

Section B - 1A - Inpatient Hospital-Acute – Base 1 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

Select enhanced benefits:

Additional Days  
 Non-Medicare-covered Stay  
 Upgrades

Select type of benefit for Additional Days:

Mandatory  
 Optional

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

Indicate number of Additional Days per benefit period:

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

Mandatory  
 Optional

Select type of benefit for Upgrades:

Mandatory  
 Optional

Section B - 1A - Inpatient Hospital-Acute – Base 2 Screen

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

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

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

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

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

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

Is there an enrollee Coinsurance?

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

Indicate Coinsurance percentage for the Medicare-covered stay:

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:

Section B - 1A - Inpatient Hospital-Acute – Base 3 Screen

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

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Lifetime Reserve Begin Day Interval 1:	Lifetime Reserve End Day Interval 1:
<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

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

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Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<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 - 1A - Inpatient Hospital-Acute – Base 5 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 5

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

Yes  
 No

Indicate Coinsurance percentage for the Non-Medicare-covered stay:

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:  Begin Day Interval 1:  End Day Interval 1:

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

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

Indicate Coinsurance percentage for Upgrades:

Section B - 1A - Inpatient Hospital-Acute – Base 6 Screen

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

File Help

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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

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

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

Zero (No 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 - 1A - Inpatient Hospital-Acute – Base 8 Screen

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

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Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)

One

Two

Three

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

Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<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 9 Screen

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

File Help

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

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

Yes  
 No

Indicate Copayment amount for the Non-Medicare-covered stay:  
[ ]

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

Indicate Copayment amount for Upgrades per stay:  
[ ]

Indicate Copayment amount for Upgrades per day:  
[ ]

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

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

Section B - 1A - Inpatient Hospital-Acute – Base 10 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 10

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

Yes  
 No

Notes (Optional):

Tiered Cost Sharing for Medical Benefits is not allowed. Cost sharing tiers may not be based on the provider group an enrollee selects within an MA plan. (See Chapter 4, Section 10.10). Basing a plan's cost sharing on the physician group a member selects has the effect of creating multiple MA plans within one MA plan, and therefore conflicts with the uniformity of premium and cost sharing requirement (see 42 CFR section 422.100(d)(2)).

Section B - 1A - Inpatient Hospital-Acute (B Only) – Base 1 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute (B Only) - Base 1

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

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

Select Maximum Plan Benefit Coverage periodicity:  
 Every year  
 Every six months  
 Every three months

Indicate number of days per period:

Select the days periodicity:  
 Every year  
 Every six months  
 Every three months

Section B - 1A - Inpatient Hospital-Acute (B Only) – Base 2 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute (B Only) - Base 2

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 year  
 Every six months  
 Every three months

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	Begin Day Interval	End Day Interval
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 - 1A - Inpatient Hospital-Acute (B Only) – Base 3 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute (B Only) - Base 3

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount per stay:

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

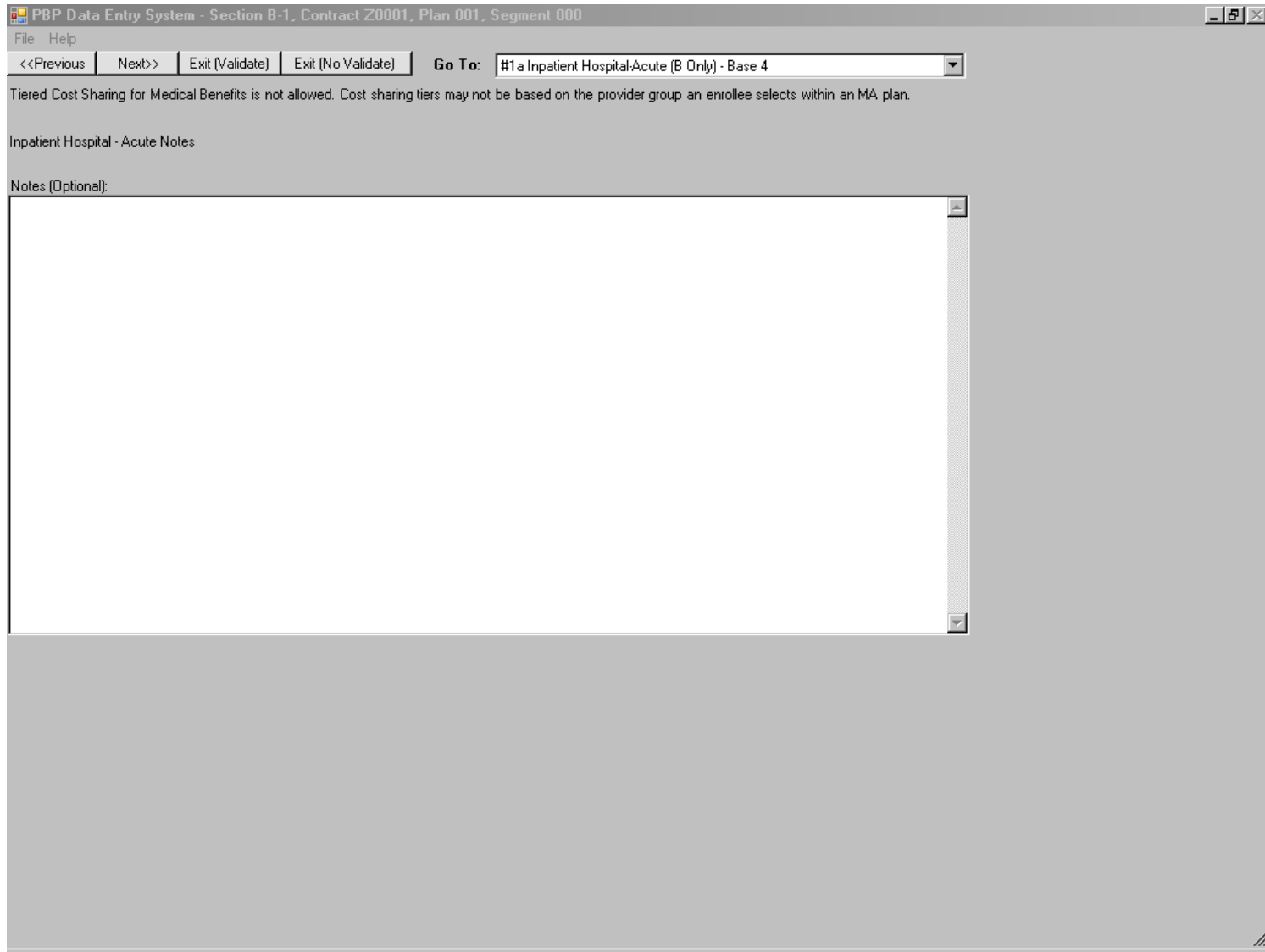
Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<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"/>

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 Hospital Psychiatric – Base 1 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - 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:

Additional Days  
 Non-Medicare-covered Stay

Select type of benefit for Additional Days:

Mandatory  
 Optional

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

Indicate number of Additional Days per benefit period:

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

Mandatory  
 Optional

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

Yes  
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Every year  
 Every six months  
 Every three months

Section B – 1B - Inpatient Hospital Psychiatric – Base 2 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<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 Hospital Psychiatric – Base 3 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 3

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 – 1B - Inpatient Hospital Psychiatric – Base 4 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 4

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:
<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 Hospital Psychiatric – Base 5 Screen

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

File Help

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

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:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

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:

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

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

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

Go To: #1b Inpatient Hospital Psychiatric - Base 6

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	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Section B – 1B - Inpatient Hospital Psychiatric – Base 7 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 7

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 Hospital Psychiatric – Base 8 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 8

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"/>

Section B – 1B - Inpatient Hospital Psychiatric – Base 9 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 9

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:

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 Hospital Psychiatric – Base 10 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 10

Tiered Cost Sharing for Medical Benefits is not allowed. Cost sharing tiers may not be based on the provider group an enrollee selects within an MA plan. (See Chapter 4, Section 10.10). Basing a plan's cost sharing on the physician group a member selects has the effect of creating multiple MA plans within one MA plan, and therefore conflicts with the uniformity of premium and cost sharing requirement (see 42 CFR section 422.100(d)(2)).

Inpatient Psychiatric Hospital Notes

Notes (Optional):



Section B – 1B - Inpatient Hospital Psychiatric (B Only) – Base 1 Screen

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

File Help

<<Previous Next>> Exit [Validate] Exit [No Validate] Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 1

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 year  
 Every six months  
 Every three months

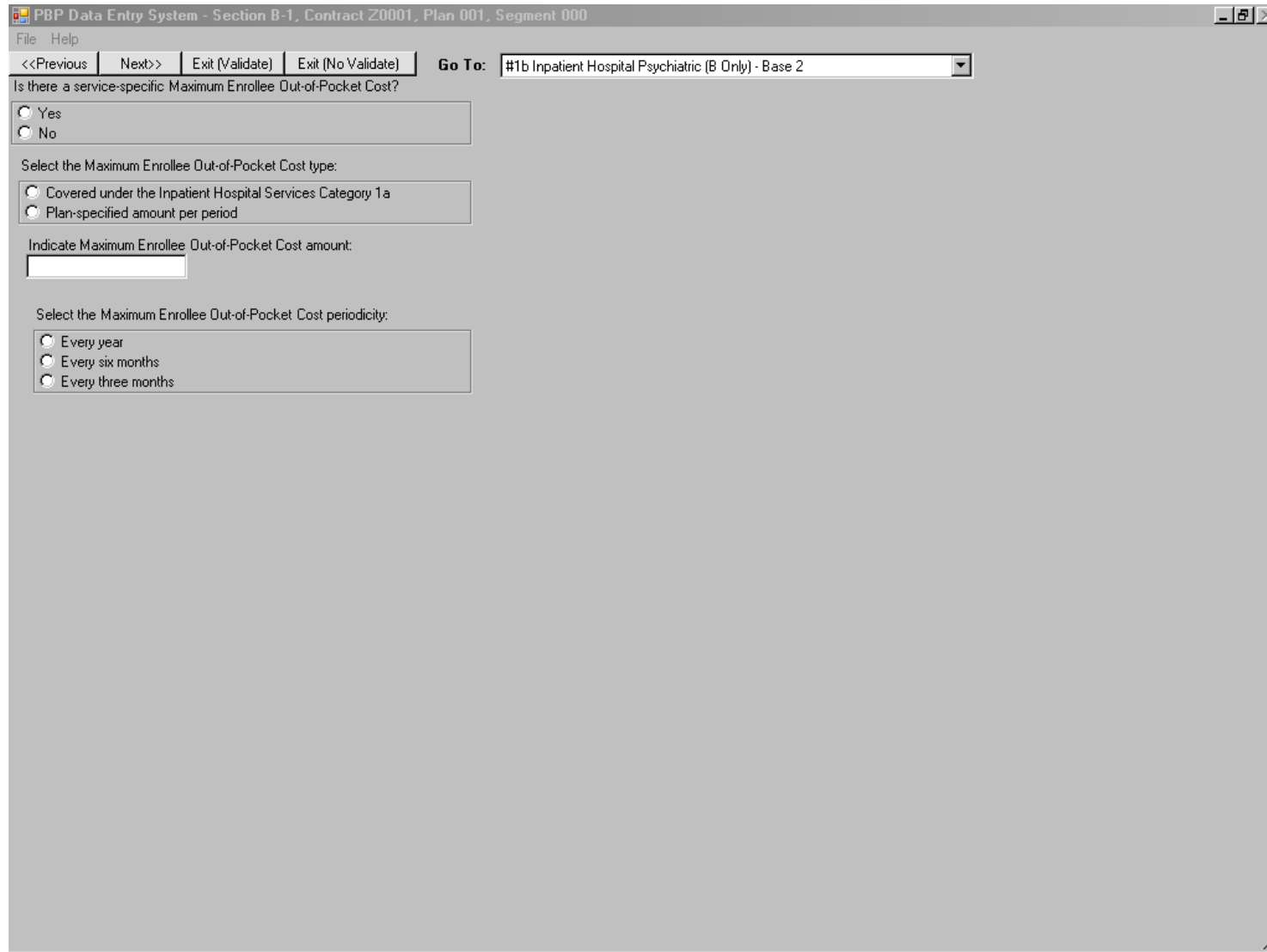
Select the Maximum Plan Benefit Coverage type:  
 Covered under Inpatient Hospital Services Category 1a  
 Plan-specified amount per period

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

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:  
 Every year  
 Every six months  
 Every three months

Section B – 1B - Inpatient Hospital Psychiatric (B Only) – Base 2 Screen



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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric (B Only) - 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 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 year  
 Every six months  
 Every three months

Section B – 1B - Inpatient Hospital Psychiatric (B Only) – Base 3 Screen

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

File Help

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

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

Is there an enrollee Coinsurance?

Yes

No

Indicate Coinsurance percentage per stay:

\_\_\_\_\_

Indicate the number of day intervals for the stay:

Zero (No Coinsurance per Day)

One

Two

Three

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

Section B – 1B - Inpatient Hospital Psychiatric (B Only) – Base 4 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 4

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per stay:  
[ ]

Indicate the number of day intervals for the stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

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

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

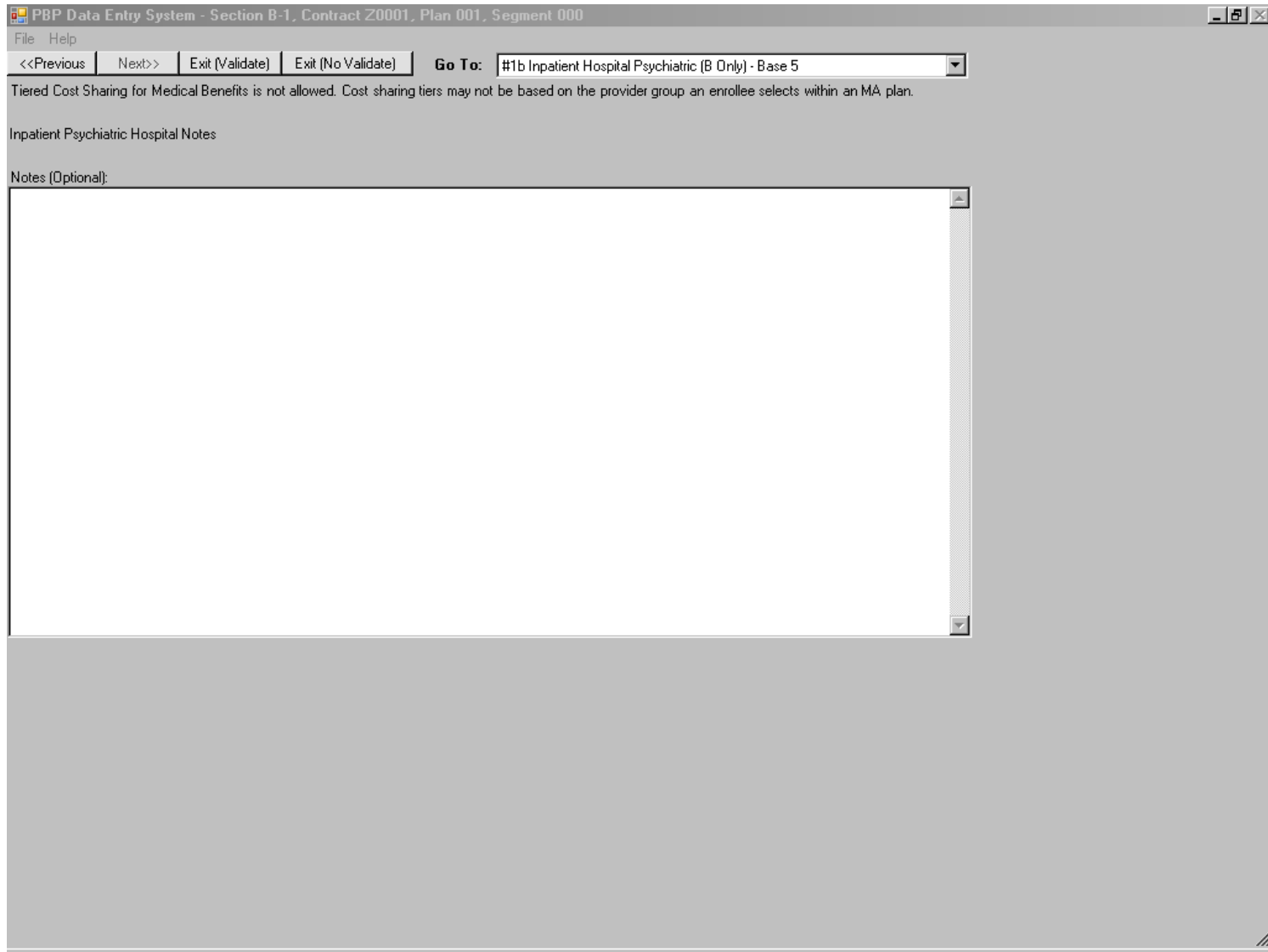
Enrollee must receive Authorization from one or more of the following:

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

Is a referral required for Inpatient Psychiatric Hospital Services?

Yes  
 No

Section B – 1B - Inpatient Hospital Psychiatric (B Only) – Base 5 Screen



Section B – 2 - SNF – Base 1 Screen

PBP Data Entry System - Section B-2, Contract 20001, 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 year  
 Every six months  
 Every three months

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:
<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 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:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

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:
<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 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:

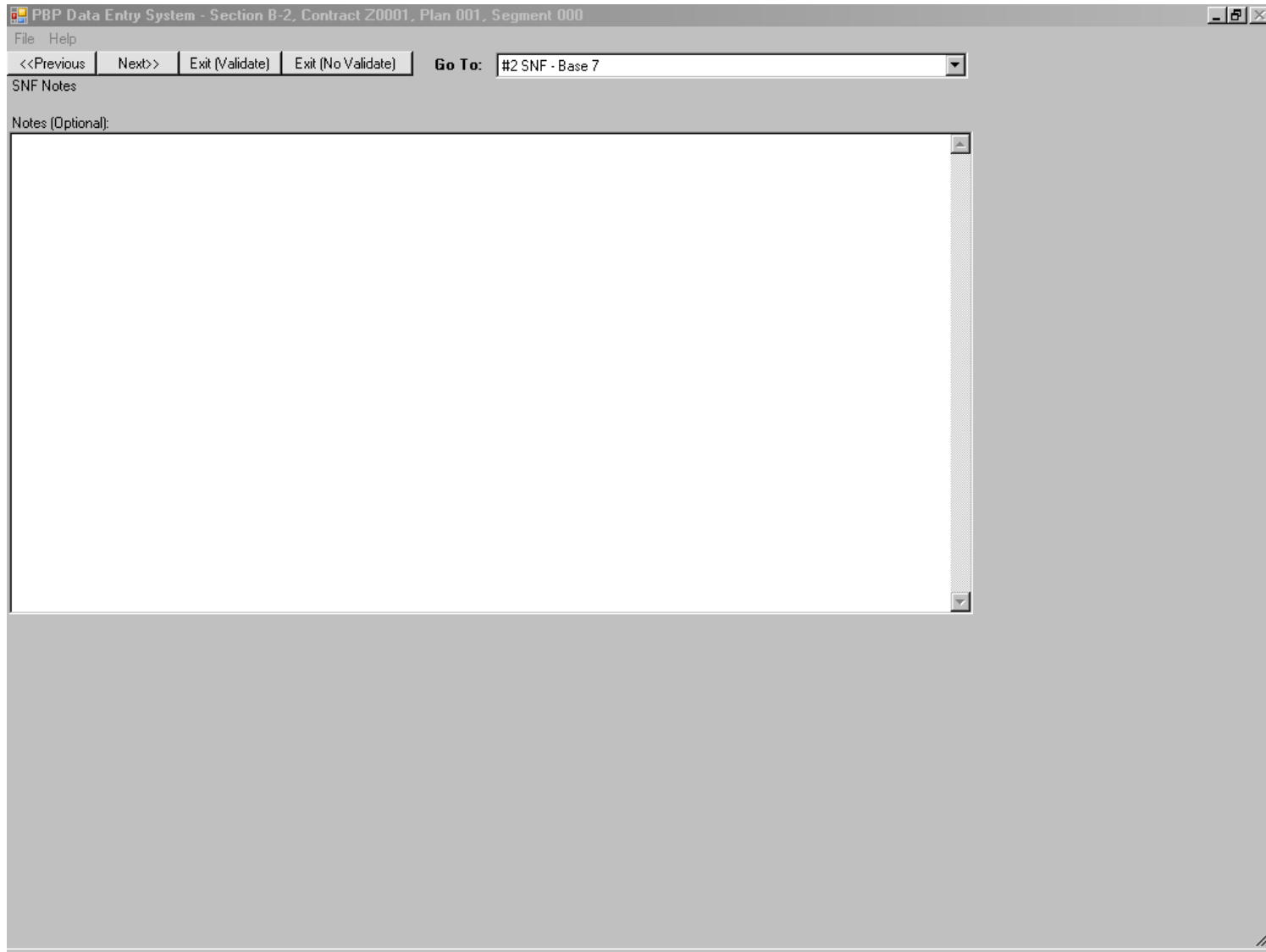
Enrollee must receive Authorization from one or more of the following:

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

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 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 year  
 Every six months  
 Every three months

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 year  
 Every six months  
 Every three months

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 year  
 Every six months  
 Every three months

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:
<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 (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	Begin Day Interval	End Day Interval
[ ]	[ ]	[ ]
[ ]	[ ]	[ ]
[ ]	[ ]	[ ]

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):

[Empty text area]



Section B – 3 – Cardiac and Pulmonary Rehabilitation Services – 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 Cardiac and Pulmonary Rehabilitation Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

Select enhanced benefit:

Additional Cardiac Rehabilitation Services  
 Additional Intensive Cardiac Rehabilitation Services  
 Additional Pulmonary Rehabilitation Services

Select type of benefit for Additional Cardiac Rehabilitation Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Cardiac Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Cardiac Rehabilitation Services:

\_\_\_\_\_

Select the Additional Cardiac Rehabilitation Services periodicity:

Every year  
 Every six months  
 Every three months

Select type of benefit for Additional Intensive Cardiac Rehabilitation Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Intensive Cardiac Rehabilitation Services:

\_\_\_\_\_

Select the Additional Intensive Cardiac Rehabilitation Services periodicity:

Every year  
 Every six months  
 Every three months

Select type of benefit for Additional Pulmonary Rehabilitation Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Pulmonary Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Pulmonary Rehabilitation Services:

\_\_\_\_\_

Select the Additional Pulmonary Rehabilitation Services periodicity:

Every year  
 Every six months  
 Every three months

Section B – 3 – Cardiac and Pulmonary Rehabilitation Services – 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 Cardiac and Pulmonary Rehabilitation Services - Base 2

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 year  
 Every six months  
 Every three months

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?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services:

Indicate Maximum Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services:

Indicate Minimum Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services:

Indicate Maximum Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services:

Indicate Minimum Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:

Indicate Maximum Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:

Indicate Minimum Coinsurance percentage for Additional Cardiac Rehabilitation Services:

Indicate Maximum Coinsurance percentage for Additional Cardiac Rehabilitation Services:

Indicate Minimum Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:

Indicate Maximum Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:

Indicate Minimum Coinsurance percentage for Additional Pulmonary Rehabilitation Services:

Indicate Maximum Coinsurance percentage for Additional Pulmonary Rehabilitation Services:

Section B – 3 – Cardiac and Pulmonary Rehabilitation Services – Base 3 Screen

Section B – 3 – Cardiac and Pulmonary Rehabilitation Services – Base 4 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 Cardiac and Pulmonary Rehabilitation 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

Cardiac and Pulmonary Rehabilitation Programs Notes

Notes (Optional):

Section B – 4A – Emergency Care – Base 1 Screen

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

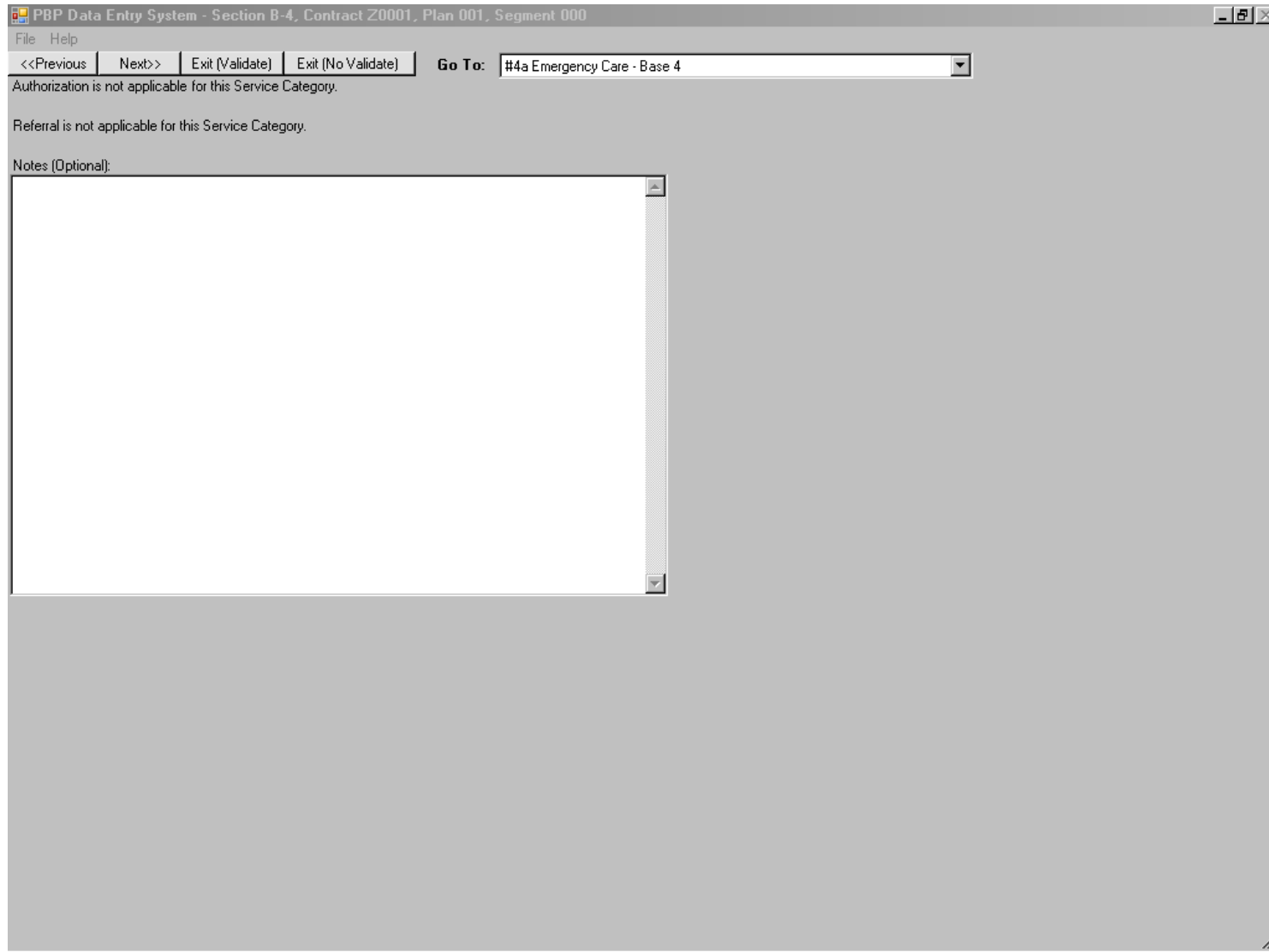
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?  
 Yes  
 No

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 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: #4b Urgently Needed Care - 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:

Indicate Minimum Enrollee Out-of-Pocket Cost periodicity:

Every year  
 Every six months  
 Every three months

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:

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Select the Maximum Enrollee Out-of-Pocket Cost type:  
 Covered under Emergency Care Service Category 4a  
 Plan-specified amount per period

Section B – 4B – Urgently Needed 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: #4b Urgently Needed Care - 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:

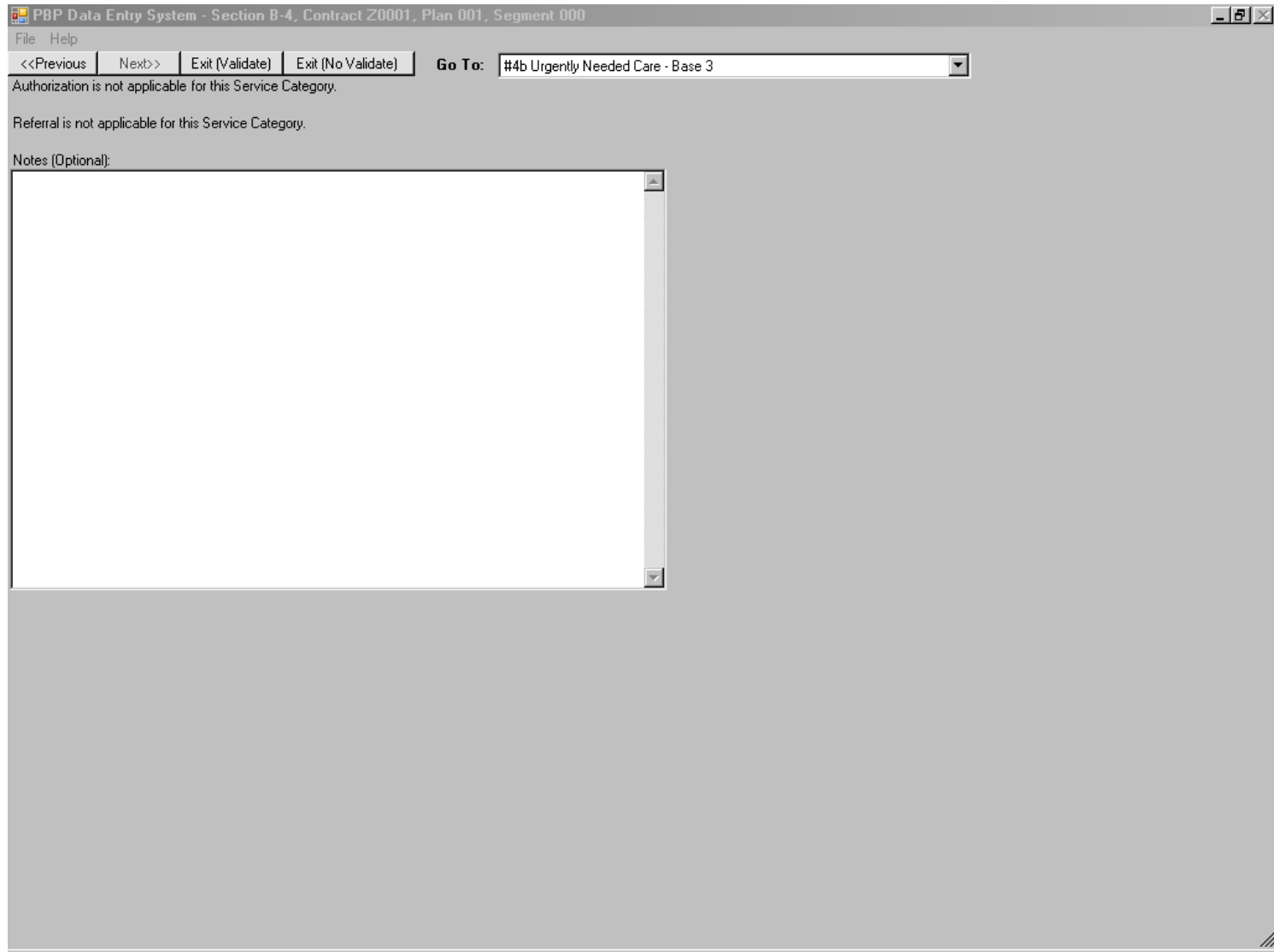
Indicate Maximum Copayment amount for Medicare-covered Benefits:

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 Care – 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 Hospitalization - 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 year  
 Every six months  
 Every three months

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 Hospitalization - 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 Services – 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 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 year  
 Every six months  
 Every three months

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Section B – 6 – Home Health Services – 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 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:

Section B – 6 – Home Health Services – 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 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 Home Health Services?

Yes

No

Notes (Optional):

[Large empty text area for notes]



Section B – 7A – Primary Care Physician 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: #7a Primary Care Physician Services - 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.

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

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 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 year  
 Every six months  
 Every three months

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 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: #7a Primary Care Physician Services - 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

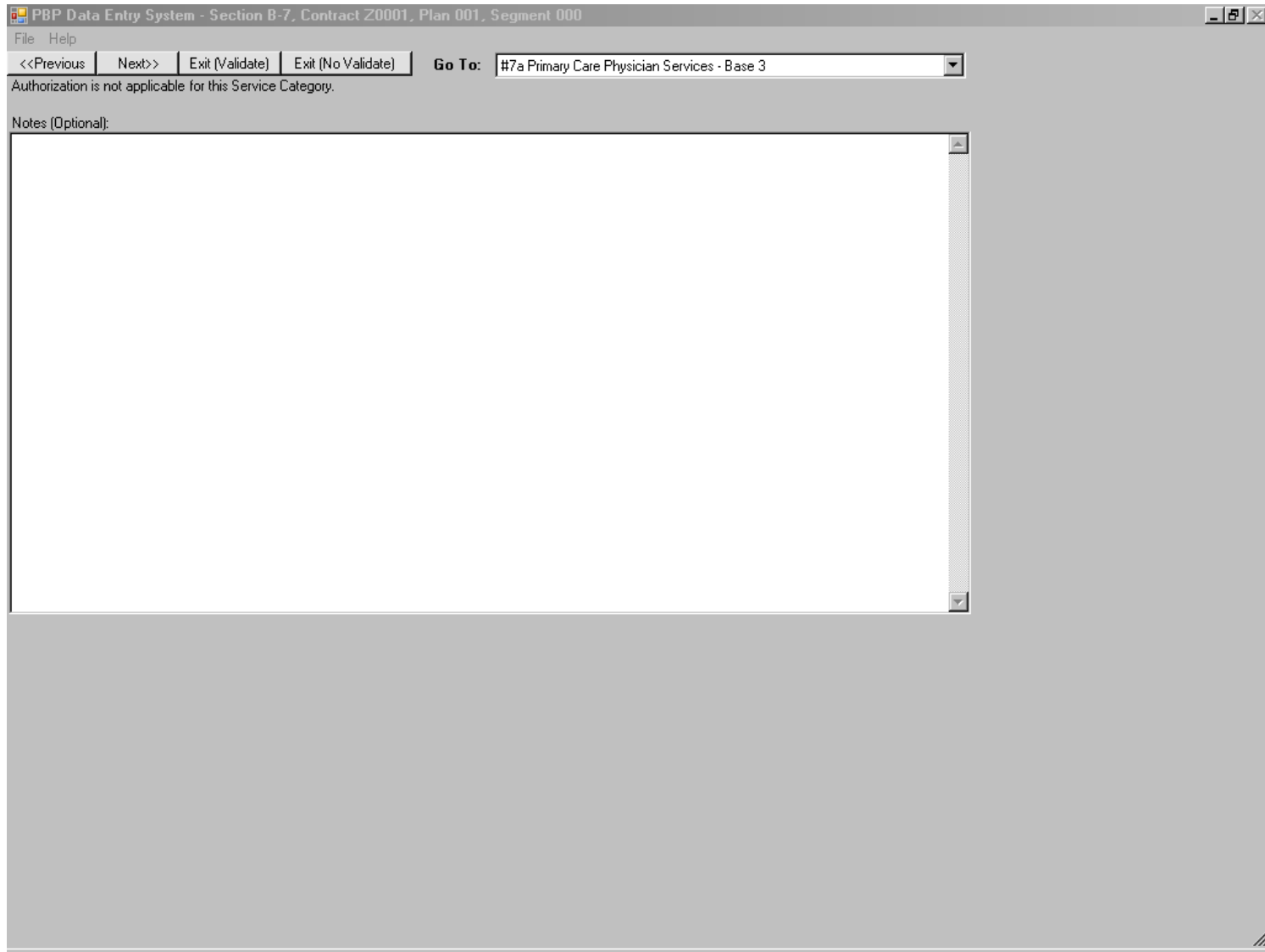
Indicate the Minimum Coinsurance percentage for In-Area, Network Urgent Care services:

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 Services – 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 Routine Care periodicity:

Every year  
 Every six months  
 Every three months

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

\_\_\_\_\_

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:

\_\_\_\_\_

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 year  
 Every six months  
 Every three months

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

Every year  
 Every six months  
 Every three months

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

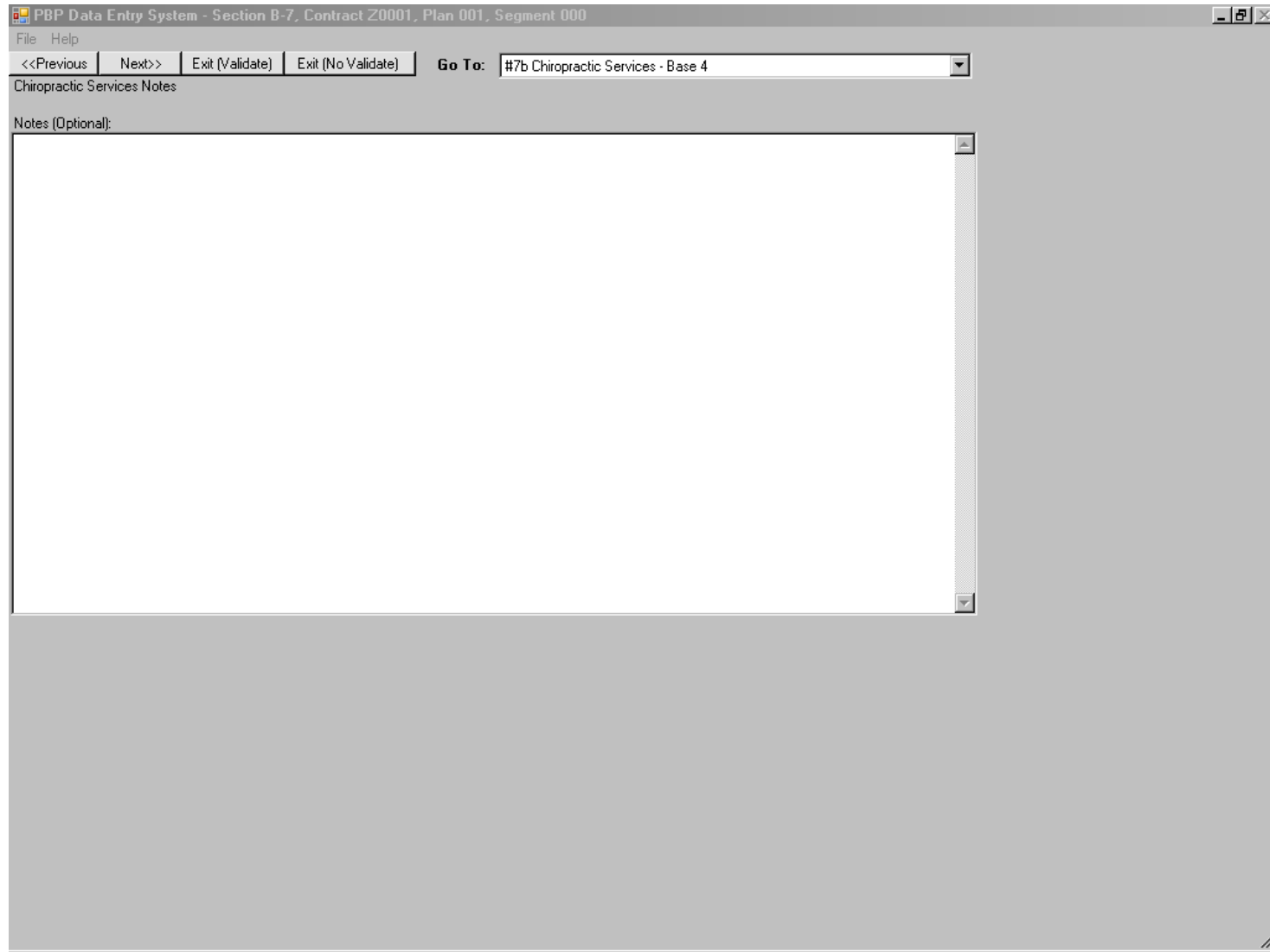
Other, describe

Is a referral required for Chiropractic Services?

Yes

No

Section B – 7B – Chiropractic Services – Base 4 Screen



Section B – 7C – Occupational Therapy 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: #7c Occupational Therapy 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 year  
 Every six months  
 Every three months

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?

Yes  
 No

Indicate 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 Copayment amount per visit for Medicare-covered Benefits:



Section B – 7C – Occupational Therapy 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: #7c Occupational Therapy 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 Occupational Therapy Services?

Yes

No

Notes (Optional):

Section B – 7D – Physician Specialist 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: #7d Physician Specialist 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 year  
 Every six months  
 Every three months

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 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: #7d Physician Specialist 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 Physician Specialist Services?

Yes

No

Notes (Optional):

[Empty text area]

Section B – 7E – Mental Health Specialty 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 Specialty 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 year

Every six months

Every three months

Section B – 7E – Mental Health Specialty 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 Specialty Services - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

Indicate minimum Coinsurance percentage for Medicare-covered Individual Sessions:  
[ ]

Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:  
[ ]

Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:  
[ ]

Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:  
[ ]

Is there an enrollee Copayment?

Yes  
 No

Indicate minimum Copayment amount for Medicare-covered Individual Sessions:  
[ ]

Indicate maximum Copayment Amount for Medicare-covered Individual Sessions:  
[ ]

Indicate minimum Copayment amount for Medicare-covered Group Sessions:  
[ ]

Indicate maximum Copayment amount for Medicare-covered Group Sessions:  
[ ]

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

Section B – 7E – Mental Health Specialty Services – Base 3 Screen

*PBP 2012 Data Entry System Screens*

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 Specialty 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 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: #7f Podiatry Services - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

Select enhanced benefits:

Routine Footcare

Select type of benefit for Routine Footcare:

Mandatory  
 Optional

Is this benefit unlimited for Routine Footcare?

Yes  
 No

Indicate number of Routine Footcare visits:

Select the Routine Footcare periodicity:

Every year  
 Every six months  
 Every three months

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 year  
 Every six months  
 Every three months

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 year  
 Every six months  
 Every three months



Section B – 7F – Podiatry Services – Base 2 Screen

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

File Help

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

Is there an enrollee Coinsurance? <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: #7f Podiatry Services - Base 3

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

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

Is a referral required for Podiatrist Services?

Yes

No

Notes (Optional):

Section B – 7G – Other Health Care Professional – 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 Professional - 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 year  
 Every six months  
 Every three months

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 Professional – 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 Professional - 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 year  
 Every six months  
 Every three months

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 minimum Coinsurance percentage for Medicare-covered Individual Sessions:  
[ ]

Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:  
[ ]

Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:  
[ ]

Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:  
[ ]

Is there an enrollee Copayment?

Yes  
 No

Indicate minimum Copayment amount for Medicare-covered Individual Sessions:  
[ ]

Indicate maximum Copayment amount for Medicare-covered Individual Sessions:  
[ ]

Indicate minimum Copayment amount for Medicare-covered Group Sessions:  
[ ]

Indicate maximum Copayment amount for Medicare-covered Group Sessions:  
[ ]

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

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

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 – PT and SP Services – Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

Do you apply the Medicare coverage limit?

Yes  
 No

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Every year  
 Every six months  
 Every three months

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?

Yes  
 No

Indicate 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 Copayment amount per visit for Medicare-covered Benefits:



Section B – 7I – PT and SP 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: #7I PT and SP Services - Base 2

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

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

Is a referral required for Physical Therapy and Speech-Language Pathology Services?

Yes

No

Notes (Optional):

[Empty text area]

Section B – 8A– Outpatient Diag Procs/Tests/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 year

Every six months

Every three months

Section B – 8A– Outpatient Diag Procs/Tests/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

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?

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 Diag Procs/Tests/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 physician/professional service cost share applies:  
 Yes  
 No  
 Sometimes, describe

Is there an enrollee Coinsurance for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:  
[ ]

Indicate Maximum Coinsurance percentage for a separate physician/professional service:  
[ ]

Is there an enrollee Copayment for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:  
[ ]

Indicate Maximum Copayment amount for a separate physician/professional service:  
[ ]

Section B – 8A– Outpatient Diag Procs/Tests/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):

Tiered Cost Sharing for Medical Benefits is not allowed. Cost sharing tiers may not be based on the provider group an enrollee selects within an MA plan. (See Chapter 4, Section 10.10). Basing a plan's cost sharing on the physician group a member selects has the effect of creating multiple MA plans within one MA plan, and therefore conflicts with the uniformity of premium and cost sharing requirement (see 42 CFR section 422.100(d)(2)).

Section B – 8B– Outpatient Diag/Therapeutic Rad 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 year  
 Every six months  
 Every three months

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?

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 (e.g., CT, MRI, etc):

Indicate Maximum Coinsurance percentage for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):

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 Diag/Therapeutic Rad 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 (e.g., CT, MRI, etc):  
[ ]

Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):  
[ ]

Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:  
[ ]

Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:  
[ ]

Indicate whether a separate physician/professional service cost share applies:

Yes  
 No  
 Sometimes, describe

Is there an enrollee Coinsurance for a separate physician/professional service?

Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:  
[ ]

Indicate Maximum Coinsurance percentage for a separate physician/professional service:  
[ ]

Is there an enrollee Copayment for a separate physician/professional service?

Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:  
[ ]

Indicate Maximum Copayment amount for a separate physician/professional service:  
[ ]

Section B – 8B– Outpatient Diag/Therapeutic Rad 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

Tiered Cost Sharing for Medical Benefits is not allowed. Cost sharing tiers may not be based on the provider group an enrollee selects within an MA plan. (See Chapter 4, Section 10.10). Basing a plan's cost sharing on the physician group a member selects has the effect of creating multiple MA plans within one MA plan, and therefore conflicts with the uniformity of premium and cost sharing requirement (see 42 CFR section 422.100(d)(2)).

Outpatient Diagnostic and Therapeutic Radiological Services Notes

Notes (Optional):



Section B – 9A– Outpatient Hospital 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: #9a Outpatient Hospital 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 year  
 Every six months  
 Every three months

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?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Section B – 9A– Outpatient Hospital 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: #9a Outpatient Hospital 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 Practic

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 Services – Base 3 Screen



Section B – 9B– ASC 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 year

Every six months

Every three months

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?

Yes

No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Section B – 9B– ASC 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:

\_\_\_\_\_

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– ASC Services – Base 3 Screen



Section B – 9C– Outpatient Substance Abuse – 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 Substance 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 year  
 Every six months  
 Every three months

Section B – 9C– Outpatient Substance Abuse – 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 Substance Abuse - Base 2

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?

Yes  
 No

Indicate minimum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:

Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate maximum Copayment amount for Medicare-covered Individual Sessions:

Indicate minimum Copayment amount for Medicare-covered Group Sessions:

Indicate maximum Copayment amount for Medicare-covered Group Sessions:



Section B – 9C– Outpatient Substance Abuse – 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 Substance Abuse - 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 Substance Abuse Services?

Yes

No

Notes (Optional):

Section B – 9D– Outpatient Blood 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 Outpatient Blood Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

If blood is given as a part of an inpatient hospital stay, the cost sharing for the blood should be included in the inpatient hospital cost sharing.

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 year  
 Every six months  
 Every three months

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage per unit for Medicare-covered Benefits:

\_\_\_\_\_

Section B – 9D– Outpatient Blood 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 Outpatient Blood Services - Base 2

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per unit for Medicare-covered Benefits:

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

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

Is a referral required for Outpatient Blood Services?

Yes  
 No

Notes (Optional):

Section B – 10A– Ambulance Services – 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 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 an enrollee Coinsurance?  
 Yes  
 No

Is there an enrollee Copayment?  
 Yes  
 No

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

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Copayment amount for Medicare-covered Benefits:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:  
 Every year  
 Every six months  
 Every three months

Is this Coinsurance waived if admitted to hospital?  
 Yes  
 No

Is this Copayment waived if admitted to hospital?  
 Yes  
 No

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Section B – 10A– Ambulance Services – 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 Services - 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 Services – 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 Services - 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 year  
 Every six months  
 Every three months

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 year  
 Every six months  
 Every three months

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 Services – 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 Services - 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 year <input type="radio"/> Every six months <input type="radio"/> Every three months</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 year <input type="radio"/> Every six months <input type="radio"/> Every three months</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 Services – 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 Services - 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 year  
 Every six months  
 Every three months

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

Notes (Optional):

Referral is not applicable for this Service Category.

Tiered Cost Sharing for Medical Benefits is not allowed. Cost sharing tiers may not be based on the provider group an enrollee selects within an MA plan. (See Chapter 4, Section 10.10). Basing a plan's cost sharing on the physician group a member selects has the effect of creating multiple MA plans within one MA plan, and therefore conflicts with the uniformity of premium and cost sharing requirement (see 42 CFR section 422.100(d)(2)).

Section B – 11B– Prosthetics/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 Prosthetics/Medical 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 year  
 Every six months  
 Every three months

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/Medical 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: #11b Prosthetics/Medical Supplies - Base 2

Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

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

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

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

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

Section B – 11B– Prosthetics/Medical Supplies – Base 3 Screen

Section B – 11C– Diabetic Supplies and Services – Base 1 Screen

Section B – 11C– Diabetic Supplies and Services – 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 Diabetic Supplies and Services - Base 2

Is there an enrollee Copayment?

Yes  
 No

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

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

Indicate Minimum Copayment Amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Indicate Maximum Copayment Amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

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.

Tiered Cost Sharing for Medical Benefits is not allowed. Cost sharing tiers may not be based on the provider group an enrollee selects within an MA plan. (See Chapter 4, Section 10.10). Basing a plan's cost sharing on the physician group a member selects has the effect of creating multiple MA plans within one MA plan, and therefore conflicts with the uniformity of premium and cost sharing requirement (see 42 CFR section 422.100(d)(2)).

Notes (Optional):

Section B – 12– End Stage Renal Disease – 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 year  
 Every six months  
 Every three months

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?

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:



Section B – 12– End Stage Renal Disease – 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):

[Large empty text area for notes]

Section B – 13A– 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: #13a 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

Indicate Number of Treatments periodicity:  
 Every year  
 Every six months  
 Every three months

Select enhanced benefit:  
 Number of Treatments

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select type of benefit for Number of Treatments:  
 Mandatory  
 Optional

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:  
 Every year  
 Every six months  
 Every three months

Is this benefit unlimited for Number of Treatments?  
 Yes  
 No

Indicate Maximum Plan Benefit Coverage periodicity:  
 Every year  
 Every six months  
 Every three months

Section B – 13A– 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: #13a 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:

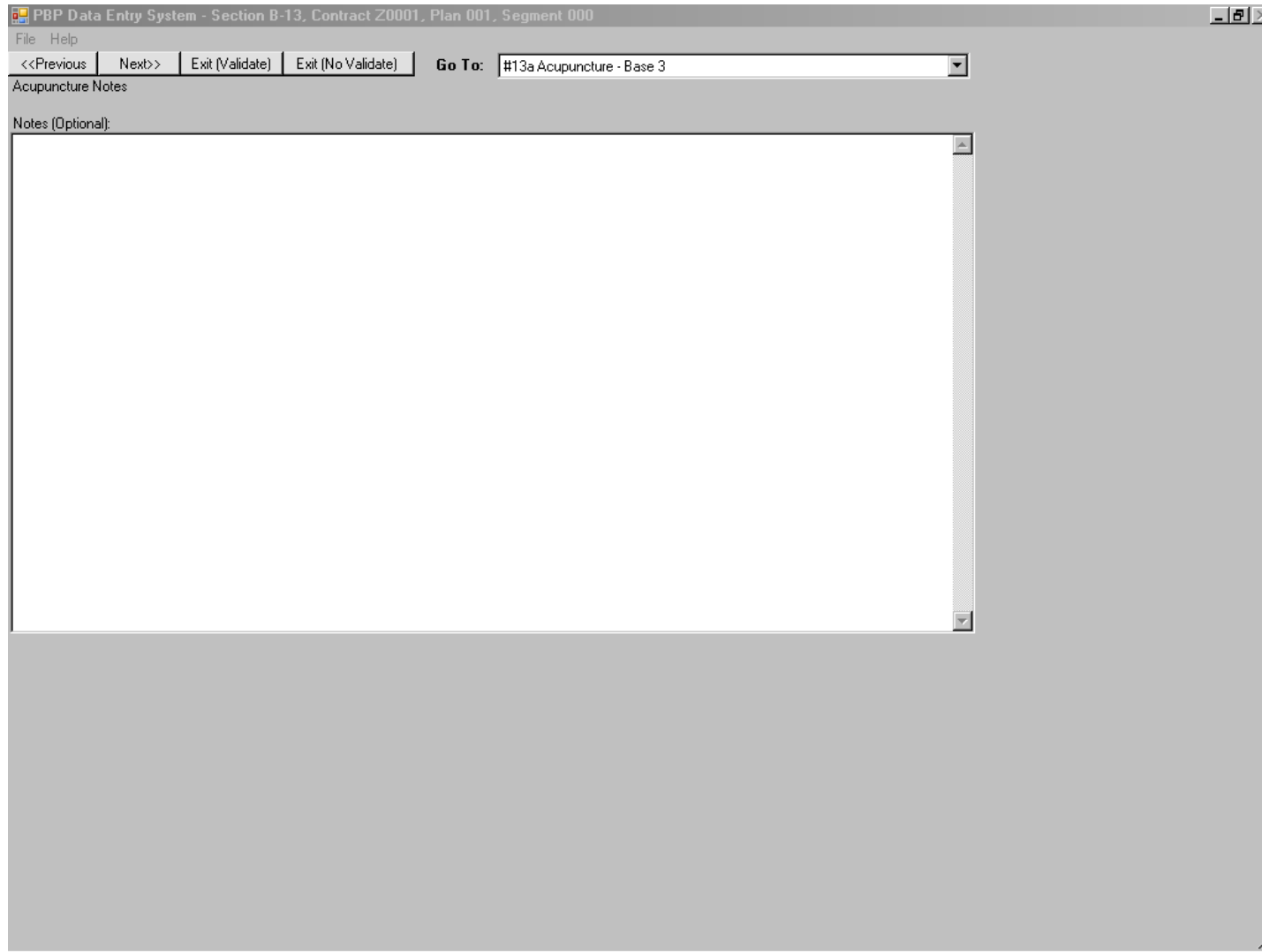
Is there an enrollee Deductible?  
 Yes  
 No

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 – 13A– Acupuncture – Base 3 Screen



Section B – 13B– OTC – 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 OTC - Base 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

Yes  
 No

Select type of benefit for OTC items:

Mandatory  
 Optional

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every year  
 Every six months  
 Every three months  
 Every month

Indicate Maximum Plan Benefit Coverage periodicity:

Every year  
 Every six months  
 Every three months  
 Every month

Section B – 13B– OTC – 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 OTC - Base 2

Is there an enrollee Coinsurance?  Yes  No

Indicate Coinsurance percentage:

Is there an enrollee Deductible?  Yes  No

Indicate Deductible Amount:

Is there an enrollee Copayment?  Yes  No

Indicate Copayment amount:

Does this cover all of the CMS OTC list?  Yes  No

Authorization is not applicable for this service category.

Referral is not applicable for this service category.

Section B – 13B– OTC – Base 3 Screen



Section B – 13C– 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: #13c Meal Benefit - Base 1

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

Yes  
 No

Select 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 year  
 Every six months  
 Every three months

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 year  
 Every six months  
 Every three months



Section B – 13C– 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: #13c Meal Benefit - 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

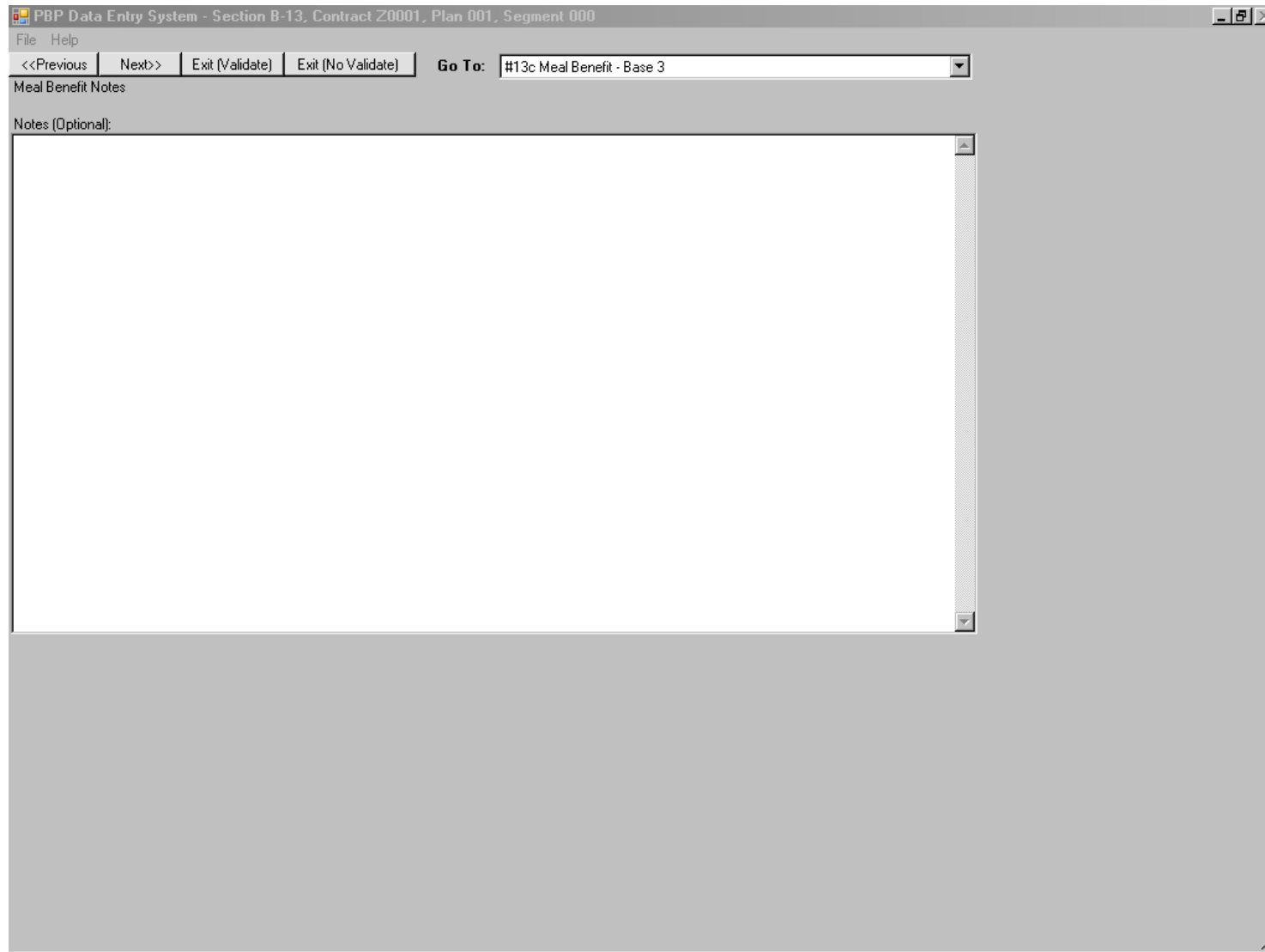
Organization Medical Director/Utilization Management/Utilization Review

Other, describe

Is a referral required for the Meal Benefit?

Yes  No

Section B – 13C– Meal Benefit – Base 3 Screen



Section B – 13D– Other 1 – Base 1 Screen

PBP Data Entry System - Section B-13, Contract 20001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13d 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 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 year  
 Every six months  
 Every three months

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 year  
 Every six months  
 Every three months

Section B – 13D– 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: #13d 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 – 13D– Other 1 – Base 3 Screen



Section B – 13E– Other 2 – Base 1 Screen

PBP Data Entry System - Section B-13, Contract 20001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13e 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 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 year  
 Every six months  
 Every three months

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 year  
 Every six months  
 Every three months

Section B – 13E– 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: #13e 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

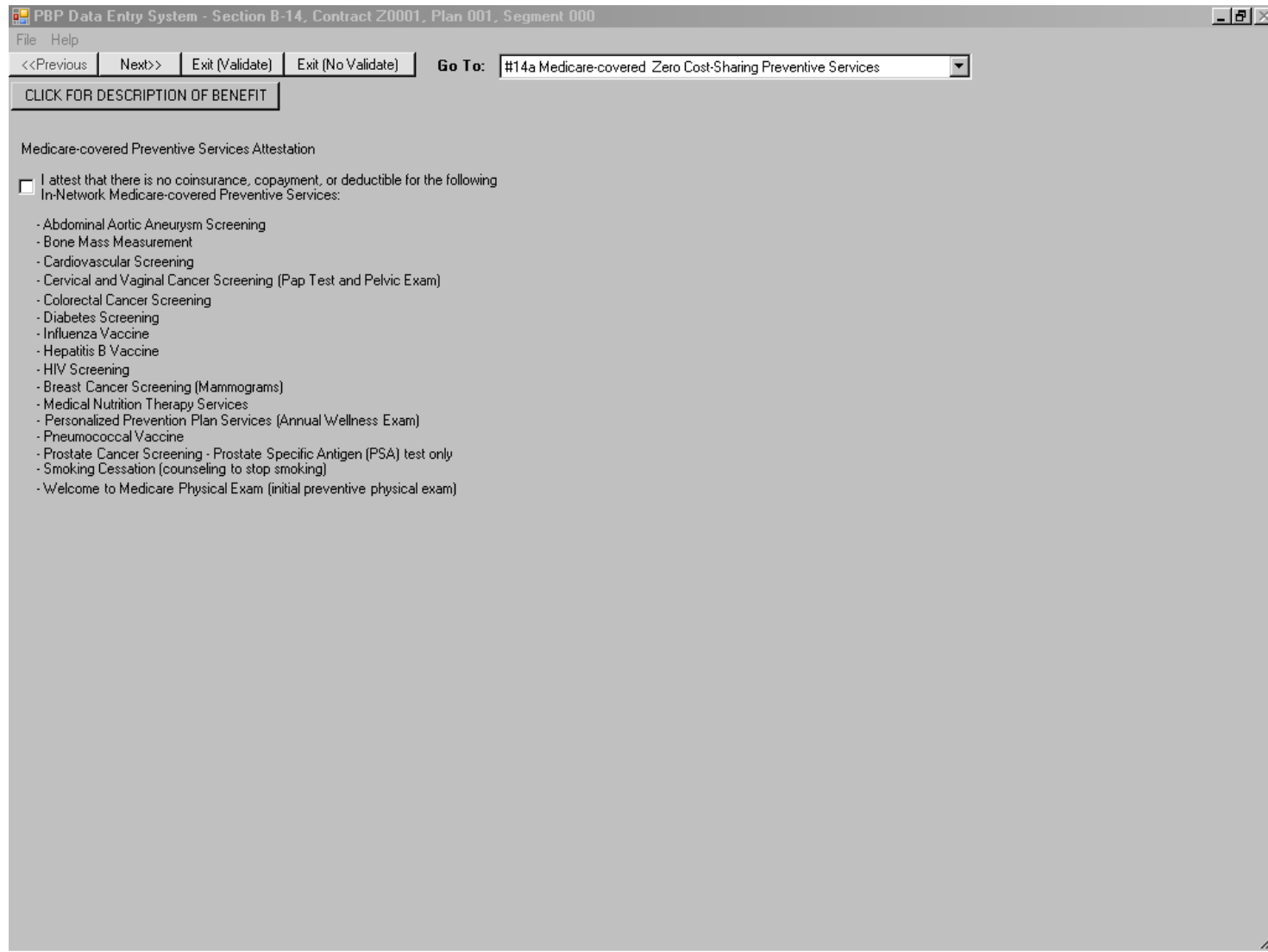
Is a referral required for Other Services?  
 Yes  
 No

Section B – 13E– Other 2 – Base 3 Screen





Section B – 14A– Medicare-covered Zero Cost Sharing Preventative Services – 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 Medicare-covered Zero Cost-Sharing Preventive Services

CLICK FOR DESCRIPTION OF BENEFIT

Medicare-covered Preventive Services Attestation

I attest that there is no coinsurance, copayment, or deductible for the following In-Network Medicare-covered Preventive Services:

- Abdominal Aortic Aneurysm Screening
- Bone Mass Measurement
- Cardiovascular Screening
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)
- Colorectal Cancer Screening
- Diabetes Screening
- Influenza Vaccine
- Hepatitis B Vaccine
- HIV Screening
- Breast Cancer Screening (Mammograms)
- Medical Nutrition Therapy Services
- Personalized Prevention Plan Services (Annual Wellness Exam)
- Pneumococcal Vaccine
- Prostate Cancer Screening - Prostate Specific Antigen (PSA) test only
- Smoking Cessation (counseling to stop smoking)
- Welcome to Medicare Physical Exam (initial preventive physical exam)

Section B – 14B– Supplemental Preventative Health Services – Base 1 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14b Supplemental Preventative Health Services - Base 1

Do you offer any Mandatory or Optional Supplemental Preventative Benefits?

Yes  
 No

Select enhanced benefit:

- Other Immunizations
- Additional Physical Exams
- Additional Pap Smears
- Additional Pelvic Exams
- Additional Prostate Exams
- Additional Colorectal Exams
- Additional Mammography Exams

Select type of benefit for Other Immunizations:

Mandatory  
 Optional

Select type of benefit for Additional Physical Exams:

Mandatory  
 Optional

Is this benefit unlimited for Additional Physical Exams?

Yes  
 No, indicate number

Indicate limit for Additional Physical Exams:

Indicate limit for Additional Physical Exams:

Select the Additional Physical Exams periodicity:

Every year  
 Every six months  
 Every three months

Section B – 14B– Supplemental Preventative Health Services – 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 Supplemental Preventative Health Services - Base 2

Select type of benefit for Additional Pap Smears:  
 Mandatory  
 Optional

Select type of benefit for Additional Pelvic Exams:  
 Mandatory  
 Optional

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

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

Indicate number of Additional Pap Smears:  
[ ]

Indicate number of Additional Pelvic Exams:  
[ ]

Select the Additional Pap Smears periodicity:  
 Every year  
 Every six months  
 Every three months

Select the Additional Pelvic Exams periodicity:  
 Every year  
 Every six months  
 Every three months

Section B – 14B– Supplemental Preventative Health Services – 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 Supplemental Preventative Health Services - Base 3

Select type of benefit for Additional Prostate Exams:

Mandatory

Optional

Is this benefit unlimited for Additional Prostate Exams?

Yes

No, indicate number

Indicate number of Additional Prostate Exams:

Select the Additional Prostate Exams periodicity:

Every year

Every six months

Every three months

Select type of benefit for Additional Colorectal Exams:

Mandatory

Optional

Is this benefit unlimited for Additional Colorectal Exams?

Yes

No, indicate number

Indicate number of Additional Colorectal Screenings:

Select the Additional Colorectal Exams periodicity:

Every year

Every six months

Every three months

Section B – 14B– Supplemental Preventative Health Services – 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: #14b Supplemental Preventative Health Services - Base 4

Select type of benefit for Additional Mammography Exams:

Mandatory

Optional

Is this benefit unlimited for Additional Mammography Exams?

Yes

No, indicate number

Indicate number of Additional Mammography Exams:

Select the Additional Additional Mammography Exams periodicity:

Every year

Every six months

Every three months

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 year

Every six months

Every three months

Section B – 14B– Supplemental Preventative Health Services – 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: #14b Supplemental Preventative Health Services - Base 5

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 year  
 Every six months  
 Every three months

Indicate Minimum Coinsurance percentage for Other Immunizations:  
[ ]

Indicate Maximum Coinsurance percentage for Other Immunizations:  
[ ]

Indicate Coinsurance percentage for Additional Physical Exams:  
[ ]

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?

Yes  
 No

Select which Supplemental Preventative Health Services have a Coinsurance (Select all that apply):

Other Immunizations  
 Additional Physical Exams  
 Additional Pap Smears  
 Additional Pelvic Exams  
 Additional Prostate Exams  
 Additional Colorectal Exams  
 Additional Mammography Exams

Section B – 14B– Supplemental Preventative Health Services – Base 6 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 Supplemental Preventative Health Services - Base 6

Indicate Coinsurance percentage for Additional Pap Smears:

Indicate Coinsurance percentage for Additional Pelvic Exams:

Indicate Coinsurance percentage for Additional Prostate Exams:

Indicate Minimum Coinsurance percentage for Additional Colorectal Exams:

Indicate Maximum Coinsurance percentage for Additional Colorectal Exams:

Indicate Coinsurance percentage for Additional Mammography Exams:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Section B – 14B– Supplemental Preventative Health Services – Base 7 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 Supplemental Preventative Health Services - Base 7

Is there an enrollee Copayment?

Yes

No

Select which Supplemental Preventative Health Services have a Copay (Select all that apply):

Other Immunizations

Additional Physical Exams

Additional Pap Smears

Additional Pelvic Exams

Additional Prostate Exams

Additional Colorectal Exams

Additional Mammography Exams

Indicate Minimum Copayment amount for Other Immunizations:

Indicate Maximum Copayment amount for Other Immunizations:

Indicate Copayment amount for Additional Physical Exams:

Indicate Copayment amount per Additional Pap Smear:

Indicate Copayment amount per Additional Pelvic Exam:

Indicate Copayment amount per Additional Prostate Exams:

Indicate Minimum Copayment amount for Additional Colorectal Exams:

Indicate Maximum Copayment amount for Additional Colorectal Exams:

Indicate Copayment amount for Additional Mammography Exams:



Section B – 14B– Supplemental Preventative Health Services – Base 8 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 Supplemental Preventive Health Services - Base 8

Indicate whether a separate physician/professional service cost share applies:

Yes  
 No  
 Sometimes, describe

Is there a separate Coinsurance for Physician/Professional Services applied during Additional Colorectal Exams?

Yes  
 No

Indicate Minimum Coinsurance percentage for Physician/Professional Services applied during Additional Colorectal Exams:

Indicate Maximum Coinsurance percentage for Physician/Professional Services applied during Additional Colorectal Exams:

Is there a separate Coinsurance for Physician/Professional Services applied during Additional Mammography Exams?

Yes  
 No

Indicate Minimum Coinsurance percentage for Physician/Professional Services applied during Additional Mammography Exams:

Indicate Maximum Coinsurance percentage for Physician/Professional Services applied during Additional Mammography Exams:

Section B – 14B– Supplemental Preventative Health Services – Base 9 Screen

PBP Data Entry System - Section B-14, Contract 20001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14b Supplemental Preventive Health Services - Base 9

Is there a separate Copay for Physician/Professional Services applied during Additional Colorectal Exams?

Yes  
 No

Indicate Minimum Copay amount for Physician/Professional Services applied during Additional Colorectal Exams:

Indicate Maximum Copay amount for Physician/Professional Services applied during Additional Colorectal Exams:

Is there a separate Copay for Physician/Professional Services applied during Additional Mammography Exams?

Yes  
 No

Indicate Minimum Copay amount for Physician/Professional Services applied during Additional Mammography Exams:

Indicate Maximum Copay amount for Physician/Professional Services applied during Additional Mammography Exams:

Section B – 14B– Supplemental Preventative Health Services – Base 10 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 Supplemental Preventative Health Services - Base 10

Enrollee must receive Authorization from one or more of the following, except for Supplemental Preventative Health Services:

- 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 Supplemental Preventative Health Services?

Yes

No

Notes (Optional):

Section B – 14C– Supplemental Education/Wellness Programs – Base 1 Screen

PBP Data Entry System - Section B-14, Contract 20001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14c Supplemental Education/Wellness Programs - Base 1

Do you offer any Mandatory or Optional Supplemental Educational/Wellness Programs?  
 Yes  
 No

Select type of benefit for Written Health Education Materials, incl. Newsletters:  
 Mandatory  
 Optional

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

Select enhanced benefit (Select all that apply):  
 Written Health Education Materials, incl. Newsletters  
 Nutritional Benefit  
 Additional Smoking Cessation  
 Membership in Health Club/Fitness Classes  
 Nursing Hotline

Select type of benefit for Nutritional Benefit:  
 Mandatory  
 Optional

Select type of benefit for Nursing Hotline:  
 Mandatory  
 Optional

Select type of benefit for Additional Smoking Cessation:  
 Mandatory  
 Optional

Section B – 14C– Supplemental Education/Wellness Programs – 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 Supplemental Education/Wellness Programs - Base 2

Is there a service-specific Maximum Plan Benefit Coverage amount for Supplemental Education/Wellness Programs?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every year  
 Every six months  
 Every three months

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Supplemental Education/Wellness Programs?

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Every year  
 Every six months  
 Every three months

Section B – 14C– Supplemental Education/Wellness Programs – 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 Supplemental Education/Wellness Programs - Base 3

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?

Yes  
 No

Select which Supplemental Education/Wellness Programs have a Coinsurance (Select all that apply)

Written Health Education Materials, incl. Newsletters  
 Nutritional Benefit  
 Additional Smoking Cessation  
 Membership in Health Club/Fitness classes  
 Nursing Hotline

Indicate Minimum Coinsurance percentage for Written Health Education Materials, incl. Newsletters:

Indicate Maximum Coinsurance percentage for Written Health Education Materials, incl. Newsletters:

Indicate Coinsurance percentage for Nutritional Benefit:

Indicate Coinsurance percentage for Additional Smoking Cessation:

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

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

Indicate Coinsurance percentage for Nursing Hotline:

Section B – 14C– Supplemental Education/Wellness Programs – 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 Supplemental Education/Wellness Programs - Base 4

Is there an enrollee Deductible?

Yes

No

Indicate Deductible Amount:

\_\_\_\_\_

Is there an enrollee Copayment?

Yes

No

Select which Supplemental Education/Wellness Programs have a Copay (Select all that apply)

Written Health Education Materials, incl. Newsletters

Nutritional Benefit

Additional Smoking Cessation

Membership in Health Club/Fitness classes

Nursing Hotline

Indicate Copayment amount for Written Health Education Materials, incl. Newsletters:

\_\_\_\_\_

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:

\_\_\_\_\_

Section B – 14C– Supplemental Education/Wellness Programs – 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: #14c Supplemental Education/Wellness Programs - 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 Supplemental Education/Wellness Programs?

Yes

No

Supplemental Education/Wellness Programs Notes

Notes (Optional):



Section B – 14D– Kidney Disease Education Services – 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 - Kidney Disease Education 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 year

Every six months

Every three months

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?

Yes

No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Section B – 14D– Kidney Disease Education Services – 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 - Kidney Disease Education 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:

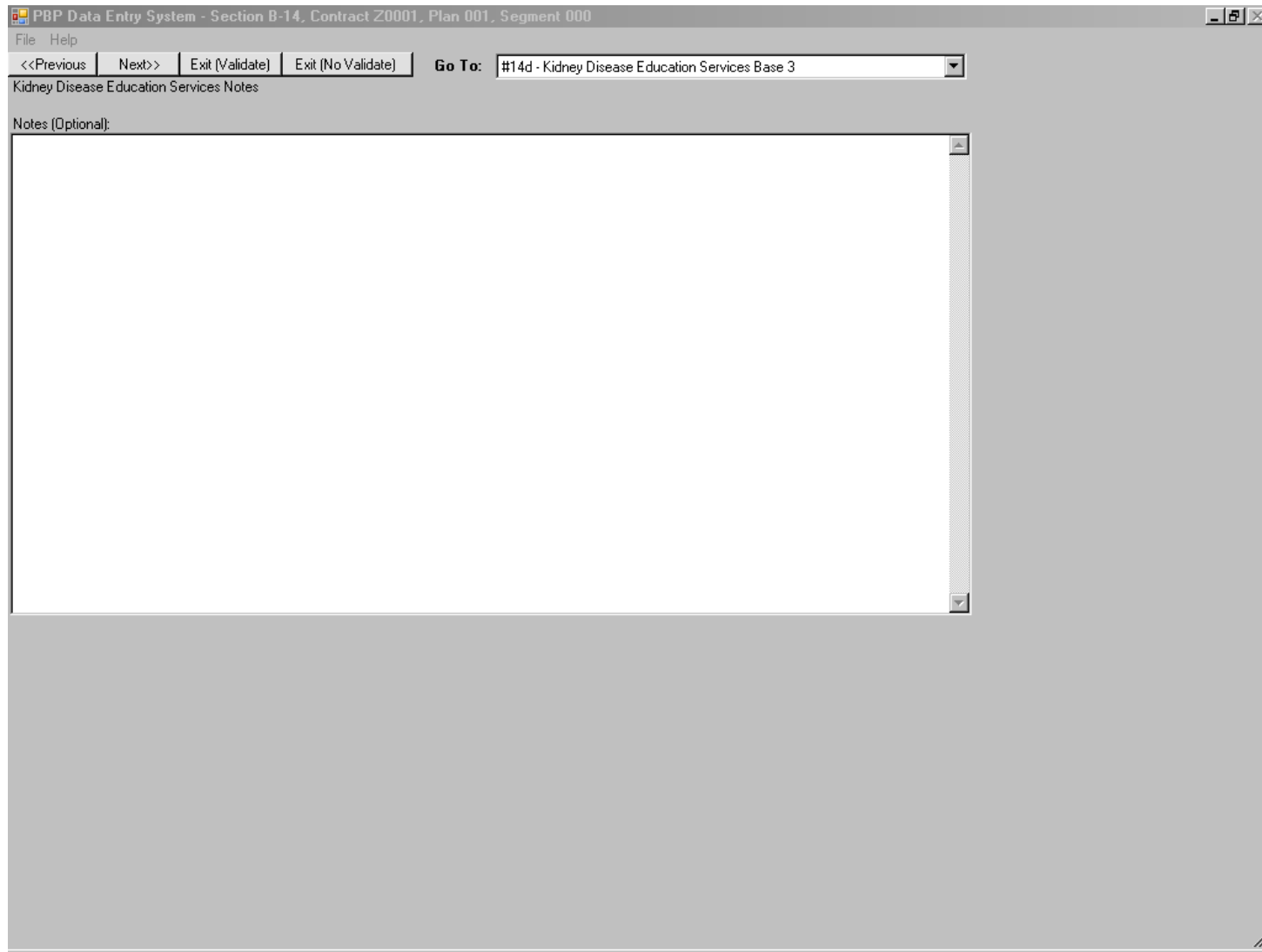
Enrollee must receive Authorization from one or more of the following:

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 Kidney Disease Education Services?

Yes  
 No

Section B – 14D– Kidney Disease Education Services – Base 3 Screen



Section B – 14E– Diabetes Self-Management Training – 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 Diabetes Self-Management Training - 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 year  
 Every six months  
 Every three months

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:

Section B – 14E– Diabetes Self-Management Training – 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 Diabetes Self-Management Training - Base 2

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 physician/professional service cost share applies:

Yes  
 No  
 Sometimes, describe

Is there an enrollee Coinsurance for a separate physician/professional service?

Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:

Indicate Maximum Coinsurance percentage for a separate physician/professional service:

Is there an enrollee Copayment for a separate physician/professional service?

Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:

Indicate Maximum Copayment amount for a separate physician/professional service:

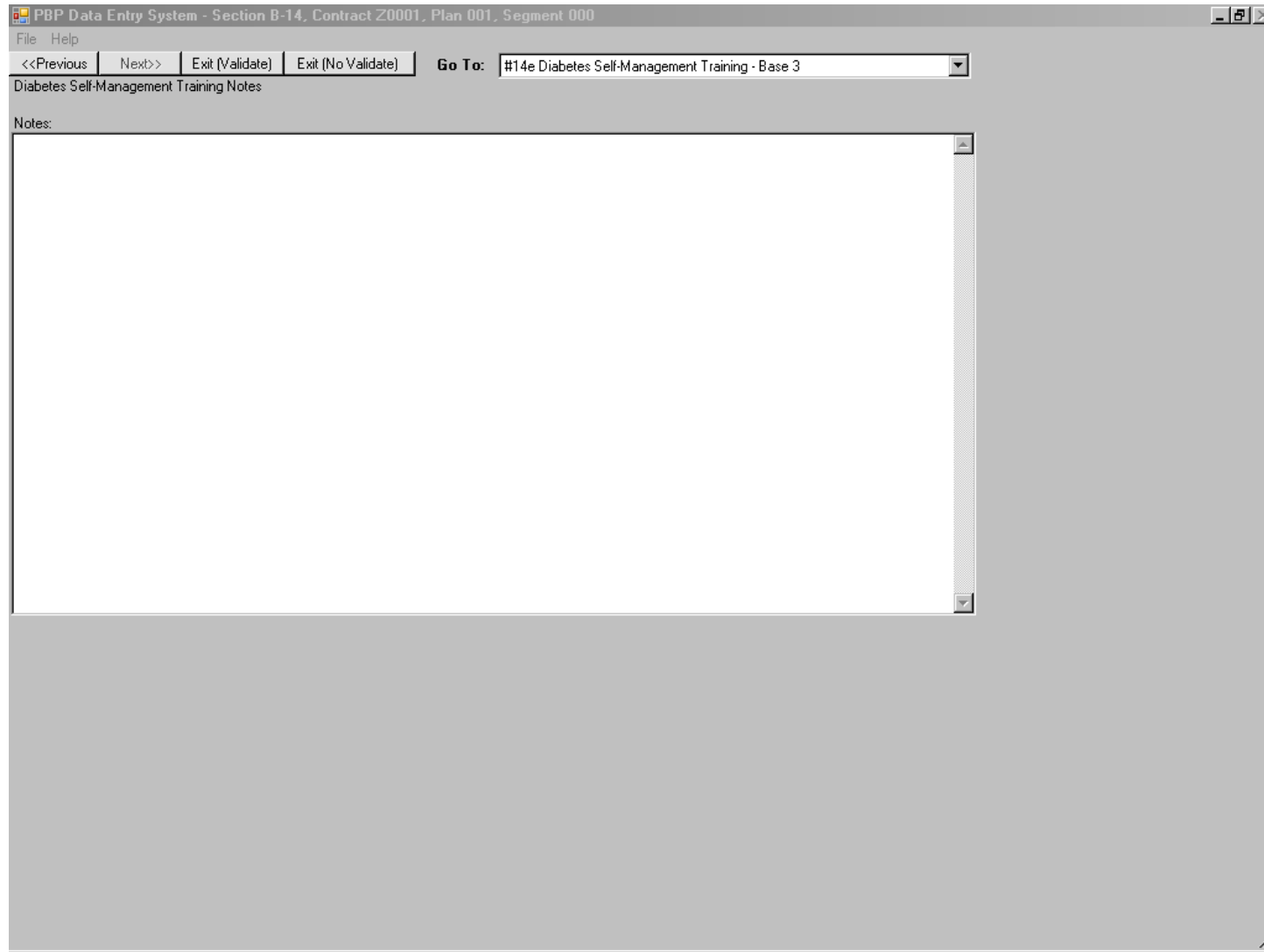
Enrollee must receive Authorization from one or more of the following:

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 Self-Management Training?

Yes  
 No

Section B – 14E– Diabetes Self-Management Training – Base 3 Screen



Section B – 15– Medicare Part B Rx 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 an enrollee Coinsurance?

Yes

No

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 year

Every six months

Every three months

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 Rx Drugs – Base 2 Screen

PBP Data Entry System - Section B-15, Contract 20001, 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

Is Authorization Required?

Yes  No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  No

Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy Drugs:

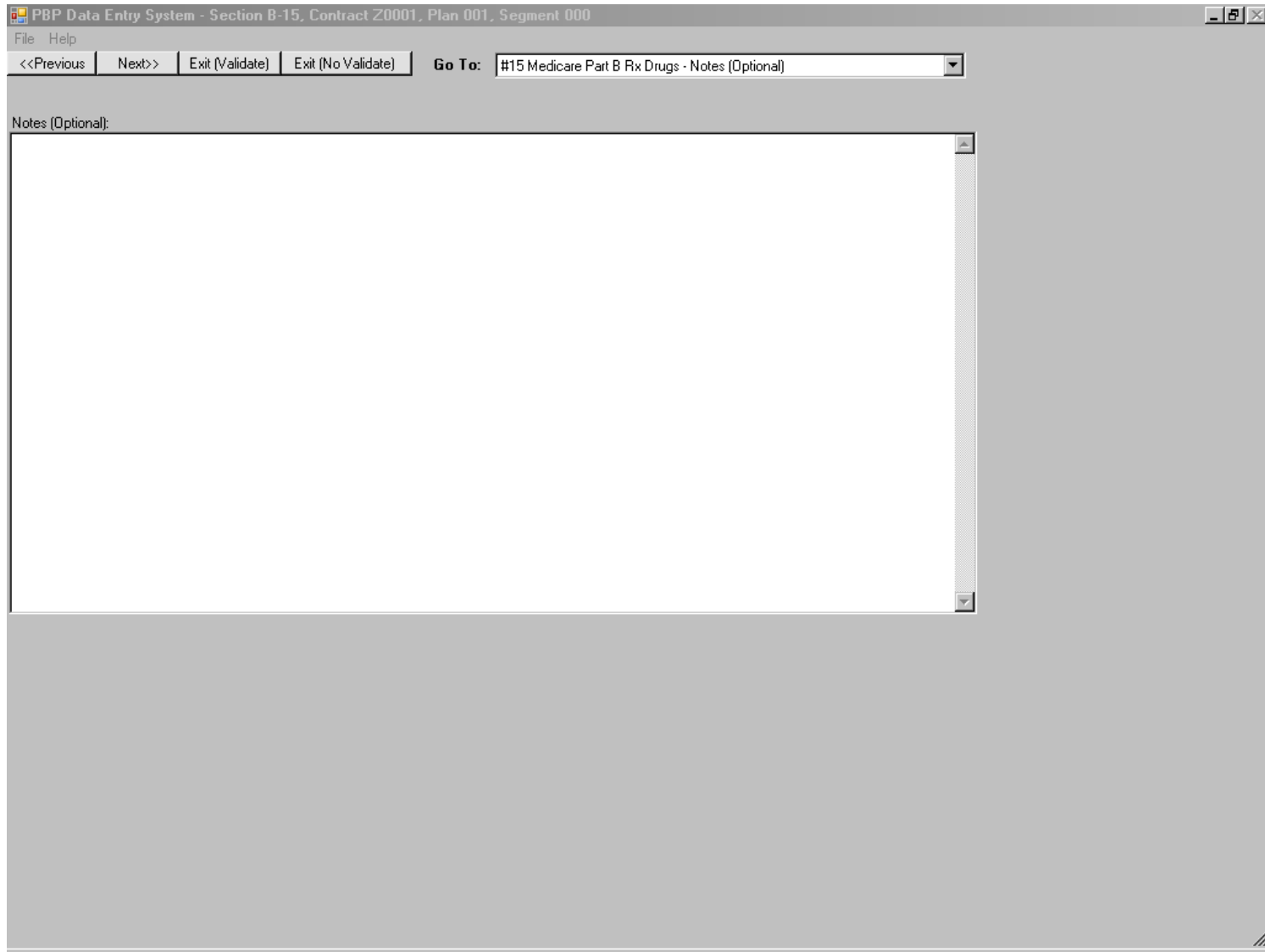
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Minimum Copayment Amount for other Medicare Part B Drugs:

Indicate Maximum Copayment Amount for other Medicare Part B Drugs:



Section B – 15– Medicare Part B Rx Drugs – Notes (Optional) Screen



Section B – 15– Part C Home Infusion Bundled Services – 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 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 by April 18, 2011.

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.

If your organization elects to provide Part D home infusion drugs as part of a bundled service under Part C then those services must be provided at \$0 cost sharing. As described in the CY 2010 Call Letter this waiver is conditioned on the application of zero cost sharing for the bundle of home infusion services provided under a Part C supplemental benefit.

Section B – 16A– Preventative 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

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

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

Section B – 16A– Preventative 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 there a service-specific Maximum Plan Benefit Coverage amount?

Yes

No

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

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?

In-network services only

Both In-network and Out-of-network services

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

Section B – 16A– Preventative Dental – Base 3 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 3

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:  
[Text Box]

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

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:  
[Text Box]

Indicate Minimum Coinsurance percentage for Oral Exams:  
[Text Box]

Indicate Maximum Coinsurance percentage for Oral Exams:  
[Text Box]

Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):  
[Text Box]

Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):  
[Text Box]

Indicate Minimum Coinsurance percentage for Fluoride Treatment:  
[Text Box]

Indicate Maximum Coinsurance percentage for Fluoride Treatment:  
[Text Box]

Indicate Minimum Coinsurance percentage for Dental X-Rays:  
[Text Box]

Indicate Maximum Coinsurance percentage for Dental X-Rays:  
[Text Box]

Section B – 16A– Preventative Dental – Base 4 Screen

PBP Data Entry System - Section B-16, Contract 20001, Plan 001, Segment 000

File Help

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

Is there an enrollee Deductible?

Yes

No

Indicate Deductible Amount:

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– Preventative Dental – Base 5 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 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 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 Comprehensive 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

Select the Diagnostic Services periodicity:

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



Section B – 16B– Comprehensive 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: #16b Comprehensive Dental - Base 2

Select type of benefit for Restorative Services:  
 Mandatory  
 Optional

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

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

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

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

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

Indicate number of visits for Restorative Services:  
[ ]

Indicate number of visits for Endodontics/Periodontics/Extractions:  
[ ]

Indicate number of visits for Prosthetics, Other Oral/Maxillofacial Surgery, Other Services:  
[ ]

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

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

Select the Prosthetics/Other Oral/Maxillofacial Surgery/Other Services periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other

Section B – 16B– Comprehensive Dental – Base 3 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 Comprehensive Dental - Base 3

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

Yes  
 No

Select the Maximum Plan Benefit Coverage type:

Covered under Preventive Dental Category 16a  
 Plan-specified amount per period

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?

In-network services only  
 Both In-network and Out-of-network services

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

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

Section B – 16B– Comprehensive 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: #16b Comprehensive Dental - Base 4

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:  
[ ]

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:  
[ ]

Indicate Minimum Coinsurance percentage for Non-routine Services:  
[ ]

Indicate Maximum Coinsurance percentage for Non-routine Services:  
[ ]

Indicate Minimum Coinsurance percentage for Diagnostic Services:  
[ ]

Indicate Maximum Coinsurance percentage for Diagnostic Services:  
[ ]

Indicate Minimum Coinsurance percentage for Restorative Services:  
[ ]

Indicate Maximum Coinsurance percentage for Restorative Services:  
[ ]

Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions:  
[ ]

Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:  
[ ]

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

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

Section B – 16B– Comprehensive Dental – Base 5 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 Comprehensive Dental - Base 5

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Minimum Copayment amount for Restorative Services:  
[ ]

Indicate Minimum Copayment amount for Medicare-covered Benefits:  
[ ]

Indicate Maximum Copayment amount for Restorative Services:  
[ ]

Indicate Maximum Copayment amount for Medicare-covered Benefits:  
[ ]

Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions:  
[ ]

Indicate Minimum Copayment amount for Non-routine Services:  
[ ]

Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions:  
[ ]

Indicate Minimum Copayment amount for Non-routine Services:  
[ ]

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

Indicate Minimum Copayment amount for Diagnostic Services:  
[ ]

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

Indicate Maximum Copayment amount for Diagnostic Services:  
[ ]

Section B – 16B– Comprehensive 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: #16b Comprehensive 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 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

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

Yes  
 No

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?

In-network services only  
 Both In-network and Out-of-network services

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

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

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 20001, Plan 001, Segment 000

File Help

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

Indicate whether a separate physician/professional service cost share applies:

Yes  
 No  
 Sometimes, describe

Is there an enrollee Coinsurance for a separate physician/professional service?

Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:

Indicate Maximum Coinsurance percentage for a separate physician/professional service:

Is there an enrollee Copayment for a separate physician/professional service?

Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:

Indicate Maximum Copayment amount for a separate physician/professional service:

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

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

Section B – 17B– Eye Wear – 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: #17b Eye Wear - Base 2

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

Select Eye Glass Frames periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other

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

File Help

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

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

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

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?  
 In-network services only  
 Both In-network and Out-of-network services

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

Indicate Combined Maximum Plan Benefit Coverage amount:

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

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

Indicate Max Plan Benefit Coverage amount for Contact Lenses:

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

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

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

Indicate Max Plan Benefit Coverage amount for Eye Glass Lenses:

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

Indicate Max Plan Benefit Coverage amount for Eye Glass Frames:

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

Indicate Max Plan Benefit Coverage amount for Upgrades:

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

Section B – 17B– Eye Wear – Base 4 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 4

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

Yes  
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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:

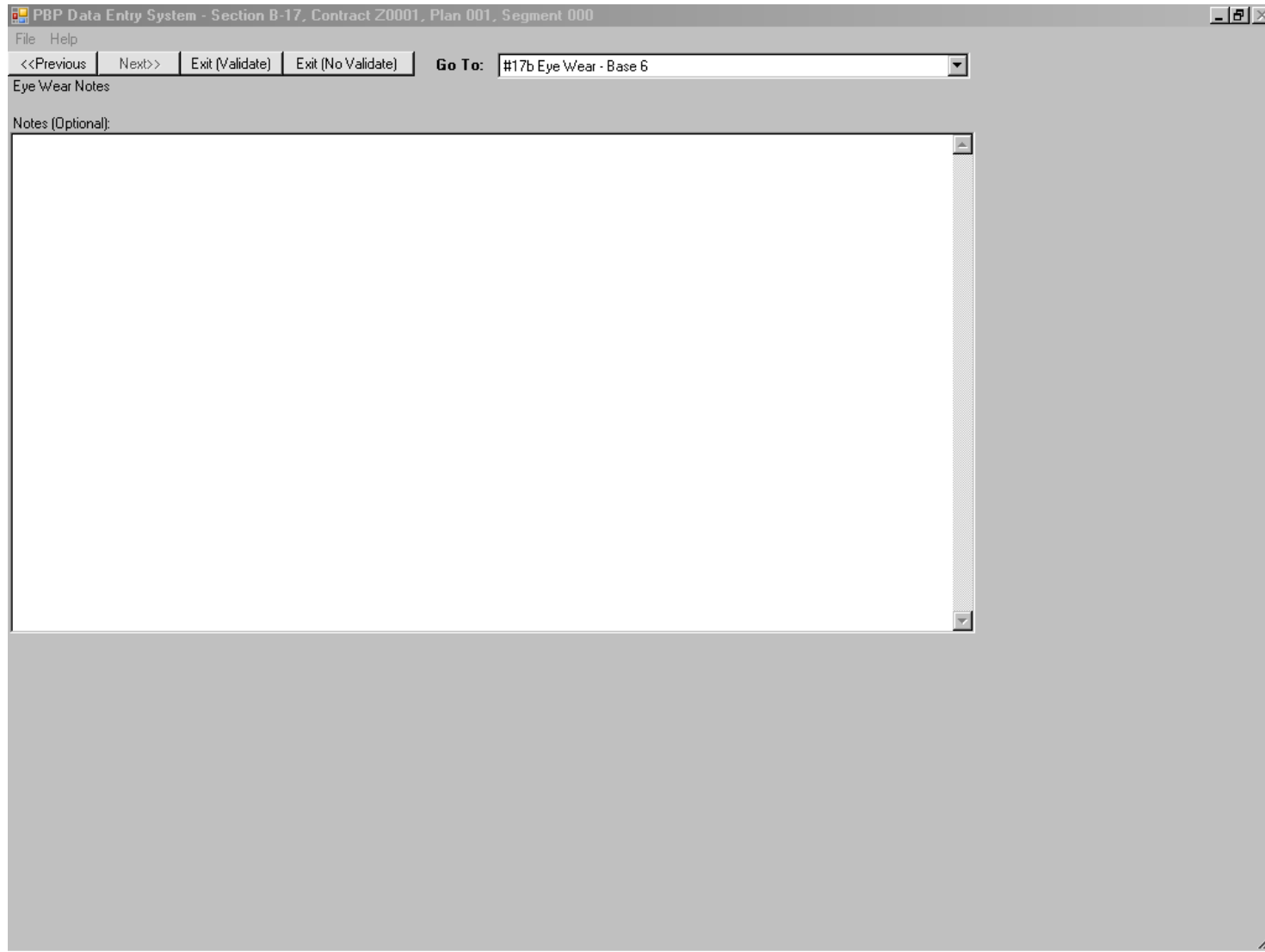
Indicate Copayment amount for Eye Glass Frames:

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



Section B – 18A– Hearing Exams – Base 1 Screen

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

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

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?  
 In-network services only  
 Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:  
[Text Input Field]

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[Text Input Field]

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:  
[Text Input Field]

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:  
[Text Input Field]

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:  
[Text Input Field]

Indicate Minimum Coinsurance percentage for Routine Hearing Tests:  
[Text Input Field]

Indicate Maximum Coinsurance percentage for Routine Hearing Tests:  
[Text Input Field]

Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:  
[Text Input Field]

Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:  
[Text Input Field]



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:

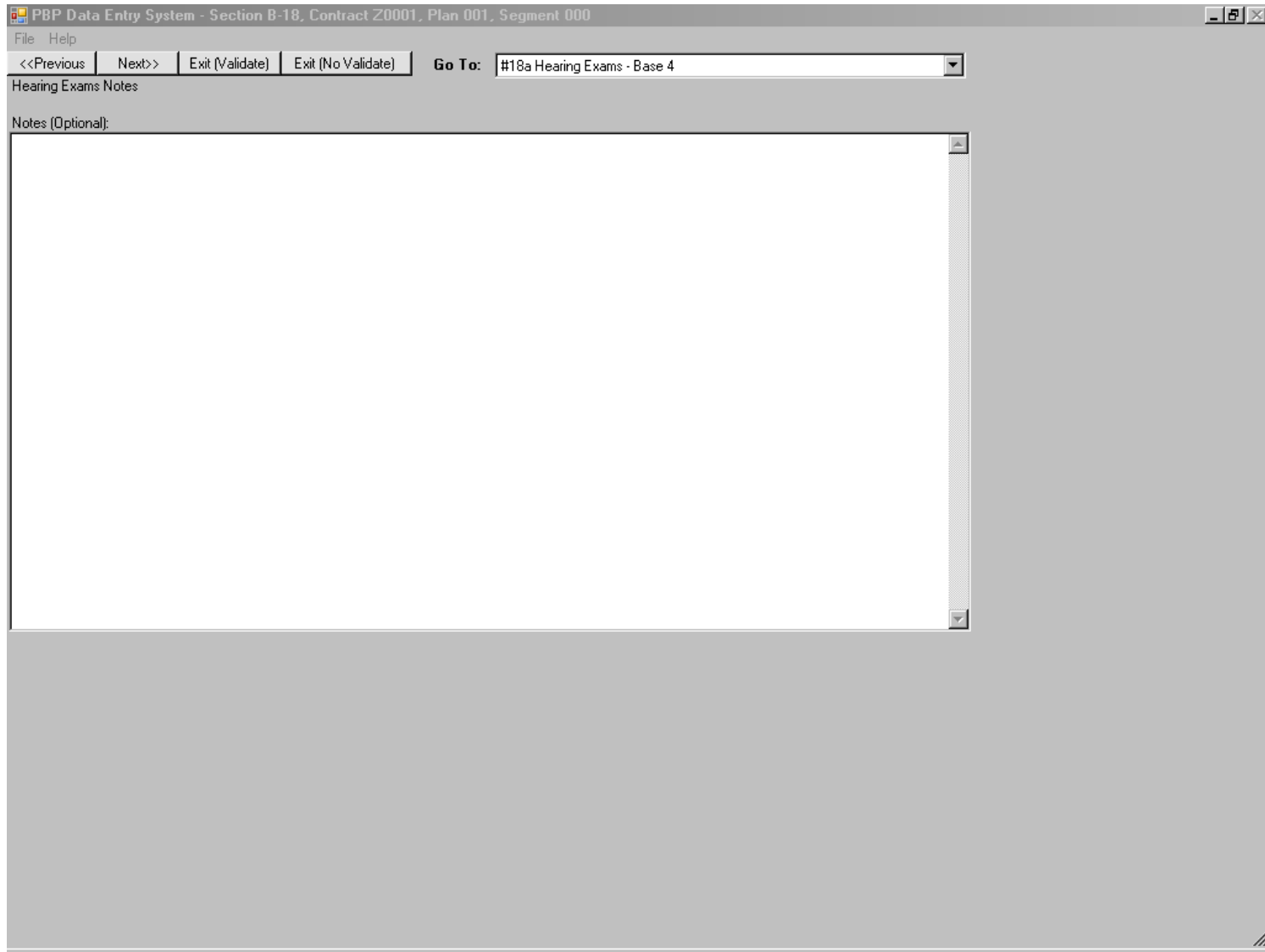
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:

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

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

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

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 quantity for Hearing Aids - Over the Ear:

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?

In-network services only

Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

Select Hearing Aids - Over the Ear periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other

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:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage for Hearing Aids (all types):

Indicate Coinsurance percentage for Hearing Aids - Inner Ear:

Indicate Coinsurance percentage for Hearing Aids - Outer Ear:

Indicate Coinsurance percentage for Hearing Aids - Over the Ear:

Section B – 18B– Hearing Aids – Base 4 Screen

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

File Help

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

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 Deductible Amount:

Indicate Copayment amount per Hearing Aid - Inner Ear:

Indicate Copayment amount per two Hearing Aids - Inner Ear:

Indicate Copayment amount per Hearing Aid - Outer Ear:

Indicate Copayment amount per two Hearing Aids - Outer Ear:

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– Outpatient 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– Outpatient 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– Outpatient 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 year  
 Every six months  
 Every three months

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– Outpatient Drugs – Base 4 Screen

PBP Data Entry System - Section B-20, Contract 20001, 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– Outpatient Drugs – Notes (Optional) Screen



Section B – 20– Outpatient 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:

Indicate Maximum Plan Benefit Coverage annual amount for Group 1:

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

Generic

Preferred Brand

Brand

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

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

Yes

No

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 for Group 1 periodicity:

Annually

Semi-annually

Quarterly

Monthly

Per Prescription

Other, describe

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

Section B – 20– Outpatient 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

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

Section B – 20– Outpatient 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: [dropdown]  
Indicate Maximum Plan Benefit Coverage annual amount for Group 2: [input]

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

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

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

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

Indicate Maximum Plan Benefit Coverage amount for Other for Group 2: [input]

Section B – 20– Outpatient 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– Outpatient 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: [dropdown]

Indicate Maximum Plan Benefit Coverage annual amount for Group 3: [input]

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

Generic

Preferred Brand

Brand

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

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

Yes

No

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3: [input]

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: [input]

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

Indicate Maximum Plan Benefit Coverage amount for Other for Group 3: [input]

Section B – 20– Outpatient Drugs- Group 3 – 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 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

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

Section B – 20– Outpatient Drugs- Group 4 – 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 4 - Base 1

Select a label for Group 4:

Indicate Maximum Plan Benefit Coverage annual amount for Group 4:

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

Generic

Preferred Brand

Brand

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– Outpatient 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

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

Section B – 20– Outpatient 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– Outpatient 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– Part C Home Infusion Bundled Services – 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 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 by April 18, 2011.

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.

If your organization elects to provide Part D home infusion drugs as part of a bundled service under Part C then those services must be provided at \$0 cost sharing. As described in the CY 2010 Call Letter this waiver is conditioned on the application of zero cost sharing for the bundle of home infusion services provided under a Part C supplemental benefit.