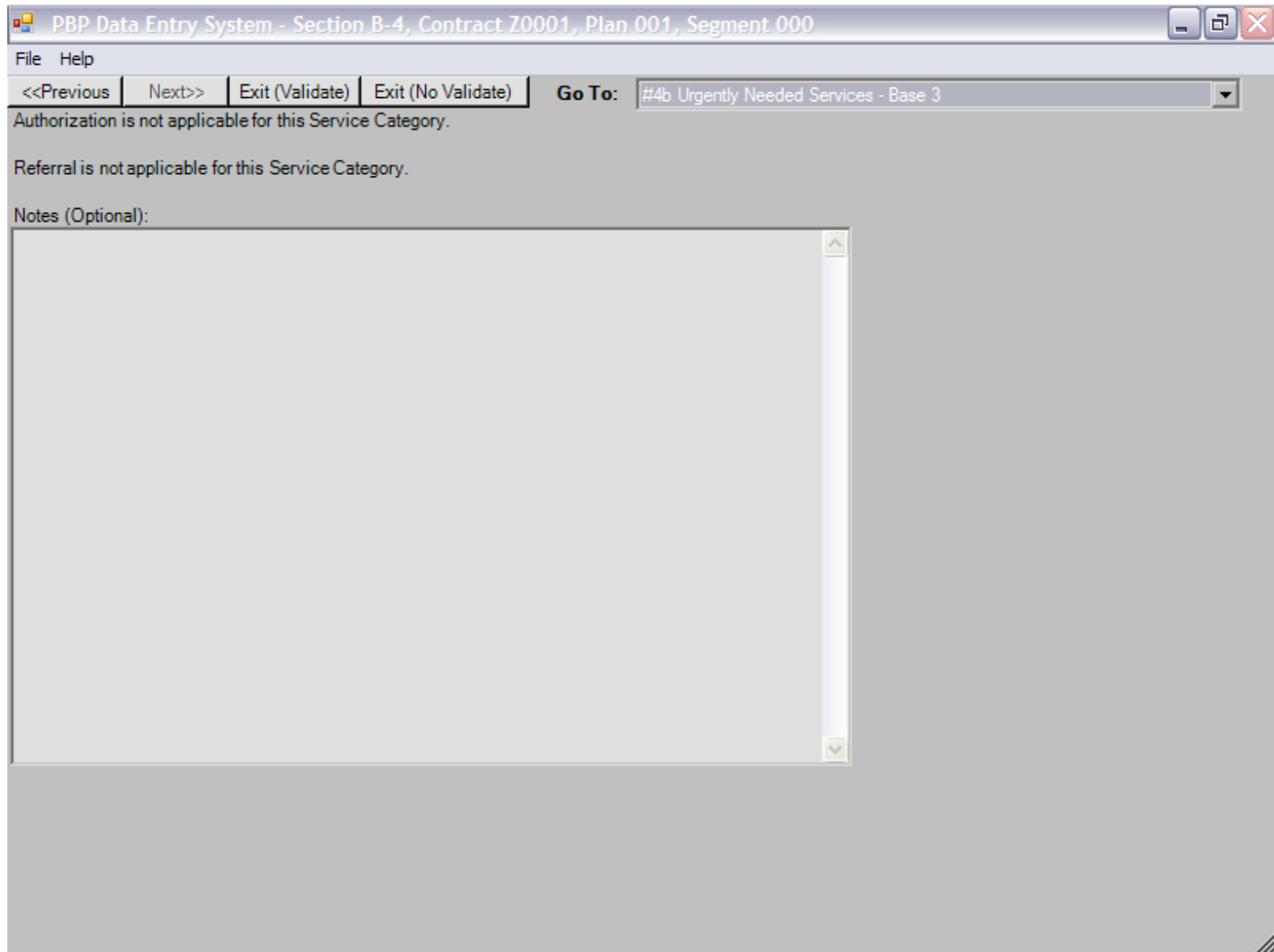
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?  
 Yes  
 No

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

File Help

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #6 Home Health - 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:  
[ ]

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #7a Primary Care - Base 2

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:

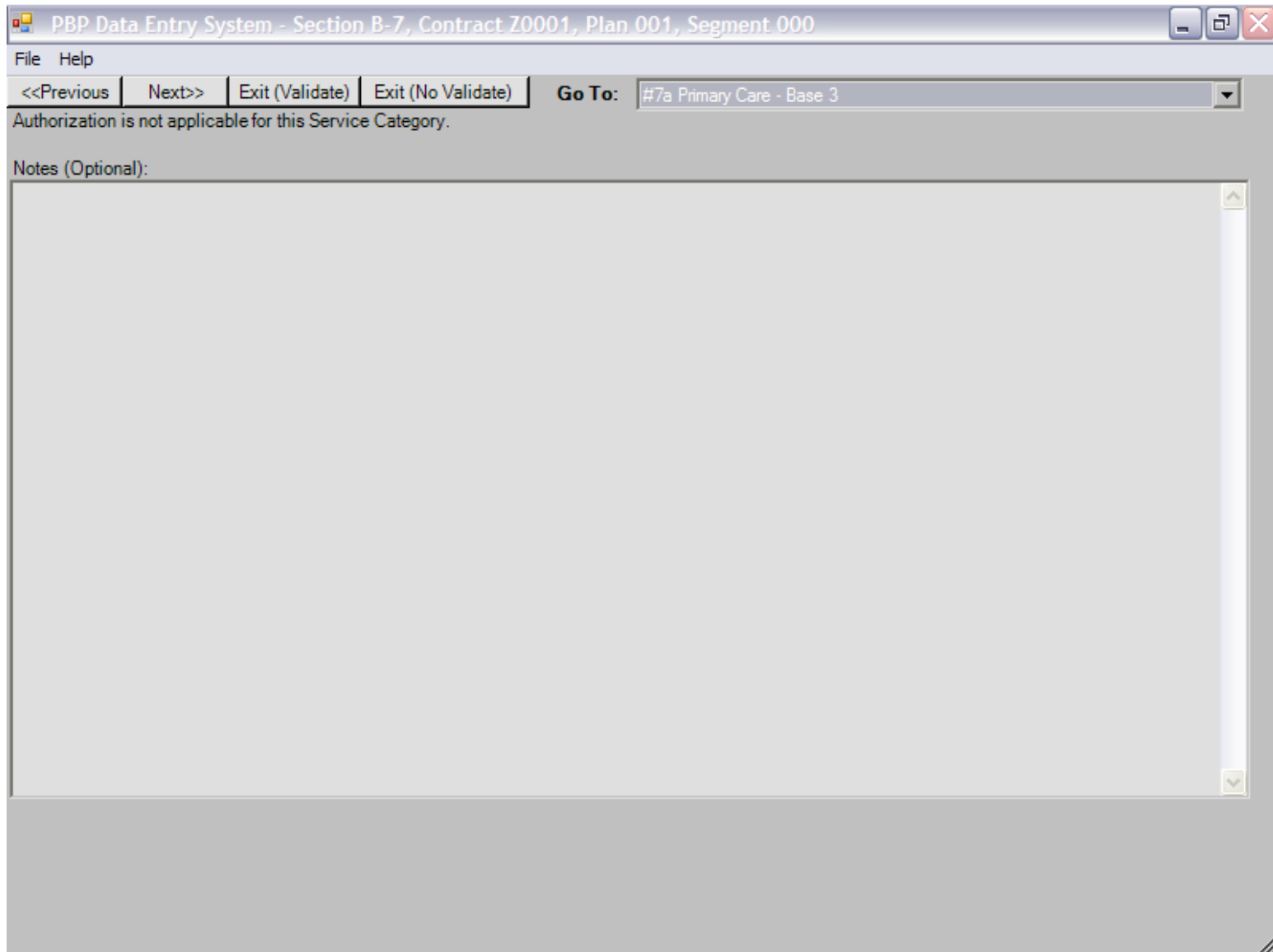
Indicate the Minimum Copayment for In-Area, Network Urgent Care services:

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

File Help

<<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:

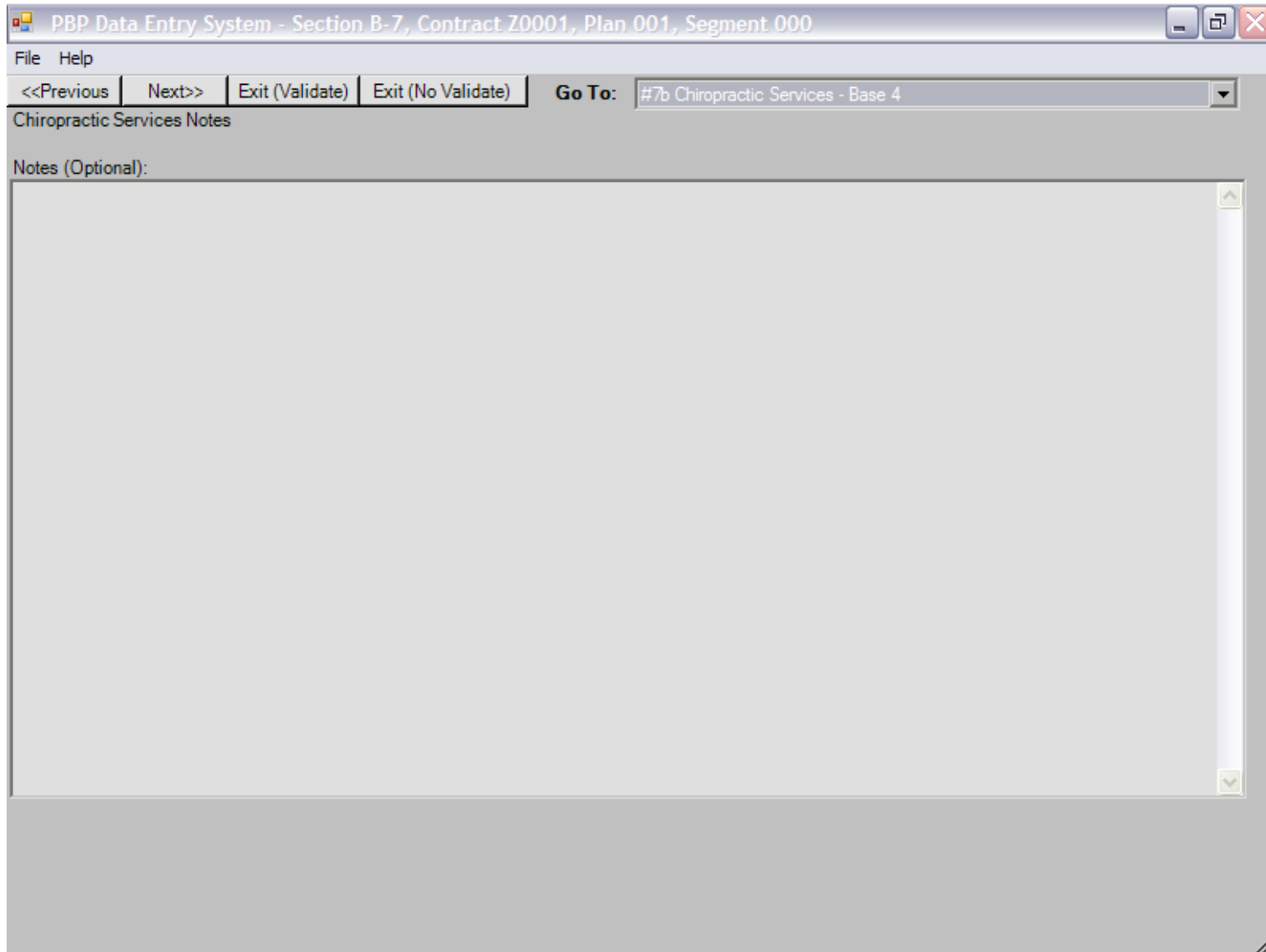
Enrollee must receive Authorization from one or more of the following:

- 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**



**SECTION B – 7C – OCCUPATIONAL THERAPY – 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: #7c Occupational Therapy - 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 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

File Help

<<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

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

File Help

<<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

File Help

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

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

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

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

<<Previous   Next>>   Exit (Validate)   Exit (No Validate)   **Go To:** #7e Mental Health - 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:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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

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

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

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

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

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

**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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #77 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 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: #77 Podiatry Services - Base 2

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



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

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7 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):

[Large empty text area for notes]

**SECTION B – 7G – OTHER HEALTH CARE PROFESSIONALS – 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: #7g Other Health Care - 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 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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7g Other Health Care - 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

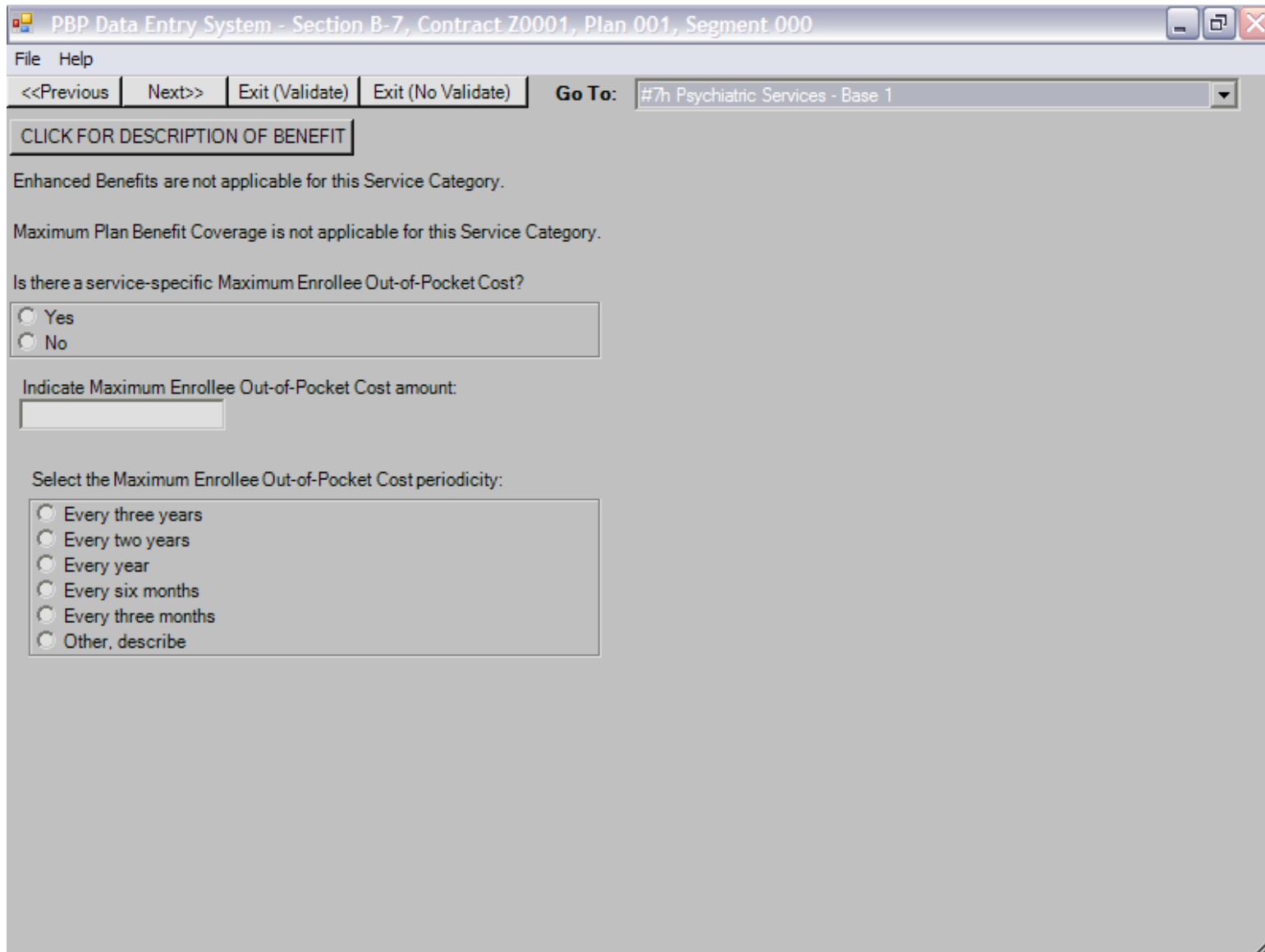
Is a referral required for Other Health Care Professional Services?

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7h Psychiatric 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

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7h Psychiatric Services - 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:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Session Interval 2:	End Session Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Session Interval 3:	End Session Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

**SECTION B – 7H – PSYCHIATRIC 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:** #7h Psychiatric Services - 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:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Session Interval 2:	End Session Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Session Interval 3:	End Session Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7h Psychiatric Services - 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:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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

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

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

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

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

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

**SECTION B – 7H – PSYCHIATRIC 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: #7h Psychiatric Services - 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 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: #7 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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7 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):

[Large empty text area for notes]

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

File Help

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

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

File Help

<<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

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

File Help

<<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

File Help

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

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

File Help

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

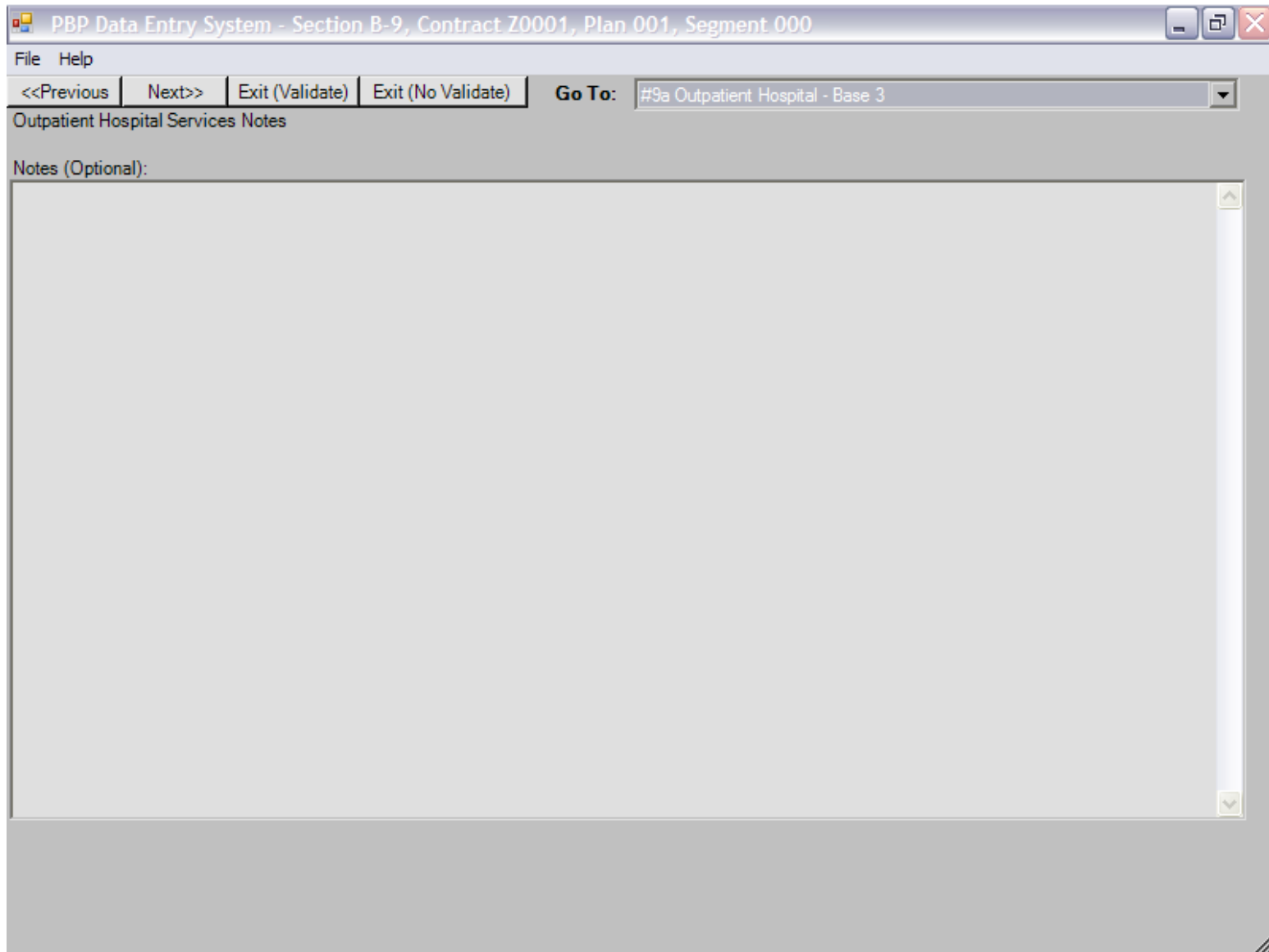
Enrollee must receive Authorization from one or more of the following:

- 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 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**

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 3

ASC Services Notes

Notes (Optional):

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

**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

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9c Outpatient Sub Abuse - 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:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Session Interval 2:	End Session Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Session Interval 3:	End Session Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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

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

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

**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:

\_\_\_\_\_

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

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 – 9D – CARDIAC REHAB SERVICES – BASE 3 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 3

Cardiac Rehabilitation Services Notes

Notes (Optional):

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

File Help

<<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

File Help

<<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

File Help

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

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Plan Benefit Coverage amount: <input type="text"/></p> <p>Select Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Enrollee Out-of-Pocket Cost amount: <input type="text"/></p> <p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Coinsurance percentage: <input type="text"/></p> <p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Deductible Amount: <input type="text"/></p>
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**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

File Help

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

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:

Notes (Optional):

Referral is not applicable for this Service Category.

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**

The screenshot shows a software window titled "PBP Data Entry System - Section B-11, Contract Z0001, Plan 001, Segment 000". The window has a menu bar with "File" and "Help". Below the menu bar are navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", "Exit (No Validate)", and "Go To:". The "Go To:" field contains "#11b Pros./Med. Supp. - Base 2".

The main area of the screen contains several input fields and radio button groups:

- "Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:" followed by an empty text box.
- "Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:" followed by an empty text box.
- "Is there an enrollee Deductible?" with radio buttons for "Yes" and "No".
- "Indicate Deductible Amount:" followed by an empty text box.
- "Is there an enrollee Copayment?" with radio buttons for "Yes" and "No".
- "Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:" followed by an empty text box.
- "Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:" followed by an empty text box.
- "Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:" followed by an empty text box.
- "Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:" followed by an empty text box.



**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

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

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

Notes (Optional):

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

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

Indicate limit for Number of Treatments:

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

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 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

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:

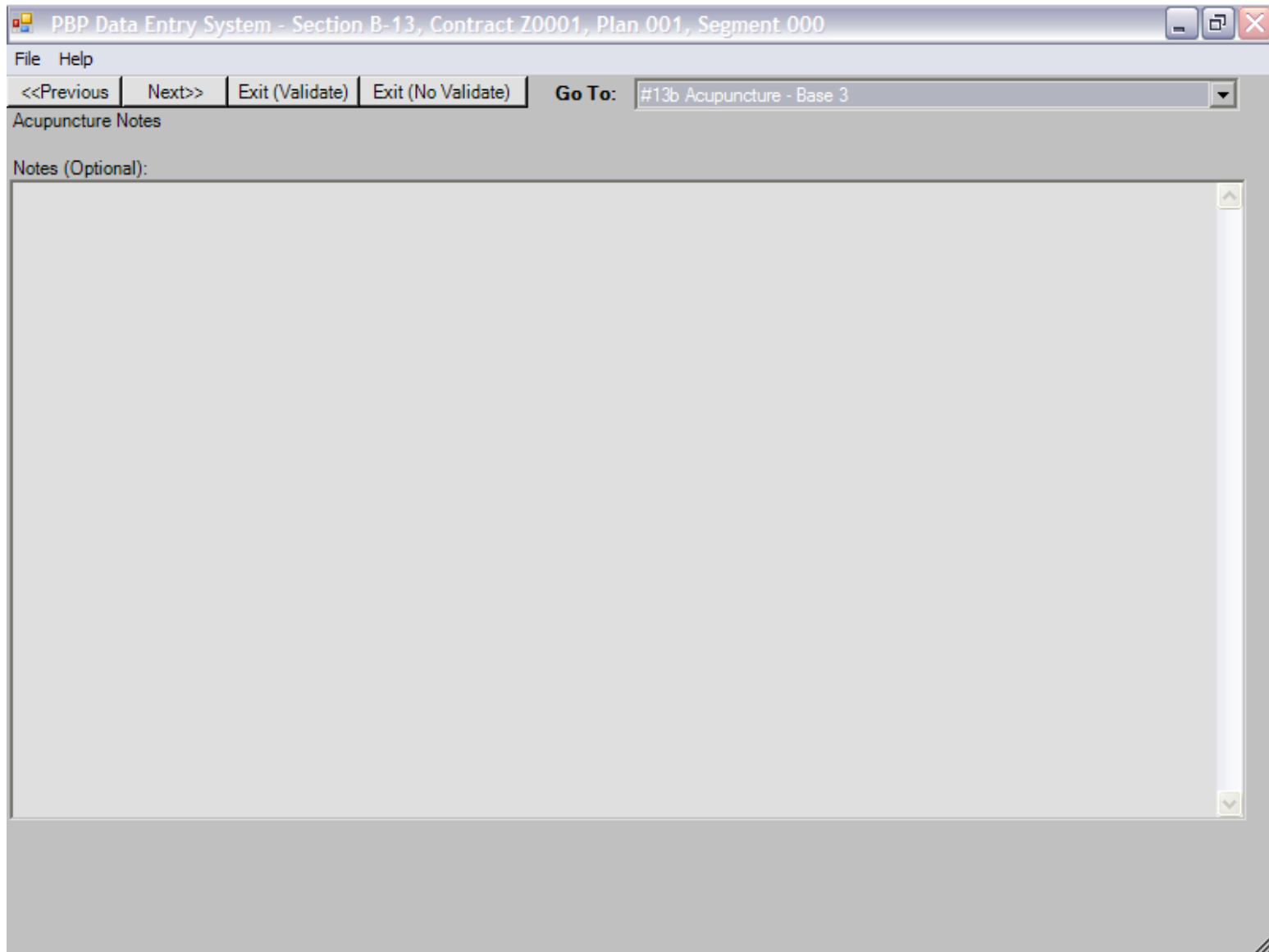
Is there an enrollee Deductible?  
 Yes  
 No

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

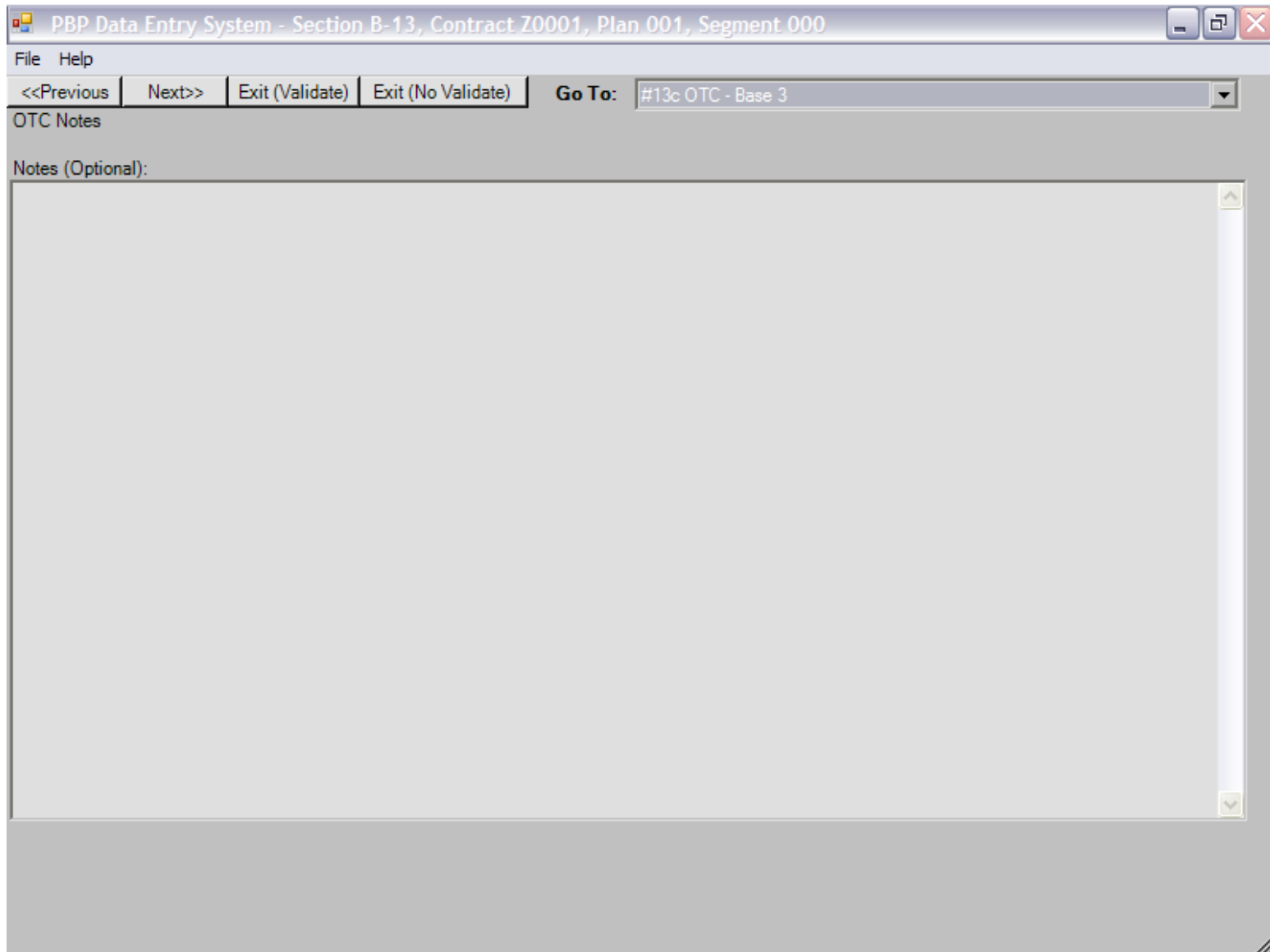
Indicate Copayment amount:

Does this cover all of the CMSOTC 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 Copayment?  
 Yes  
 No

Indicate Copayment amount:

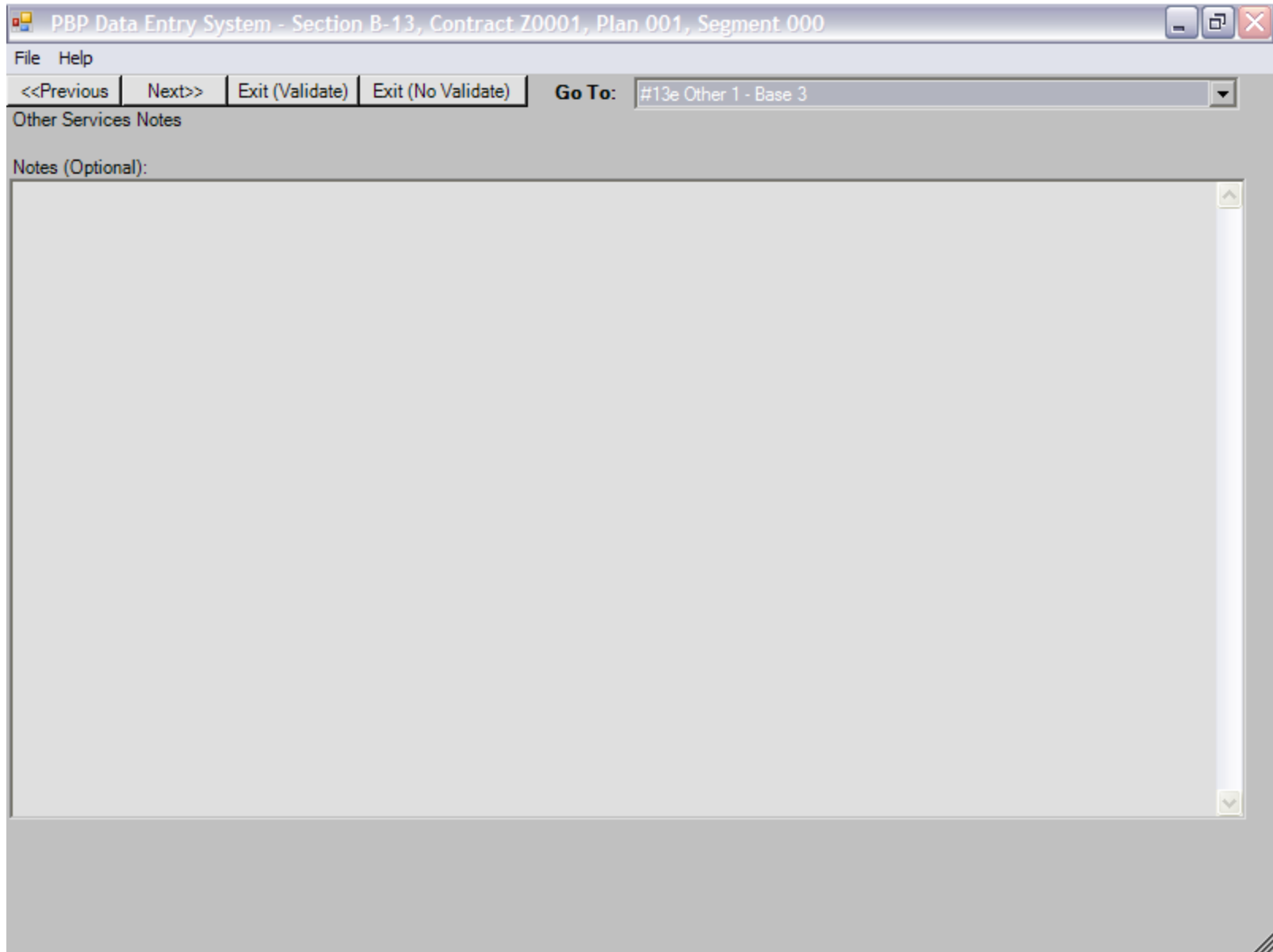
Is there an enrollee Deductible?  
 Yes  
 No

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 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 Copayment?

Yes  
 No

Indicate Copayment amount:

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 Other Services?

Yes  
 No

**SECTION B – 13F – OTHER 2 – 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: #13f Other 2 - Base 3

Other Services Notes

Notes (Optional):

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

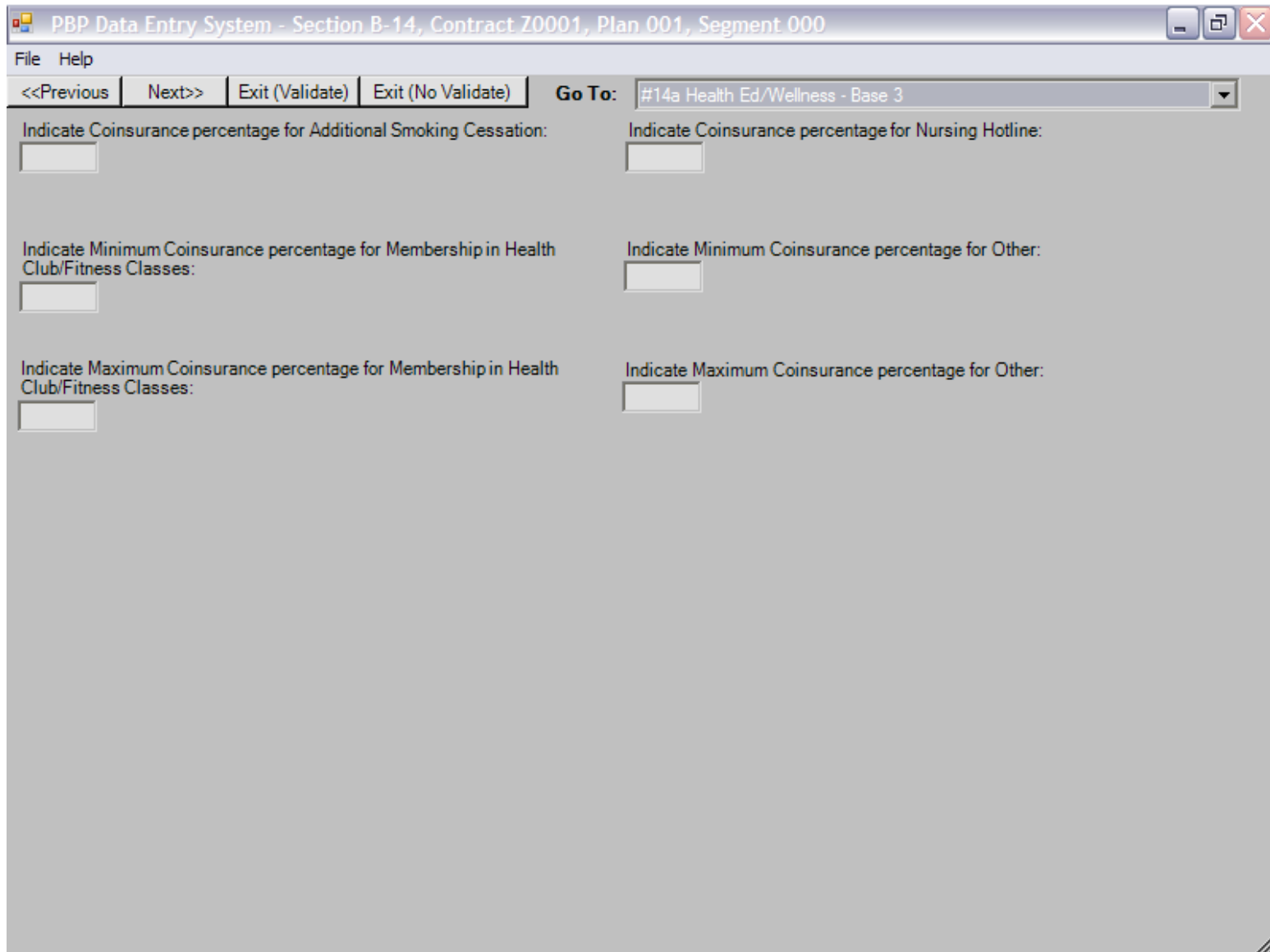
File Help

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

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Plan Benefit Coverage amount: <input type="text"/></p> <p>Select Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Enrollee Out-of-Pocket Cost amount: <input type="text"/></p> <p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate the Minimum Coinsurance percentage for the Medicare-covered Smoking Cessation benefit: <input type="text"/></p> <p>Indicate the Maximum Coinsurance percentage for the Medicare-covered Smoking Cessation benefit: <input type="text"/></p> <p>Indicate Minimum Coinsurance percentage for Written health education materials, incl. newsletters: <input type="text"/></p> <p>Indicate Maximum Coinsurance percentage for Written health education materials, incl. newsletters: <input type="text"/></p> <p>Indicate Coinsurance percentage for Nutritional Benefit: <input type="text"/></p> <p>Indicate Coinsurance percentage for Nutritional Training: <input type="text"/></p>
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**SECTION B – 14A – HEALTH EDUCATION AND WELLNESS – 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:** #14a Health Ed/Wellness - Base 3

Indicate Coinsurance percentage for Additional Smoking Cessation:

Indicate Coinsurance percentage for Nursing Hotline:

Indicate Minimum Coinsurance percentage for Membership in Health Club/Fitness Classes:

Indicate Minimum Coinsurance percentage for Other:

Indicate Maximum Coinsurance percentage for Membership in Health Club/Fitness Classes:

Indicate Maximum Coinsurance percentage for Other:

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

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

Indicate limit for Routine Exams:

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

Select the Routine Exams periodicity:

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

Is this benefit unlimited for Routine Exams?

Yes  
 No, indicate number

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14d Pap/Pelvic - Base 5

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

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14e Prostate Screening - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Indicate number of Additional Prostate Screenings:

Select the Maximum Plan Benefit Coverage type:

Covered under Preventive Services Category 14a

Plan-specified amount per period

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

Select the Additional Prostate Screenings periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, describe

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, describe

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

Yes

No



**SECTION B – 14E – PROSTATE 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: #14e Prostate Screening - Base 2

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

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14e Prostate Screening - Base 4

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

Indicate number of Additional Colorectal Screenings:

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

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

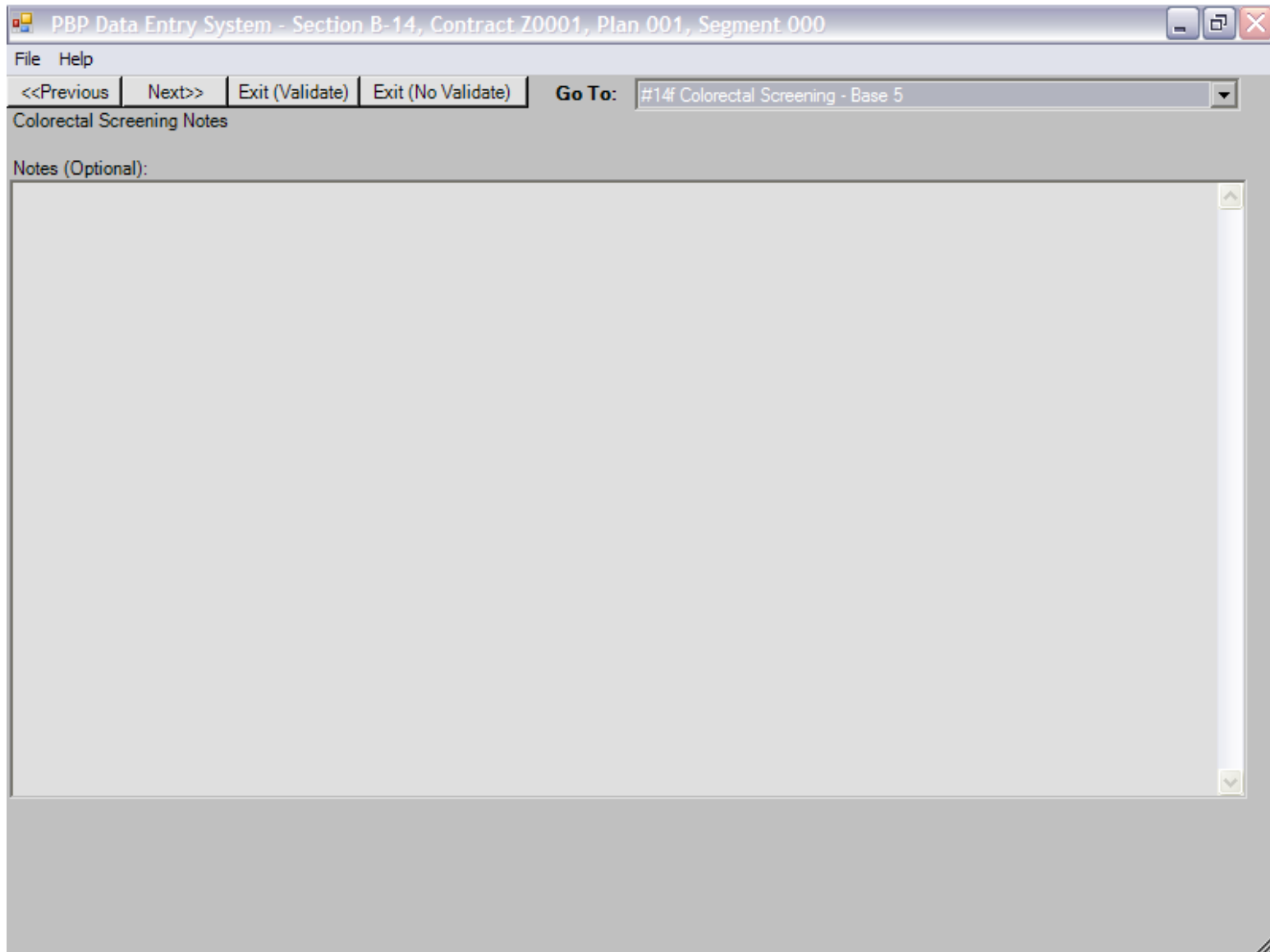
Is there an enrollee Coinsurance for a separate office visit?  
 Yes  
 No  
 Indicate Minimum Coinsurance for a separate office visit:  
  
 Indicate Maximum Coinsurance for a separate office visit:  
  
 Is there an enrollee Copayment for a separate office visit?  
 Yes  
 No  
 Indicate Minimum Copayment 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

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 – 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

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14g Bone Mass Meas. - 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 – 14G – BONE MASS MEASUREMENT – 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: #14g Bone Mass Meas. - 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

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

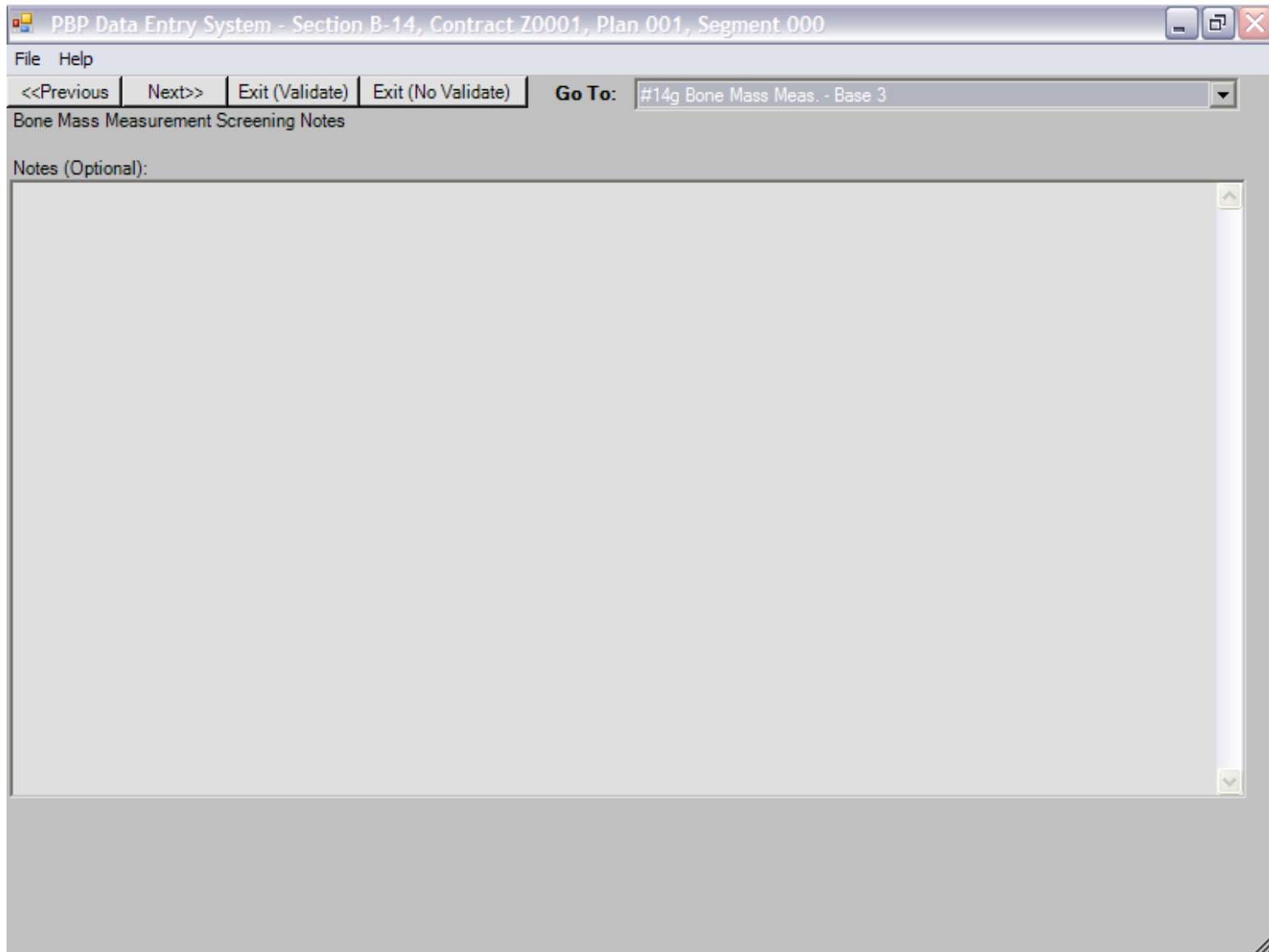
Indicate Minimum Copayment for a separate office visit:

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**



**SECTION B – 14H – MAMMOGRAPHY – 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: #14h Mammography - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Indicate number of Additional Mammography Screenings:

Indicate Maximum Plan Benefit Coverage amount:

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

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

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14h Mammography - Base 2

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:

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage for Medicare-covered Benefits:

Indicate Coinsurance percentage for Additional Screenings:

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

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

**SECTION B – 14H – MAMMOGRAPHY – BASE 3 SCREEN**

PBP 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

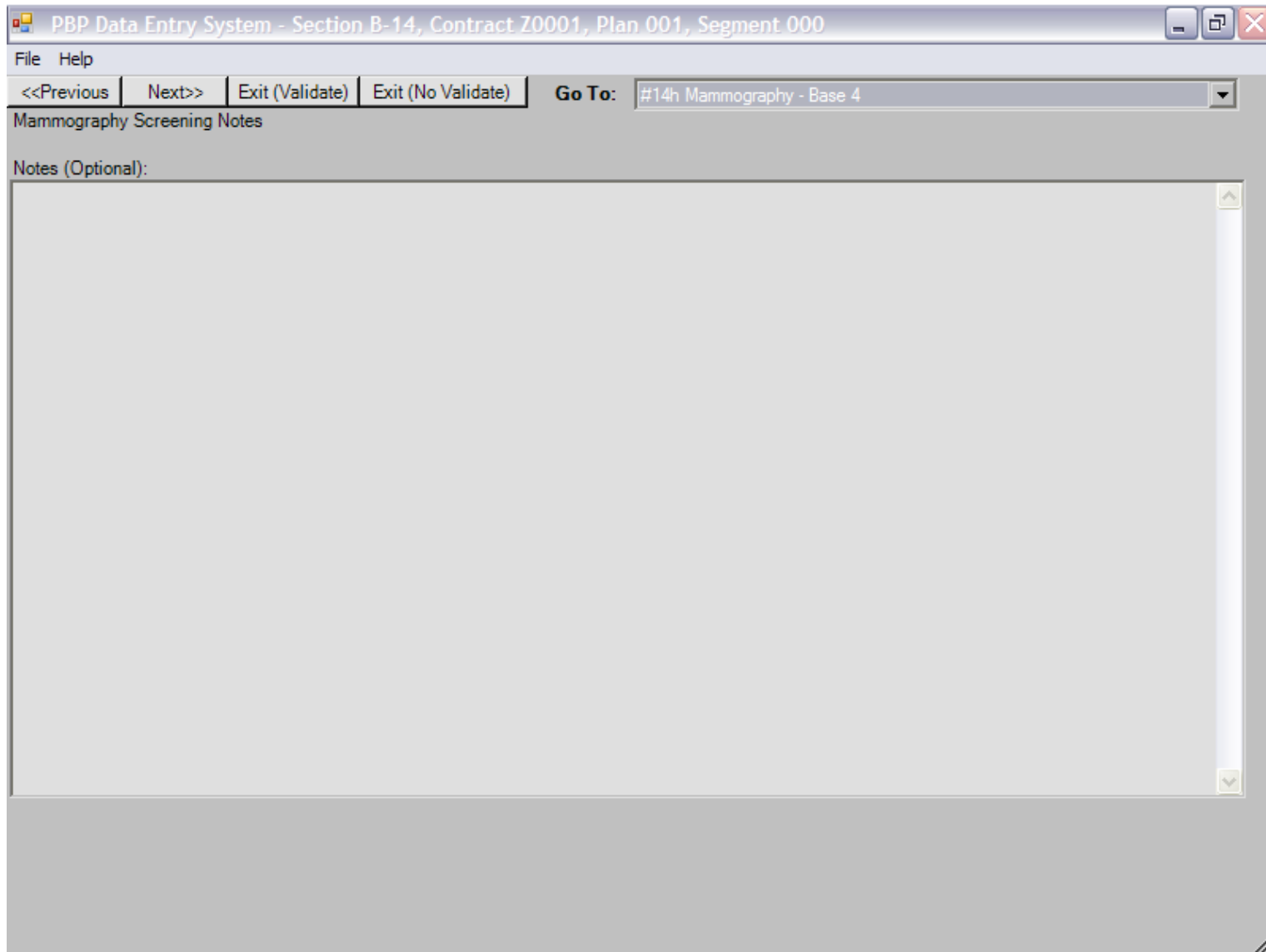
Indicate Minimum Copayment for a separate office visit:

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

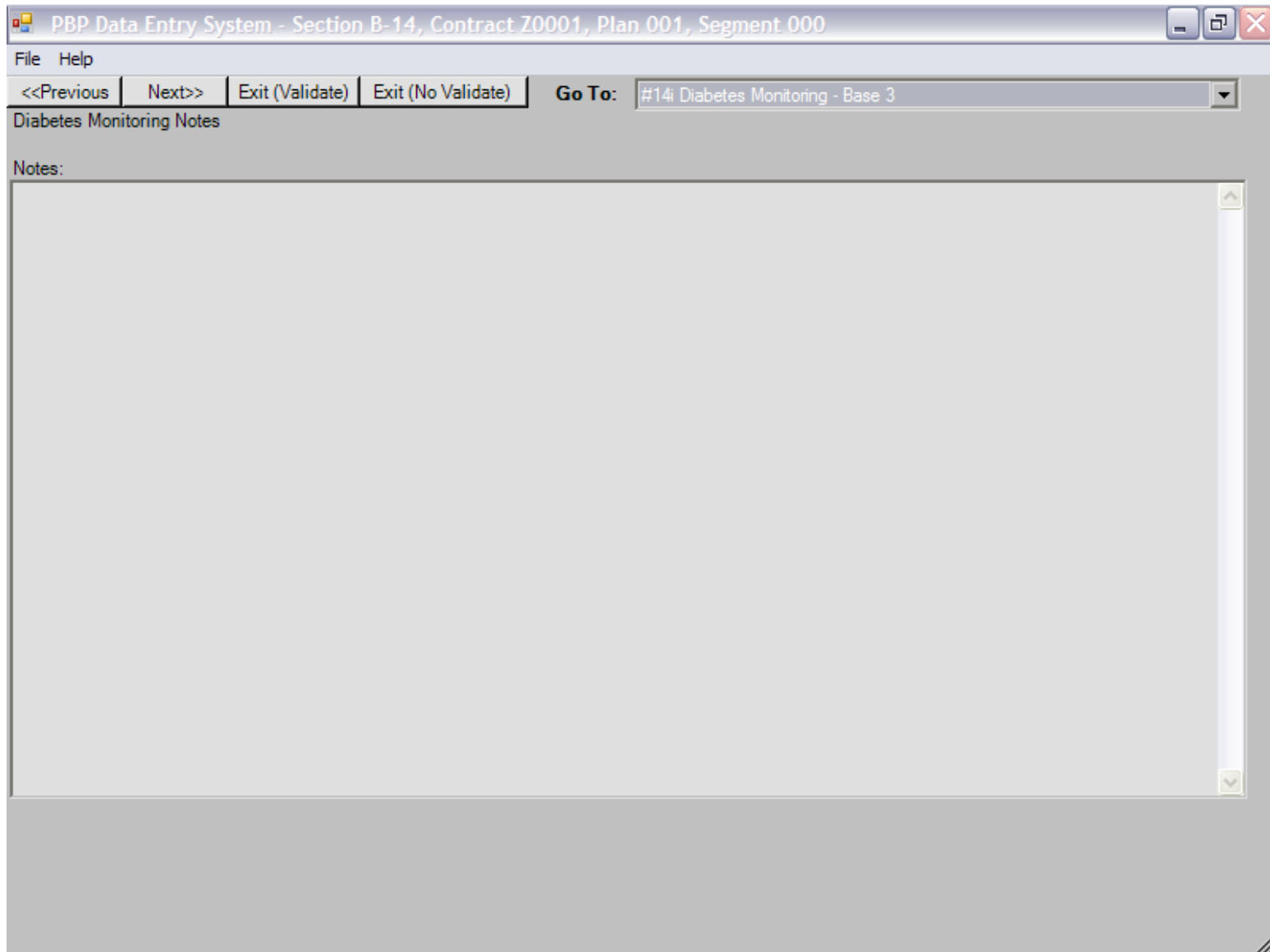
Indicate Minimum Copayment for a separate office visit:

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

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14j Nutrition Therapy - 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 –14J – NUTRITION THERAPY FOR DIABETES AND RENAL DISEASE – 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: #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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14j Nutrition Therapy - Base 3

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

File Help

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

File Help

<<Previous    Next>>    Exit (Validate)    Exit (No Validate)    **Go To:** #15 Medicare Part B Rx Drugs - 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 Part B  
Chemotherapy Drugs:

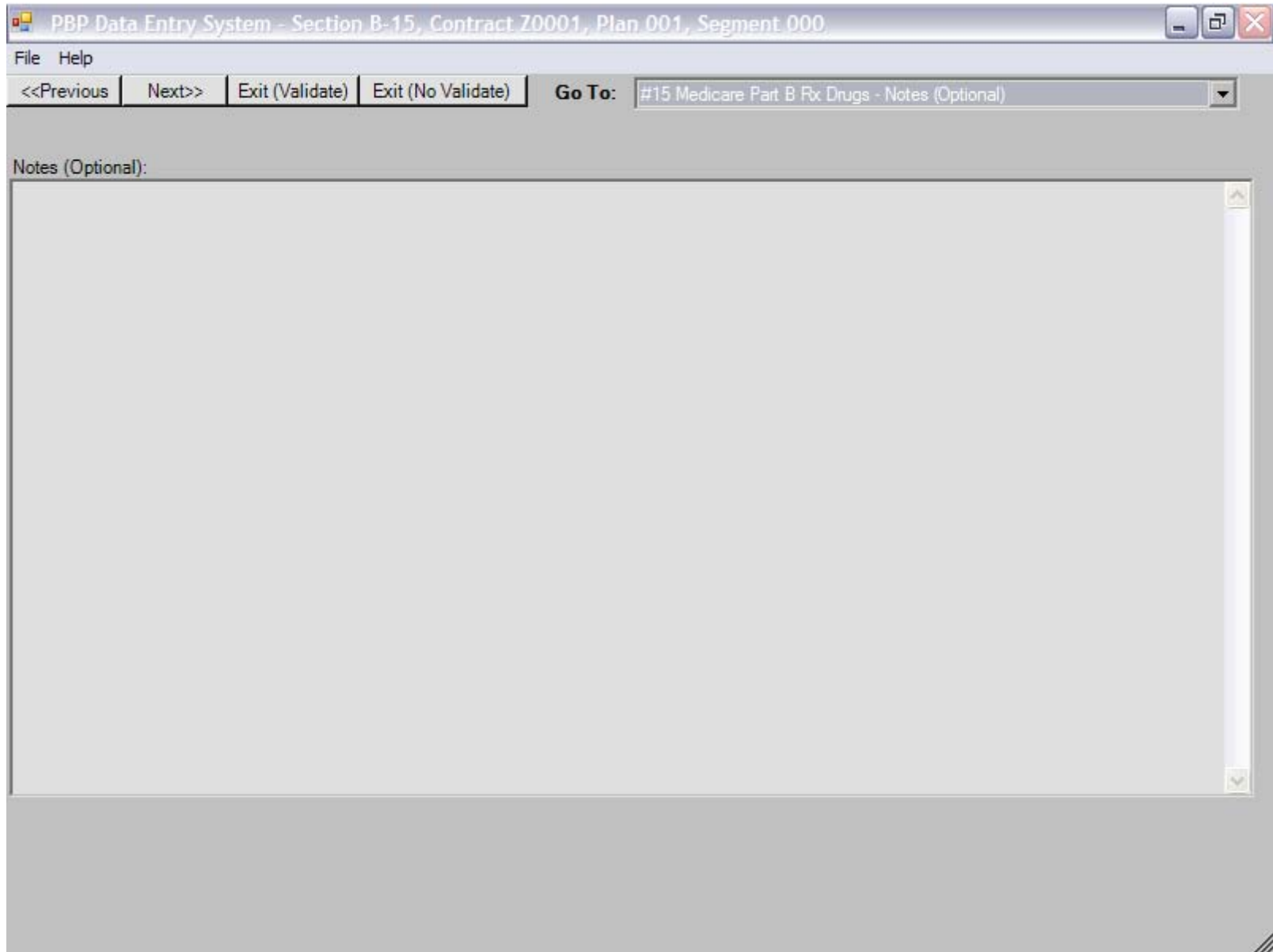
Indicate Maximum Copayment Amount for Medicare Part B  
Chemotherapy Drugs:

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)**





B – 15 – PART C HOME INFUSION DRUGS

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #15 Part C Home Infusion Bundled Services

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 Copayment for Home Infusion bundled services?

Yes  
 No

Indicate Minimum Copayment amount for Home Infusion bundled services:

Indicate Maximum Copayment amount for Home Infusion bundled services:

Is there an enrollee Coinsurance for Home Infusion bundled services?

Yes  
 No

Indicate Minimum Coinsurance percentage for Home Infusion bundled services:

Indicate Maximum Coinsurance percentage 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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #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 B – 16A – PREVENTIVE DENTAL – BASE 2 SCREEN

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #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 B – 16A – PREVENTIVE DENTAL – BASE 3 SCREEN

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

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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

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

File Help

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

Indicate Minimum Coinsurance percentage for Oral Exams: <input type="text"/>	Indicate Minimum Coinsurance percentage for Dental X-Rays: <input type="text"/>
Indicate Maximum Coinsurance percentage for Oral Exams: <input type="text"/>	Indicate Maximum Coinsurance percentage for Dental X-Rays: <input type="text"/>
Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning): <input type="text"/>	Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No
Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning): <input type="text"/>	Indicate Deductible Amount: <input type="text"/>
Indicate Minimum Coinsurance percentage for Fluoride Treatment: <input type="text"/>	
Indicate Maximum Coinsurance percentage for Fluoride Treatment: <input type="text"/>	

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

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

File Help

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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**

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #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 B – 16B – COMPREHENSIVE DENTAL – BASE 1 SCREEN

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

File Help

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

Select type of benefit for Diagnostic Services:

Mandatory  
 Optional

Is this benefit unlimited for Non-routine Services?

Yes  
 No, indicate number

Is this benefit unlimited for Diagnostic Services?

Yes  
 No, indicate number

Indicate number of visits for Non-routine Services:

Indicate number of visits for Diagnostic Services:

Select the Non-routine Services periodicity:

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

Select the Diagnostic Services periodicity:

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



**SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 2 SCREEN**

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

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

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

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

File Help

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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

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

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate 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

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

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

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

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

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

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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

PBP Data Entry System - Section B-17, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #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 B – 17A – EYE EXAMS – BASE 2 SCREEN

PBP Data Entry System - Section B-17, Contract Z0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Deductible?  Yes  No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-17, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #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 B – 17B – EYE WEAR – BASE 1 SCREEN

PBP Data Entry System - Section B-17, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #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 B – 17B – EYE WEAR – BASE 2 SCREEN

PBP Data Entry System - Section B-17, Contract Z0001, Plan 001, Segment 000

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Select type of benefit for Eye Glass Lenses:  
 Mandatory  
 Optional

Select type of benefit for Eye Glass Frames:  
 Mandatory  
 Optional

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

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

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

Indicate quantity for Eye Glass Frames:

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

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

PBP Data Entry System - Section B-17, Contract Z0001, Plan 001, Segment 000

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<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select the Maximum Plan Benefit Coverage type:</p> <p><input type="radio"/> Covered under Eye Exams Category 17a <input type="radio"/> Plan-specified amount per period</p> <p>Do you offer a Combined Max Plan Benefit Coverage Amount for all Eye Wear?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Combined Maximum Plan Benefit Coverage amount:</p> <input type="text"/> <p>Select the Combined Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p>	<p>Select the type of eye wear with Individual Max Plan Benefit Coverage amount:</p> <p><input type="checkbox"/> Contact Lenses <input type="checkbox"/> Eye Glasses (Lenses and Frames) <input type="checkbox"/> Eye Glass Lenses <input type="checkbox"/> Eye Glass Frames <input type="checkbox"/> Upgrades</p> <p>Indicate Max Plan Benefit Coverage amount for Contact Lenses:</p> <input type="text"/> <p>Select the Individual Maximum Plan Benefit Coverage periodicity for Contact Lenses:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p>	<p>Indicate Max Plan Benefit Coverage amount for Eye Glasses (Lenses and Frames):</p> <input type="text"/> <p>Select the Individual Maximum Plan Benefit Coverage periodicity for Eye Glasses (Lenses and Frames):</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p> <p>Indicate Max Plan Benefit Coverage amount for Eye Glass Lenses:</p> <input type="text"/> <p>Select the Individual Maximum Plan Benefit Coverage periodicity for Eye Glasses Lenses:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p>	<p>Indicate Max Plan Benefit Coverage amount for Eye Glass Frames:</p> <input type="text"/> <p>Select the Individual Maximum Plan Benefit Coverage periodicity for Eye Glasses Frames:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p> <p>Indicate Max Plan Benefit Coverage amount for Upgrades:</p> <input type="text"/> <p>Select the Individual Maximum Plan Benefit Coverage periodicity for Upgrades:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p>
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SECTION B – 17B – EYE WEAR – BASE 4 SCREEN

PBP Data Entry System - Section B-17, 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 Eye Exams Category 17a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage for Medicare-covered Benefits:

Indicate Coinsurance percentage for Contact Lenses:

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

Indicate Coinsurance percentage for Eye Glass Lenses:

Indicate Coinsurance percentage for Eye Glass Frames:

Indicate Coinsurance percentage for Upgrades:

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

PBP Data Entry System - Section B-17, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous    Next>>    Exit (Validate)    Exit (No Validate)    **Go To:** #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 B – 17B – EYE WEAR – BASE 6 SCREEN**

PBP Data Entry System - Section B-17, Contract Z0001, Plan 001, Segment 000

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

Eye Wear Notes

Notes (Optional):

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

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

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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:

Routine Hearing Tests  
 Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Tests:

Mandatory  
 Optional

Is this benefit unlimited for Routine Hearing Tests?

Yes  
 No, indicate number

Indicate number for Routine Hearing Tests:

Select Routine Hearing Tests periodicity:

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

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

Mandatory  
 Optional

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

Yes  
 No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

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

SECTION B – 18A – HEARING EXAMS – BASE 2 SCREEN

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

File Help

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

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Plan Benefit Coverage amount: <input type="text"/></p> <p>Select the Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p> <p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Deductible Amount: <input type="text"/></p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Enrollee Out-of-Pocket Cost amount: <input type="text"/></p> <p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe</p>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits: <input type="text"/></p> <p>Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits: <input type="text"/></p> <p>Indicate Minimum Coinsurance percentage for Routine Hearing Tests: <input type="text"/></p> <p>Indicate Maximum Coinsurance percentage for Routine Hearing Tests: <input type="text"/></p> <p>Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid: <input type="text"/></p> <p>Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid: <input type="text"/></p>
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SECTION B – 18A – HEARING EXAMS – BASE 3 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: #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:

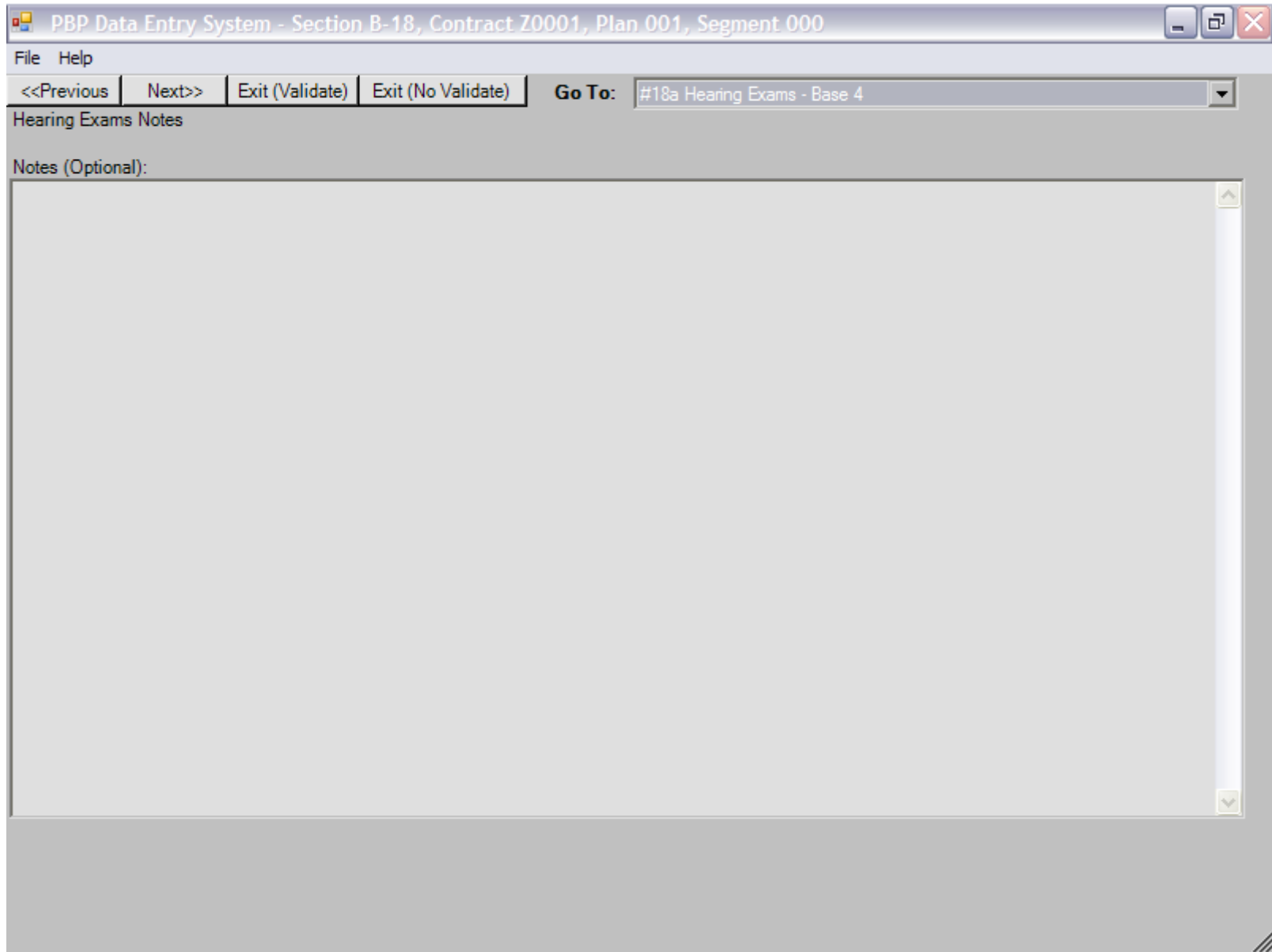
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:

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

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

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

Mandatory  
 Optional

Select the Maximum Plan Benefit Coverage type:

Covered under Hearing Exams Category - 18a  
 Plan-specified amount per period

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

Yes  
 No, indicate number

Indicate Maximum Plan Benefit Coverage amount:

Indicate quantity for Hearing Aids - Over the Ear:

Indicate Maximum Plan Benefit Coverage periodicity:

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

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount: [text box]

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): [text box]

Indicate Coinsurance percentage for Hearing Aids - Inner Ear: [text box]

Indicate Coinsurance percentage for Hearing Aids - Outer Ear: [text box]

Indicate Coinsurance percentage for Hearing Aids - Over the Ear: [text box]

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 Copayment amount per Hearing Aid - Over the Ear:

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

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

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Copayment amount per Hearing Aid - Inner Ear:

Indicate Deductible Amount:

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:

**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 – OUTPAT 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 – OUTPAT DRUGS – 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 - Base 2

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 – OUTPAT DRUGS – BASE 4 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 4

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Notes (Optional)

Outpatient Drugs Notes

Notes (Optional):

SECTION B – 20 – OUTPAT DRUGS – GROUP 1- 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 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 – OUTPAT 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: <input type="text"/>	Indicate Copayment amount for Group 1 Designated Retail Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 1 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 1 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 1 HMO-Owned Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 1 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 1 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 1 Mail Order: <input type="text"/>	Up to a _____ day supply covered for Group 1 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 1 Other: <input type="text"/>	Indicate Copayment amount for Group 1 Other: <input type="text"/>	Up to a _____ day supply covered for Group 1 Other: <input type="text"/>

SECTION B – 20 – OUTPAT DRUGS – GROUP 2- 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 2 - Base 1

Select a label for Group 2:    Indicate Maximum Plan Benefit Coverage annual amount for Group 2:

Select the drug type(s) covered for Group 2:  
 Generic   Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:   
 Preferred Brand  
 Brand

Is there a Maximum Plan Benefit Coverage amount for Group 2?  
 Yes   Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:   
 No

Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:  
 Annually   Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:   
 Semi-annually  
 Quarterly  
 Monthly  
 Per Prescription   Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:   
 Other, describe  
  
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

File Help

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

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: <input type="text"/>	Indicate Copayment amount for Group 2 Designated Retail Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 2 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 2 for HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 2 HMO-Owned Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 2 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 2 for Mail Order: <input type="text"/>	Indicate Copayment amount for Group 2 Mail Order: <input type="text"/>	Up to a ____ day supply covered for Group 2 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 2 for Other: <input type="text"/>	Indicate Copayment amount for Group 2 Other: <input type="text"/>	Up to a ____ day supply covered for Group 2 Other: <input type="text"/>



SECTION B – 20 – OUTPAT 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:

Indicate Maximum Plan Benefit Coverage annual amount for Group 3:

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

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

Is there a Maximum Plan Benefit Coverage amount for Group 3?  
 Yes  
 No

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3:

Indicate Maximum Plan Benefit Coverage Group 3 periodicity:  
 Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Per Prescription  
 Other, describe

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 – OUTPAT 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: <input type="text"/>	Indicate Copayment amount for Group 3 Designated Retail Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 3 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 3 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 3 HMO-Owned Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 3 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 3 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 3 Mail Order: <input type="text"/>	Up to a ____ day supply covered for Group 3 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 3 Other: <input type="text"/>	Indicate Copayment amount for Group 3 Other: <input type="text"/>	Up to a ____ day supply covered for Group 3 Other: <input type="text"/>

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

Select a label for Group 4:

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

Indicate Maximum Plan Benefit Coverage annual amount for Group 4:

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

Is there a Maximum Plan Benefit Coverage amount for Group 4?  
 Yes  
 No

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4:

Indicate Maximum Plan Benefit Coverage Group 4:  
 Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Per Prescription  
 Other, describe

Indicate Maximum Plan Benefit Coverage monthly amount for Group 4:

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

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

SECTION B – 20 – OUTPAT DRUGS – GROUP 4- 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 4 - Base 2

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: <input type="text"/>	Indicate Copayment amount for Group 4 Designated Retail Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 4 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 4 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 4 HMO-Owned Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 4 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 4 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 4 Mail Order: <input type="text"/>	Up to a _____ day supply covered for Group 4 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 4 Other: <input type="text"/>	Indicate Copayment amount for Group 4 Other: <input type="text"/>	Up to a _____ day supply covered for Group 4 Other: <input type="text"/>

SECTION B – 20 – OUTPAT DRUGS – GROUP 5- 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 5 - Base 1

Select a label for Group 5:

Indicate Maximum Plan Benefit Coverage annual amount for Group 5:

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

Generic

Preferred Brand

Brand

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

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

Yes

No

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:

Indicate Maximum Plan Benefit Coverage for Group 5 periodicity:

Annually

Semi-annually

Quarterly

Monthly

Per Prescription

Other, describe

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 – OUTPAT DRUGS – GROUP 5- 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 5 - Base 2

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: <input type="text"/>	Indicate Copayment amount for Group 5 Designated Retail Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 5 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 5 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 5 HMO-Owned Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 5 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 5 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 5 Mail Order: <input type="text"/>	Up to a _____ day supply covered for Group 5 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 5 Other: <input type="text"/>	Indicate Copayment amount for Group 5 Other: <input type="text"/>	Up to a _____ day supply covered for Group 5 Other: <input type="text"/>

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 Copayment for Home Infusion bundled services?

Yes  
 No

Indicate Minimum Copayment amount for Home Infusion bundled services:

Indicate Maximum Copayment amount for Home Infusion bundled services:

Is there an enrollee Coinsurance for Home Infusion bundled services?

Yes  
 No

Indicate Minimum Coinsurance percentage for Home Infusion bundled services:

Indicate Maximum Coinsurance percentage for Home Infusion bundled services: