

Section D-Plan Deductible (Combined) - Base 1 Screen

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

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

Yes  
 No

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

Yes  
 No

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

Select the benefits that apply to the Combined Deductible:

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

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

Yes  
 No

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

1a: Inpatient Hospital-Acute:  
 1b: Inpatient Hospital Psychiatric:  
 2: Skilled Nursing Facility (SNF):  
 3: Cardiac Rehabilitation Services:  
 3: Intensive Cardiac Rehabilitation Services:  
 3: Pulmonary Rehabilitation Services:  
 5: Partial Hospitalization:  
 7a: Primary Care Physician Services:

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

Yes  
 No

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

1a: Inpatient Hospital-Acute:  
 1b: Inpatient Hospital Psychiatric:  
 2: Skilled Nursing Facility (SNF):  
 4a: Emergency Care:  
 7b: Chiropractic Services:  
 7f: Podiatry Services:  
 9d: Outpatient Blood Services:  
 10b: Transportation Services:  
 13a: Acupuncture:  
 13b: Over-the-Counter (OTC) Items:  
 13c: Meal Benefit:  
 13d: Other 1:  
 13e: Other 2:

Section D-Plan Deductible (Combined) - Base 2 Screen

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

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

Yes  
 No

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

Yes  
 No

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

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

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

- 1a: Inpatient Hospital-Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 4a: Emergency Care:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:
- 14b: Supplemental Preventive health Services:

Section D-Plan Deductible (In-Network) - Screen

Section D-Plan Deductible (RPPD-Differential Deductible) – Base 1 Screen

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

Yes  
 No

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

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

Indicate Differential Deductible Amount for Inpatient Hospital Services including Acute:	<input type="text"/>	Indicate Differential Deductible Amount for Partial Hospitalization:	<input type="text"/>
Indicate Differential Deductible Amount for Inpatient Psychiatric Hospital Services:	<input type="text"/>	Indicate Differential Deductible Amount for Home Health Services:	<input type="text"/>
Indicate Differential Deductible Amount for Skilled Nursing Facility (SNF):	<input type="text"/>	Indicate Differential Deductible Amount for Primary Care Physician Services:	<input type="text"/>
Indicate Differential Deductible Amount for Cardiac and Pulmonary Rehabilitation Services:	<input type="text"/>	Indicate Differential Deductible Amount for Chiropractic Services:	<input type="text"/>
Indicate Differential Deductible Amount for Emergency Care:	<input type="text"/>	Indicate Differential Deductible Amount for Occupational Therapy Services:	<input type="text"/>
Indicate Differential Deductible Amount for Urgently Needed Services:	<input type="text"/>	Indicate Differential Deductible Amount for Physician Specialist Services:	<input type="text"/>

Section D-Plan Deductible (RPPD-Differential Deductible) – Base 2 Screen

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

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Indicate Differential Deductible Amount for Mental Health Specialty Services - Non-Psychiatric:	Indicate Differential Deductible Amount for Outpatient Diagnostic and Therapeutic Radiological Services:	Indicate Differential Deductible Amount for Transportation Service:	Indicate Differential Deductible Amount for OTC:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Differential Deductible Amount for Podiatry Services:	Indicate Differential Deductible Amount for Outpatient Hospital Services:	Indicate Differential Deductible Amount for Durable Medical Equipment (DME):	Indicate Differential Deductible Amount for Meal Benefit:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Differential Deductible Amount for Other Health Care Professional Services:	Indicate Differential Deductible Amount for Ambulatory Surgical Center (ASC) Services:	Indicate Differential Deductible Amount for Prosthetics/Medical Supplies:	Indicate Differential Deductible Amount for Other 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Differential Deductible Amount for Psychiatric Services:	Indicate Differential Deductible Amount for Outpatient Substance Abuse Services:	Indicate Differential Deductible Amount for Diabetic Supplies and Services:	Indicate Differential Deductible Amount for Other 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Differential Deductible Amount for Physical Therapy and Speech-Language Pathology Services:	Indicate Differential Deductible Amount for Outpatient Blood Services:	Indicate Differential Deductible Amount for End-Stage Renal Disease:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Indicate Differential Deductible Amount for Outpatient Diagnostic Procedures and Test and Lab Services:	Indicate Differential Deductible Amount for Ambulance Services:	Indicate Differential Deductible Amount for Acupuncture:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Section D-Plan Deductible (RPPD-Differential Deductible) – Base 3 Screen

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Indicate Differential Deductible Amount for Supplemental Preventive Health Services: <input type="text"/>	Indicate Differential Deductible Amount for Preventive Dental: <input type="text"/>	Indicate Differential Deductible Amount for Hearing Aids: <input type="text"/>
Indicate Differential Deductible Amount for Supplemental Education/Wellness Programs: <input type="text"/>	Indicate Differential Deductible Amount for Comprehensive Dental: <input type="text"/>	
Indicate Differential Deductible Amount for Kidney Disease Educational Services: <input type="text"/>	Indicate Differential Deductible Amount for Eye Exams: <input type="text"/>	
Indicate Differential Deductible Amount for Diabetes Self-Management Training: <input type="text"/>	Indicate Differential Deductible Amount for Eye Wear: <input type="text"/>	
Indicate Differential Deductible Amount for Medicare Part B Rx Drugs: <input type="text"/>	Indicate Differential Deductible Amount for Hearing Exams: <input type="text"/>	

Section D-Plan Deductible (Out-of-Network) – Screen

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

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

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

Yes  
 No

Do you charge the Medicare-defined Part B Deductible amount? Indicate Out-of-Network Plan Deductible Amount:

Yes  
 No

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

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

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

Yes  
 No

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

- 1a: Inpatient Hospital-Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4b: Urgently Needed Care:
- 5: Partial Hospitalization:

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

Yes  
 No

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

- 1a: Inpatient Hospital-Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 4a: Emergency Care:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:

Section D-Max Enrollee Cost Limit (Combined) – Base 1 Screen

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

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Is your Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost at the Voluntary or Mandatory Level?

Voluntary  
 Mandatory

All MA plans must have a maximum out-of-pocket (MOOP) that covers all A/B services. For a list of the Voluntary and Mandatory Limits, please right-click on the "Is your Combined Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level?" question and view the Variable Help.

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

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

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

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

Yes  
 No

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

1a: Inpatient Hospital-Acute:  
 1b: Inpatient Hospital Psychiatric:  
 2: Skilled Nursing Facility (SNF):  
 3: Cardiac Rehabilitation Services:  
 3: Intensive Cardiac Rehabilitation Services:  
 3: Pulmonary Rehabilitation Services:  
 4a: Emergency Care:  
 5: Partial Hospitalization:  
 7a: Primary Care Physician Services:  
 7b: Chiropractic Services:  
 7c: Occupational Therapy Services:  
 7d: Physician Specialist Services:

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

Yes  
 No

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

1a: Inpatient Hospital-Acute:  
 1b: Inpatient Hospital Psychiatric:  
 2: Skilled Nursing Facility (SNF):  
 4a: Emergency Care:  
 7b: Chiropractic Services:  
 7f: Podiatry Services:  
 9d: Outpatient Blood Services:  
 10b: Transportation Services:  
 13a: Acupuncture:  
 13b: Over-the-Counter (OTC) Items:  
 13c: Meal Benefit:  
 13d: Other 1:



Section D-Max Enrollee Cost Limit (Combined) – Base 2 Screen

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All MA plans (except MSAs) must have a maximum out-of-pocket (MOOP) that covers all A/B services for CY 2011. Refer to CMS HPMS Benefits Memorandum (early April 2010) for specific MOOP requirements.

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

Yes  
 No

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

Yes  
 No

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

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

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

- 1a: Inpatient Hospital-Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 4a: Emergency Care:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:
- 14b: Supplemental Preventive Health Services:

Section D-Max Enrollee Cost Limit (In-Network) – Screen

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

Yes  
 No

Is your In-Network maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?

Voluntary  
 Mandatory

All MA plans (except MSAs) must have a maximum out-of-pocket (MOOP) that covers all A/B services for CY 2011. Refer to CMS HPMS Benefits Memorandum (early April 2010) for specific MOOP requirements. For a list of the Voluntary and Mandatory Limits, please right-click on the Is your Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level? Question and view the Variable Help.

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

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

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

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

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

Yes  
 No

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

- 1a: Inpatient Hospital-Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4a: Emergency Care:
- 5: Partial Hospitalization:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:

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

Yes  
 No

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

- 1a: Inpatient Hospital-Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 4a: Emergency Care:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:

Section D-Max Enrollee Cost Limit (Out-of-Network) – Screen

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Is there an Out-of-Network Maximum Enrollee Out-of-Pocket Cost?  
 Yes  
 No

Is your an Out-of-Network Maximum Enrollee Out-of-Pocket Cost Voluntary or Mandatory?  
 Voluntary  
 Mandatory

All MA plans (except MSAs) must have a maximum out-of-pocket (MOOP) that covers all A/B services for CY 2011. Refer to CMS HPMS Benefits Memorandum (early April 2010) for specific MOOP requirements. For a list of the Voluntary and Mandatory Limits, please right-click on the Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level? Question and view the Variable Help.

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

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

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

Does the Out-of-Network Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Medicare-covered plan services?  
 Yes  
 No

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

- 1a: Inpatient Hospital-Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4b: Urgently Needed Care:
- 5: Partial Hospitalization:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:

Does the Out-of-Network Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Non-Medicare-covered plan services?  
 Yes  
 No

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

- 1a: Inpatient Hospital-Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 4a: Emergency Care:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:

Section D-Max Enrollee Cost Limit (Non-Network) – Screen

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Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level?

Voluntary  
 Mandatory

All MA plans (except MSAs) must have a maximum out-of-pocket (MOOP) that covers all A/B services for CY 2011. Refer to CMS HPMS Benefits Memorandum (early April 2010) for specific MOOP requirements. For a list of the Voluntary and Mandatory Limits, please right-click on the Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level? Question and view the Variable Help.

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

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

Medicare-covered benefits  
 Non-Medicare-covered benefits

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

Yes  
 No

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

1a: Inpatient Hospital-Acute:  
1b: Inpatient Hospital Psychiatric:  
2: Skilled Nursing Facility (SNF):  
3: Cardiac Rehabilitation Services:  
3: Intensive Cardiac Rehabilitation Services:  
3: Pulmonary Rehabilitation Services:  
4a: Emergency Care:  
5: Partial Hospitalization:

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

Yes  
 No

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

1a: Inpatient Hospital-Acute:  
1b: Inpatient Hospital Psychiatric:  
2: Skilled Nursing Facility (SNF):  
4a: Emergency Care:  
7b: Chiropractic Services:  
7f: Podiatry Services:  
9d: Outpatient Blood Services:  
10b: Transportation Services:  
13a: Acupuncture:  
13b: Over-the-Counter (OTC) Items:  
13c: Meal Benefit:  
13d: Other 1:

Section D-Max Plan Benefit Coverage – Screen

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

Is there a Maximum Plan Benefit Coverage Amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

Every year  
 Every six months  
 Every three months

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

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

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

Yes  
 No

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

1a: Inpatient Hospital-Acute;  
1b: Inpatient Hospital Psychiatric;  
2: Skilled Nursing Facility (SNF);  
4a: Emergency Care;  
7b: Chiropractic Services;  
7f: Podiatry Services;

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

Yes  
 No

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

1a: Inpatient Hospital-Acute;  
1b: Inpatient Hospital Psychiatric;  
2: Skilled Nursing Facility (SNF);  
4a: Emergency Care;  
7b: Chiropractic Services;  
7f: Podiatry Services;  
9d: Outpatient Blood Services;  
10b: Transportation Services;  
13a: Acupuncture;

Section D-Max Plan Benefit Coverage (Non-Network) – Screen

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

Is there a Maximum Plan Benefit Coverage Amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

Every year  
 Every six months  
 Every three months

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

Yes  
 No

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

1a: Inpatient Hospital-Acute;  
1b: Inpatient Hospital Psychiatric;  
2: Skilled Nursing Facility (SNF);  
4a: Emergency Care;  
7b: Chiropractic Services;  
7f: Podiatry Services;

Section D-Plan Premium/Rebate Reduction – Screen

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Indicate Plan Premium Amount (Part A/B):

Indicate Plan Premium Amount (B Only):

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

Indicate the Part B Premium reduction amount:

Section D-PFFS Balance Billing – Screen

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Do you permit balance billing?  Yes  No

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

What category of providers do you permit to balance bill?

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4a: Emergency Care:
- 4b: Urgently Needed Care:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diag Procs/Tests/Lab Services:
- 8b: Outpatient Diag/Therapeutic Rad Services:
- 9a: Outpatient Hospital Services:
- 9b: Ambulatory Surgical Center (ASC) Services:
- 9c: Outpatient Substance Abuse:
- 9d: Outpatient Blood Services:
- 10a: Ambulance Services:
- 10b: Transportation Services:
- 11a: Durable Medical Equipment (DME):

Enter Minimum percentage for balance billing:

Enter Maximum percentage for balance billing:



Section D-MSA Annual Deductible/Deposit – Screen

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

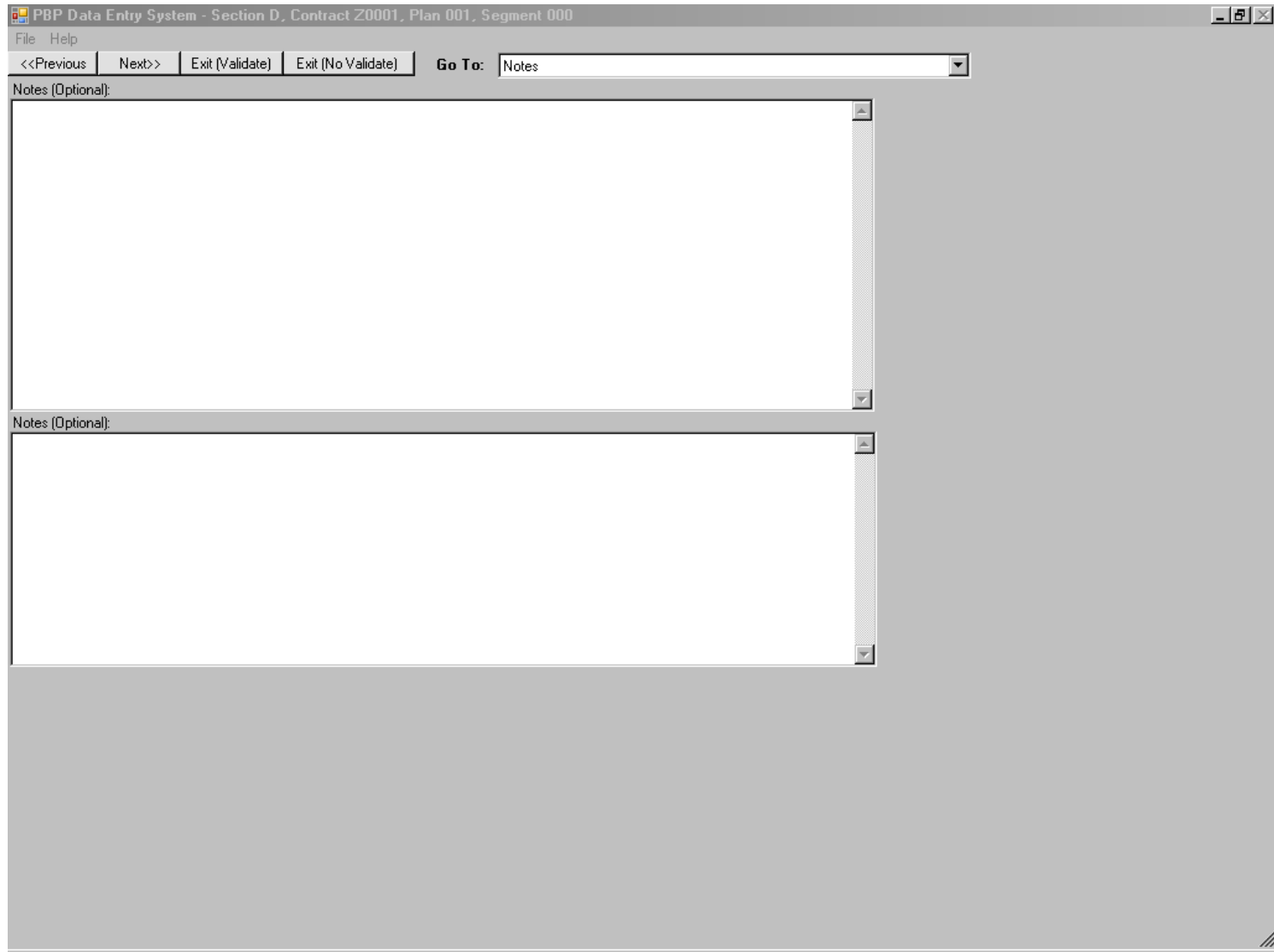
File Help

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

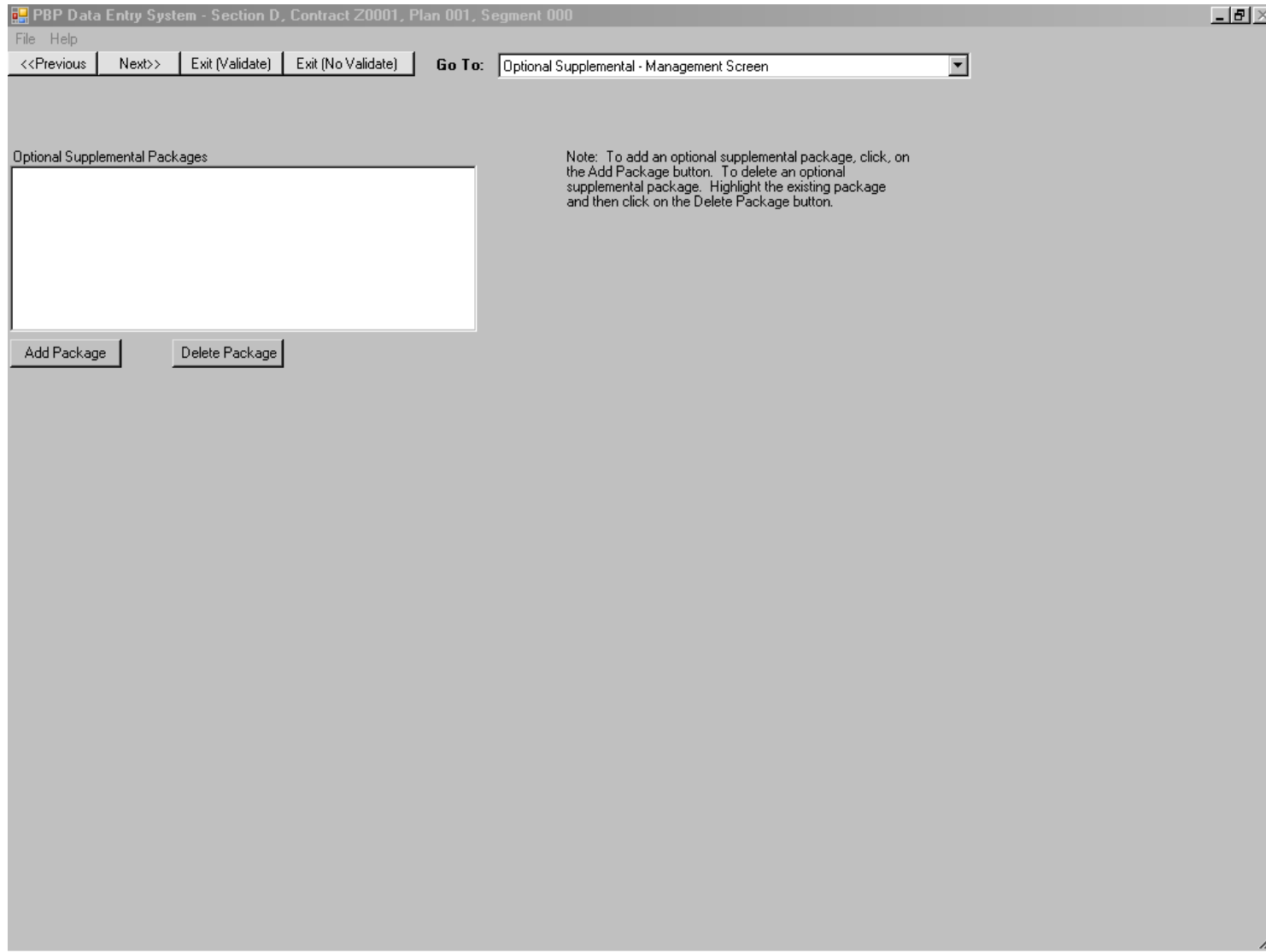
Indicate Annual MSA Deductible amount:

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

Section D-Notes – Screen



Section D-Optional Supplemental- Management Screen



Section D-Optional Supplemental– Label and Premium Screen

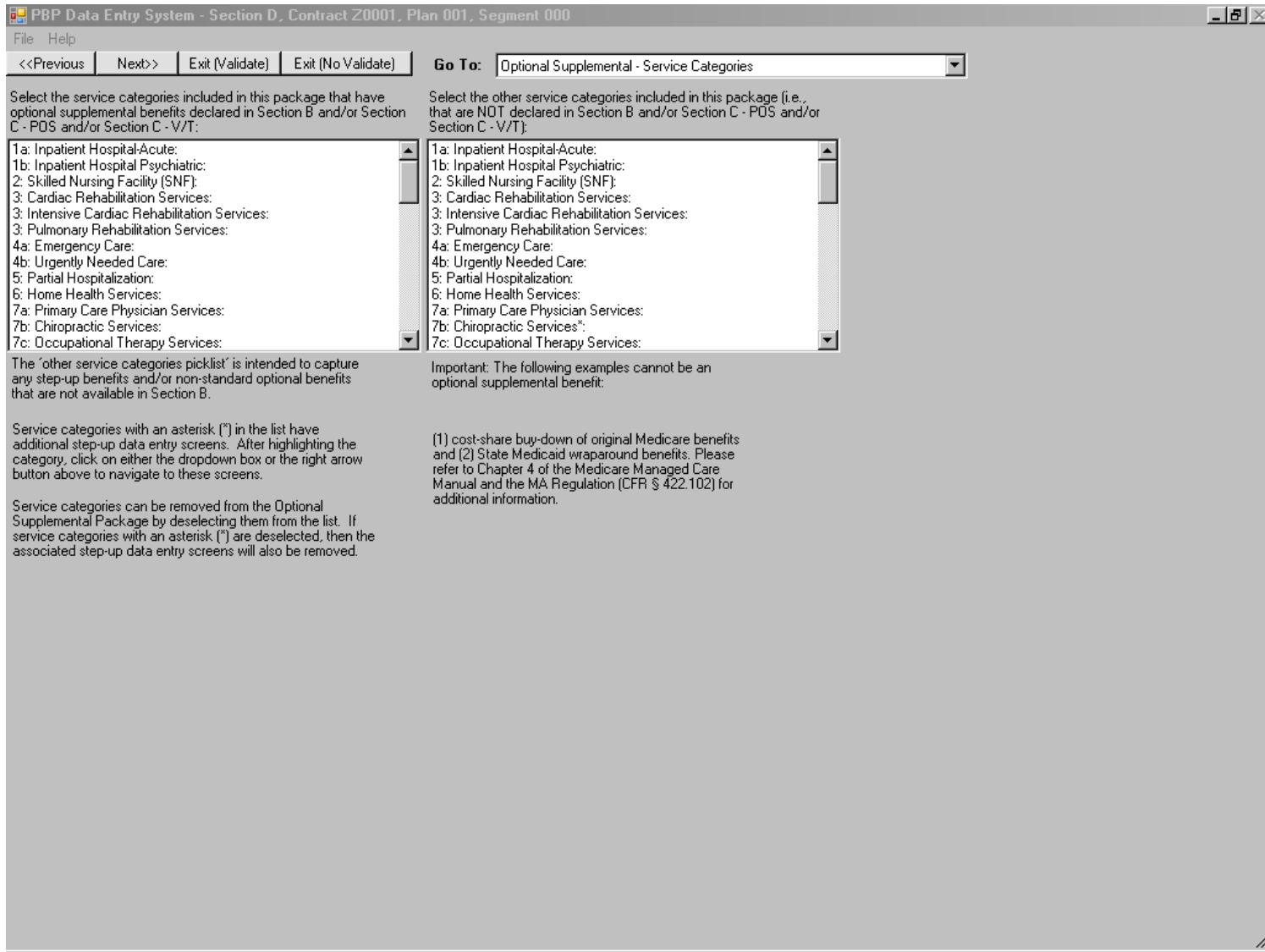
PBP 2012 Data Entry System Screens

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract Z0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a navigation bar with buttons for "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "Optional Supplemental - Label and Premium".

The main form area contains the following fields and controls:

- Optional Supplemental Benefits ID:** A text input field.
- Optional Supplemental Package Description:** A text input field.
- Indicate Optional Supplemental Premium Amount:** A text input field.
- Is there a Maximum Plan Benefit Coverage Amount for this package?:** Radio buttons for "Yes" and "No".
- Indicate Maximum Plan Benefit Coverage Amount for this package:** A text input field.
- Select the Maximum Plan Benefit Coverage periodicity:** Radio buttons for "Every year", "Every six months", and "Every three months".
- Notes:** A large text area for entering notes.

Section D-Optional Supplemental– Services Categories Screen



Section D-Optional Supplemental- OON Stepup Screen

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

File Help

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

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

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

Is there an OON Copayment?  
 Yes  
 No

Enter Minimum Copayment Amount:  
[Text Input]

Enter Maximum Copayment Amount:  
[Text Input]

Is there an OON Coinsurance?  
 Yes  
 No

Enter Minimum Coinsurance Percentage:  
[Text Input]

Enter Maximum Coinsurance Percentage:  
[Text Input]

Notes:  
[Text Area]

Section D-Optional Supplemental- OON Optional Screen

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

File Help

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

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

Is there an OON Copayment?  
 Yes  
 No

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

Is there an OON Coinsurance?  
 Yes  
 No

Enter Minimum Copayment Amount:  
[ ]

Enter Maximum Copayment Amount:  
[ ]

Enter Minimum Coinsurance Percentage:  
[ ]

Enter Maximum Coinsurance Percentage:  
[ ]

Notes:  
[ ]



Section D-Step Up 7B Chiropractic Services– Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

Select enhanced benefit:  
 Routine Care

Select type of benefit for Routine Care:  
 Mandatory  
 Optional

Is this benefit unlimited for Routine Care?  
 Yes  
 No, indicate number

Indicate number of visits for Routine Care:

Select Routine Care periodicity:  
 Every 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:

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 D-Step Up 7B Chiropractic Services– Base 2 Screen

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

File Help

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

Is there an enrollee Coinsurance?

Yes

No

Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:

Indicate the Minimum Coinsurance percentage per visit for Routine Care:

Indicate the Maximum Coinsurance percentage per visit for Routine Care:

Section D-Step Up 7B Chiropractic Services– Base 3 Screen

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

File Help

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?

Yes  
 No

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

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

Indicate Minimum Copayment amount per visit for Routine Care:  
[ ]

Indicate Maximum Copayment amount per visit for Routine Care:  
[ ]

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

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

Is a referral required for Chiropractic Services?

Yes  
 No

Section D-Step Up 7B Chiropractic Services– Base 4 Screen



Section D-Step Up 7F Podiatry Services– Base 1 Screen

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

File Help

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

**CLICK FOR DESCRIPTION OF BENEFIT**

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

Select enhanced benefits:

Routine Footcare

Select type of benefit for Routine Footcare:

Mandatory  
 Optional

Is this benefit unlimited for Routine Footcare?

Yes  
 No

Indicate number of Routine Footcare visits:

Select the Routine Footcare periodicity:

Every 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 D-Step Up 7F Podiatry Services– Base 2 Screen

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

File Help

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

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

Section D-Step Up 7F Podiatry Services– Base 3 Screen

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

File Help

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

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

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

Is a referral required for Podiatrist Services?

Yes

No

Notes (Optional):

[Empty text area]

Section D-Step Up 10B Transportation Services– Base 1 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #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 D-Step Up 10B Transportation Services– Base 2 Screen

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

File Help

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

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

Indicate Maximum Plan Benefit Coverage amount:  
[Text Box]

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:  
[Text Box]

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:  
[Text Box]

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[Text Box]

Section D-Step Up 10B Transportation Services– Base 3 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #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 D-Step Up 16A Preventative Dental- Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

Select enhanced benefits:

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

Select type of benefit for Oral Exams:

Mandatory  
 Optional

Is this benefit unlimited for Oral Exams?

Yes  
 No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

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

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 D-Step Up 16A Preventative Dental- Base 2 Screen

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

File Help

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

Select type of benefit for Dental X-Rays:

Mandatory

Optional

Is 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 D-Step Up 16A Preventative Dental– Base 3 Screen

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

File Help

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

Go To: Step Up #16a Preventive Dental - Base 3

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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:

Indicate Minimum Coinsurance percentage for Oral Exams:

Indicate Maximum Coinsurance percentage for Oral Exams:

Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Minimum Coinsurance percentage for Fluoride Treatment:

Indicate Maximum Coinsurance percentage for Fluoride Treatment:

Indicate Minimum Coinsurance percentage for Dental X-Rays:

Indicate Maximum Coinsurance percentage for Dental X-Rays:

Section D-Step Up 16A Preventative Dental- Base 4 Screen

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

File Help

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

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 D-Step Up 16A Preventative Dental– Base 5 Screen

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

File Help

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

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):

[Empty text area]

Section D-Step Up 16B Comprehensive Dental- Base 1 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) **Go To:** Step Up #16b 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

Indicate number of visits for Non-routine Services:

Select the Non-routine Services periodicity:

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

Is this benefit unlimited for Diagnostic Services?

Yes  
 No, indicate number

Indicate number of visits for Diagnostic Services:

Select the Diagnostic Services periodicity:

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



Section D-Step Up 16B Comprehensive Dental- Base 2 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #16b 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 D-Step Up 16B Comprehensive Dental– Base 3 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #16b 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 D-Step Up 16B Comprehensive Dental- Base 4 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #16b 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 D-Step Up 16B Comprehensive Dental- Base 5 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #16b 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 D-Step Up 16B Comprehensive Dental- Base 6 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #16b 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 D-Step Up 17A Eye Exams– Base 1 Screen

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

File Help

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

**CLICK FOR DESCRIPTION OF BENEFIT**

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

Select enhanced benefit:

Routine Eye Exams

Select type of benefit for Routine Eye Exams:

Mandatory  
 Optional

Is this benefit unlimited for Routine Eye Exams?

Yes  
 No, indicate number

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

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

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 D-Step Up 17A Eye Exams– Base 2 Screen

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

File Help

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

Is there an enrollee Coinsurance?  Yes  No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Eye Exams:

Indicate Maximum Coinsurance percentage for Routine Eye Exams:

Is there an enrollee 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 D-Step Up 17A Eye Exams– Base 3 Screen

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

File Help

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

Indicate whether a separate 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 D-Step Up 17B Eye Wear– Base 1 Screen

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

File Help

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

**CLICK FOR DESCRIPTION OF BENEFIT**

Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

Select enhanced benefits:

Contact Lenses  
 Eye Glasses (Lenses and Frames)  
 Eye Glass Lenses  
 Eye Glass Frames  
 Upgrades

Select type of benefit for Contact Lenses:

Mandatory  
 Optional

Is this benefit unlimited for Contact Lenses?

Yes  
 No, indicate number

Indicate quantity (number of pairs) for Contact Lenses:

Select Contact Lenses periodicity:

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

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 D-Step Up 17B Eye Wear– Base 2 Screen

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

File Help

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

Select type of benefit for Eye Glass Lenses:  
 Mandatory  
 Optional

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 D-Step Up 17B Eye Wear– Base 3 Screen

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

File Help

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

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

Select the Maximum Plan Benefit Coverage type:  
 Covered under Eye Exams Category  
 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 Glass 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 Glass 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 D-Step Up 17B Eye Wear– Base 4 Screen

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

File Help

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

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

Yes  
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage for Medicare-covered Benefits:

Indicate Coinsurance percentage for Contact Lenses:

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

Indicate Coinsurance percentage for Eye Glass Lenses:

Indicate Coinsurance percentage for Eye Glass Frames:

Indicate Coinsurance percentage for Upgrades:

Section D-Step Up 17B Eye Wear- Base 5 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #17b Eye Wear - Base 5

Is there an enrollee Deductible?

Yes

No

Indicate Deductible Amount:

\_\_\_\_\_

Is there an enrollee Copayment?

Yes

No

Indicate Copayment amount for Medicare-covered Benefits:

\_\_\_\_\_

Indicate Copayment amount for Contact Lenses:

\_\_\_\_\_

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

\_\_\_\_\_

Indicate Copayment amount for Eye Glass Lenses:

\_\_\_\_\_

Indicate Copayment amount for Eye Glass Frames:

\_\_\_\_\_

Indicate Copayment amount for Upgrades:

\_\_\_\_\_

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

None

Primary Care Physician (Internist/Family Practice, General Practice)

Physician Specialist

Organization Medical Director/Utilization Management/Utilization Review

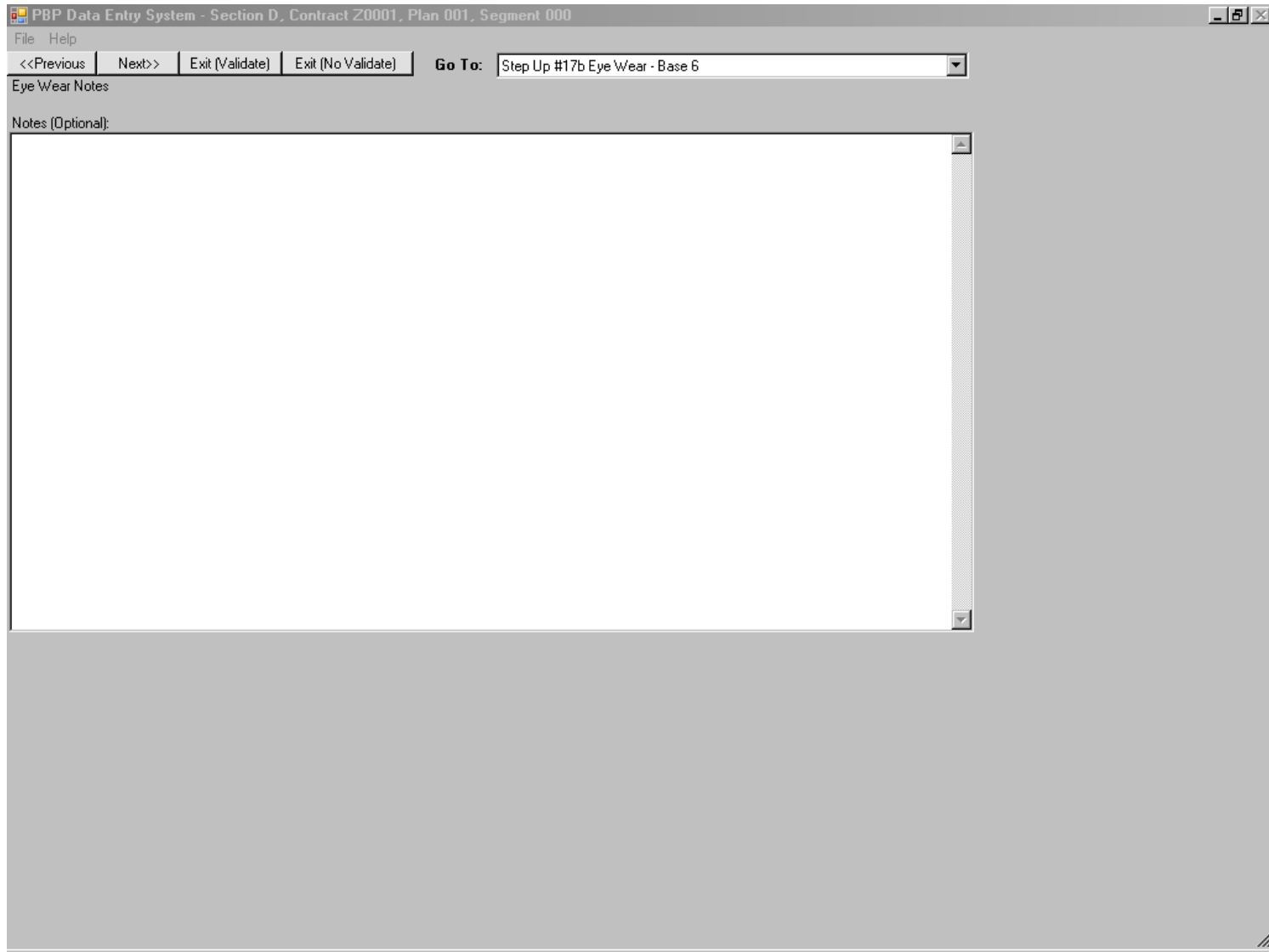
Other, describe

Is a referral required for Eye Wear?

Yes

No

Section D-Step Up 17B Eye Wear– Base 6 Screen



Section D-Step Up 18A Hearing Exams– Base 1 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #18a Hearing Exams - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

Select enhanced benefits:

Routine Hearing Tests  
 Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Tests:

Mandatory  
 Optional

Is this benefit unlimited for Routine Hearing Tests?

Yes  
 No, indicate number

Indicate number for Routine Hearing Tests:

Select Routine Hearing Tests periodicity:

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

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

Mandatory  
 Optional

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

Yes  
 No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

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

Section D-Step Up 18A Hearing Exams– Base 2 Screen

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

File Help

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

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</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>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>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?</p> <p><input type="radio"/> In-network services only <input type="radio"/> Both In-network and Out-of-network services</p>	<p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <input type="text"/>	<p>Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:</p> <input type="text"/>
<p>Indicate Maximum Plan Benefit Coverage amount:</p> <input type="text"/>	<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other</p>	<p>Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:</p> <input type="text"/>
<p>Select the Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other</p>		<p>Indicate Minimum Coinsurance percentage for Routine Hearing Tests:</p> <input type="text"/>
<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>		<p>Indicate Maximum Coinsurance percentage for Routine Hearing Tests:</p> <input type="text"/>
<p>Indicate Deductible Amount:</p> <input type="text"/>		<p>Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:</p> <input type="text"/>
		<p>Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:</p> <input type="text"/>



Section D-Step Up 18A Hearing Exams– Base 3 Screen

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

File Help

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

Go To: Step Up #18a Hearing Exams - Base 3

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Routine Hearing Tests:

Indicate Maximum Copayment amount for Routine Hearing Tests:

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

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

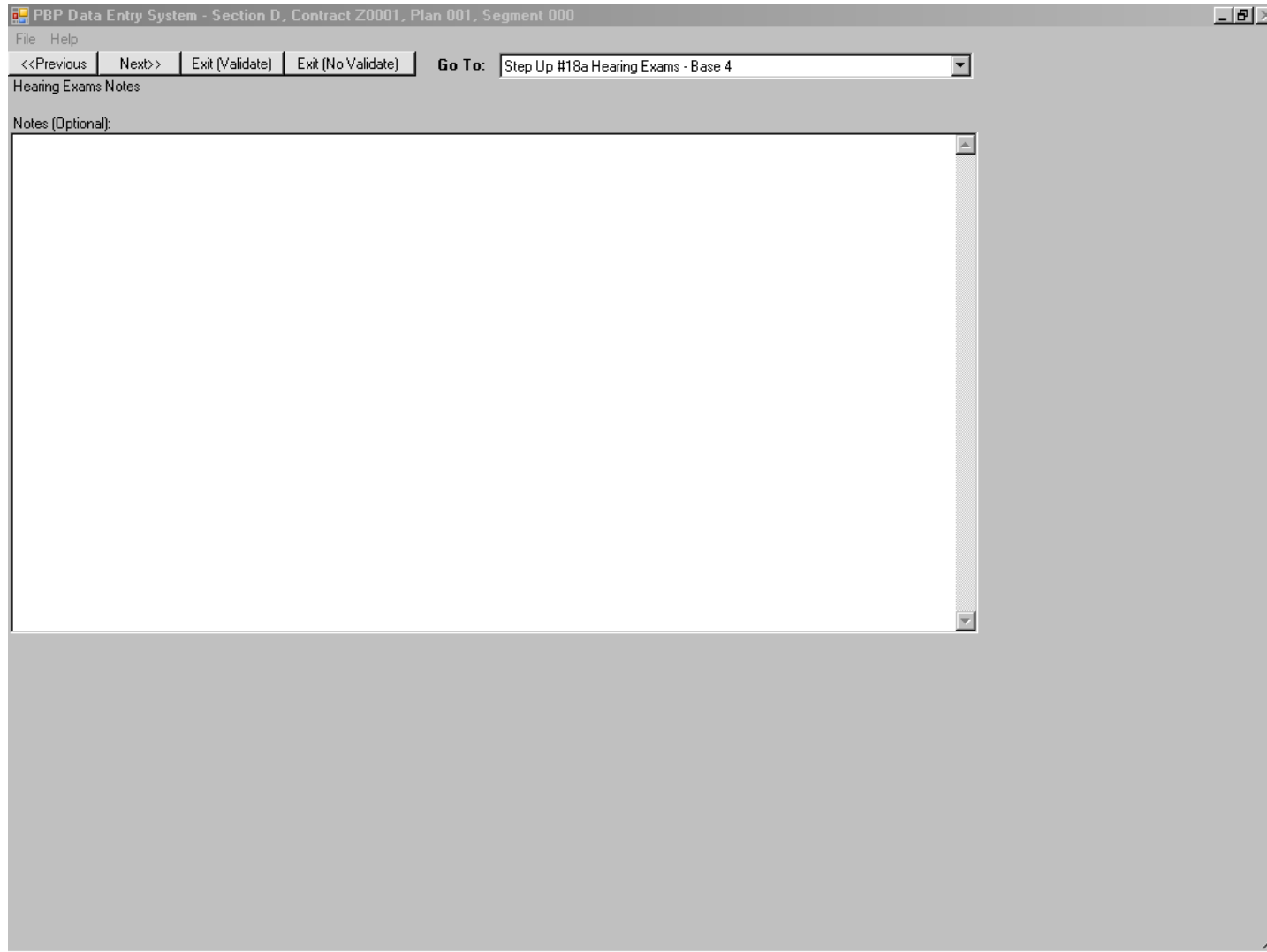
Enrollee must receive Authorization from one or more of the following:

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

Is a referral required for Hearing Exams?

Yes  
 No

Section D-Step Up 18A Hearing Exams– Base 4 Screen



Section D-Step Up 18B Hearing Aids- Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes  
 No

Select enhanced benefits:

Hearing Aids (all types)  
 Hearing Aids - Inner Ear  
 Hearing Aids - Outer Ear  
 Hearing Aids - Over the Ear

Select type of benefit for Hearing Aids (all types):

Mandatory  
 Optional

Is this benefit unlimited for Hearing Aids (all types)?

Yes  
 No, indicate number

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity:

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

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 - Inner Ear:

Mandatory  
 Optional

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 D-Step Up 18B Hearing Aids– Base 2 Screen

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

File Help

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

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

Mandatory

Optional

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

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 quantity for Hearing Aids - Over the Ear:

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 D-Step Up 18B Hearing Aids– Base 3 Screen

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

File Help

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

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

Yes  
 No

Is there an enrollee Coinsurance?

Yes  
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate 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:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Section D-Step Up 18B Hearing Aids- Base 4 Screen

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

File Help

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

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount per Hearing Aid - Over the Ear:  
[ ]

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

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

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Copayment amount per Hearing Aid - Inner Ear:  
[ ]

Indicate Deductible Amount:  
[ ]

Indicate Copayment amount per two Hearing Aids - Inner Ear:  
[ ]

Indicate Copayment amount per Hearing Aid - Outer Ear:  
[ ]

Indicate Copayment amount per two Hearing Aids - Outer Ear:  
[ ]

Section D-Step Up 18B Hearing Aids– Base 5 Screen

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

File Help

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

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

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

Is a referral required for Hearing Aids?

Yes

No

Notes (Optional):