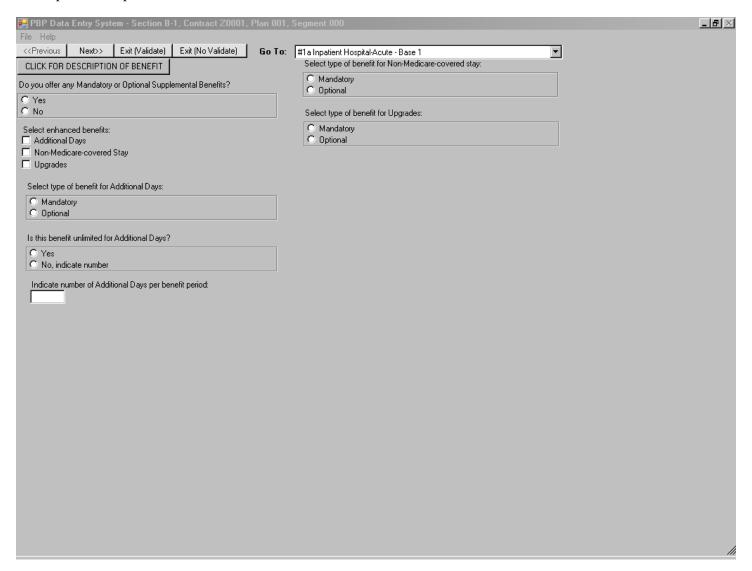
Section B - 1A - Inpatient Hospital-Acute – Base 1 Screen



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

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001,	Segment 000	_ 8 ×
File Help  < <pre> &lt;<pre> File Help  &lt;<pre> &lt;<pre> File Help  </pre> <pre> Serit (Validate)</pre></pre></pre></pre>	#1a Inpatient Hospital-Acute - Base 2 Indicate the number of day intervals for the Medicare-covered stay:	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  C Yes C No	C Zero (No Coinsurance per Day) C One C Two C Three	
Indicate the Maximum Enrollee Out-of-Pocket Cost amount:	Indicate the coinsurance percentage and day interval(s) for the Medicare -covered stay (e.g., 1 to 30; 31 to 90):	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
C Every six months C Every three months	Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Is there an enrollee Coinsurance?  C Yes C No	Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  C. Yes C. No		
Indicate Coinsurance percentage for the Medicare-covered stay:		

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

🔛 PBP Data Entry System - Section	B-1, Contract Z0001, Plan	001, Segment 000		_ B ×
File Help				
< <pre>&lt;<pre>&lt;&lt; Previous</pre></pre>	e) Exit (No Validate) Go	To: #1a Inpatient Hospital-Acut	e - Base 3	<u> </u>
Indicate the number of day intervals for the	Medicare-covered Lifetime Rese	erve Days:		
C Zero (No Coinsurance per Day) C One C Two C Three				
Indicate the coinsurance percentage and Days (i.e., 1 - 60):	day interval(s) for the 60 Medica	are-covered Lifetime Reserve		
Coinsurance % Interval 1: Lifetime Rese	erve Begin Day Interval 1: Li	ifetime Reserve End Day Interval 1:		
Coinsurance % Interval 2: Lifetime Rese	erve Begin Day Interval 2: Li	ifetime Reserve End Day Interval 2:		
Coinsurance % Interval 3: Lifetime Rese	erve Begin Day Interval 3: Li	ifetime Reserve End Day Interval 3:		

Section B - 1A - Inpatient Hospital-Acute – Base 4 Screen

🔐 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000	_ & ×
File Help	
< <pre></pre>	
Indicate the number of day intervals for Additional Days:	
© Zero (No Coinsurance per Day)	
C One C Two	
C Three	
Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):	
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	

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Section B - 1A - Inpatient Hospital-Acute – Base 5 Screen

Keyley outs Newt> 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. Zero (No Coinsurance per Day) One Two Three Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter '939' if unlimited days are offered; e.g.; 1 to 999); Coinsurance ≈ Interval 1: Begin Day Interval 2: End Day Interval 3: End Day Interval 3
Indicate Coinsurance percentage for the Non-Medicare-covered stay:  Indicate Coinsurance percentage for the Non-Medicare-covered stay:  Indicate the number of day intervals for the Non-Medicare-covered stay:  Indicate the number of day intervals for the Non-Medicare-covered stay:  Indicate the number of day intervals for the Non-Medicare-covered stay:  Indicate the coinsurance per Day)  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 2:  Begin Day Interval 2:  End Day Interval 2:
Yes   Indicate Coinsurance percentage for the Non-Medicare-covered stay:   Indicate the number of day intervals for the Non-Medicare-covered stay:   C Zero (No Coinsurance per Day)   O 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:   End Day Interval 2:   End Day Interval 3:   End Da
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 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:  End Day Interval 2: End Day Interval 2:
Indicate Coinsurance percentage for the Non-Medicare-covered stay:  Indicate the number of day intervals for the Non-Medicare-covered stay:  C Zero (No Coinsurance per Day) One C 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:
Indicate the number of day intervals for the Non-Medicare-covered stay:  C Zero (No Coinsurance per Day) C One C 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:
C Zero (No Coinsurance per Day) C One C Two C 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:
C One C Two C 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:
C Two C 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:
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:
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 3: End Day Interval 3
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1: End Day Interval 2: End Day Interval 3: End Day Interval 3
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	8 ×
File Help		
< <pre>&lt;<pre>&lt;<pre>c<pre>vious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre></pre>	Go To: #1a Inpatient Hospital-Acute - Base 6	
Is there an enrollee Deductible?	Indicate the number of day intervals for the Medicare-covered stay:	
⊙ Yes	C Zero (No Copayment per Day)	
○ No	C One C Two	
Indicate Deductible Amount:	C Three	
	Indicate the copayment amount and day interval(s) for the Medicare -covered stay (e.g., 1 to 30; 31 to 90):	
Is there an enrollee Copayment?		
O Yes	Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
○ No		
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the		
the total charges for all services provided to the enrollee in the inpatient facility.)	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
O Yes		
O No		
	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
Indicate Copayment amount for the Medicare-covered stay:		
		- //

Section B - 1A - Inpatient Hospital-Acute – Base 7 Screen

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000	_ B ×
File Help	
< <pre>&lt;</pre> Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 7	
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	
C Zero (No Copayment per Day)	
O One	
C Two	
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: Lifetime Reserve End Day Interval 1:	
Copayment Amt Interval 2: Lifetime Reserve Begin Day Interval 2: Lifetime Reserve End Day Interval 2:	
Copayment Amt Interval 3: Lifetime Reserve Begin Day Interval 3: Lifetime Reserve End Day Interval 3:	
	11.

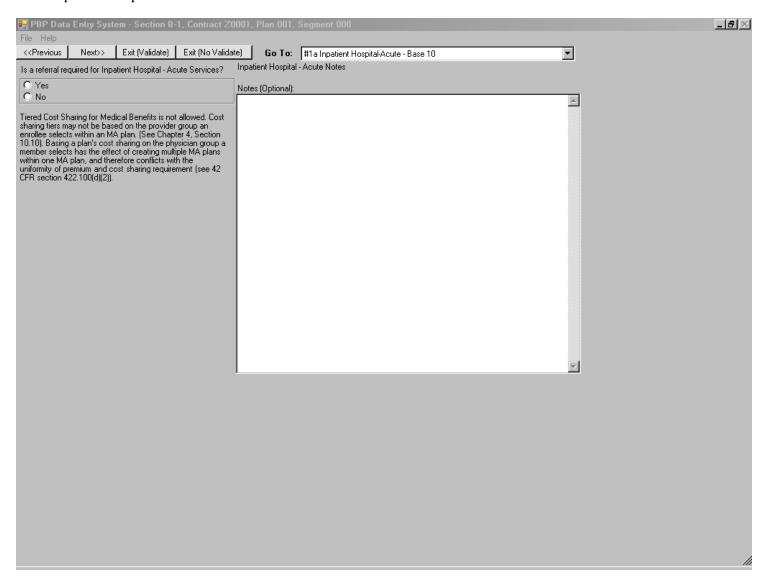
Section B - 1A - Inpatient Hospital-Acute – Base 8 Screen

🔛 PBP Data Entry Syste	m - Section B-1, Contr	act Z0001, Plan 001,	, Segment 000	₽ ×
File Help				
< <pre>&lt;<pre>&lt;&lt; Previous</pre></pre>	Exit (Validate)   Exit (No	Validate) Go To:	#1a Inpatient Hospital-Acute - Base 8	
Indicate the number of day in	tervals for Additional Days:			
C Zero (No Copayment per C One C Two C Three	Day)			
Indicate the copayment amo (enter '999' if unlimited days a	unt and day interval(s) for A are offered; e.g., 91 to 999)	Additional Days :		
Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:		
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:		
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:		
				//

Section B - 1A - Inpatient Hospital-Acute – Base 9 Screen

📴 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001,	Segment 000
File Help	
< <pre>&lt;<pre>revious</pre></pre>	#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?	Indicate Copayment amount for Upgrades per stay:
© Yes	
O No	Indicate Copayment amount for Upgrades per day:
Indicate Copayment amount for the Non-Medicare-covered stay:	
	Enrollee must receive Authorization from one or more of the following:
Indicate the number of day intervals for the Non-Medicare-covered stay:	☐ None
C Zero (No Copayment per Day)	Primary Care Physician (Internist/Family Practice, General Practice)
O One	☐ Physician Specialist ☐ Organization Medical Director/Utilization Management/Utilization Review
C Two	Other, describe
C 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 Amit merval 1. Begin Day merval 1. End Day merval 1.	
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
	,

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



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

🔛 PBP Data Entry System - Section B-1, Contract Z0001, F	Plan 001, Segment 000	_ B ×
File Help		
<pre>&lt;<pre>&lt;<pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate)</pre></pre></pre>	Go To: #1a Inpatient Hospital-Acute (B Only) - Base 1	▼
Do you offer Inpatient Hospital - Acute Services as a benefit?	Is there a service-specific Maximum Plan Benefit Coverage amount?	
C Yes C No	C Yes C No	
Select type of benefit for Inpatient Hospital - Acute Services:		
Mandatory	Indicate Maximum Plan Benefit Coverage amount:	
C Optional		
	Select Maximum Plan Benefit Coverage periodicity:	
Does this benefit have unlimited days?	© Every year	
C Yes C No, indicate number	C Every six months C Every three months	
	C Lycly tillee months	
Indicate number of days per period:		
Select the days periodicity:		
© Every year	1	
C Every six months		
C Every three months		

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

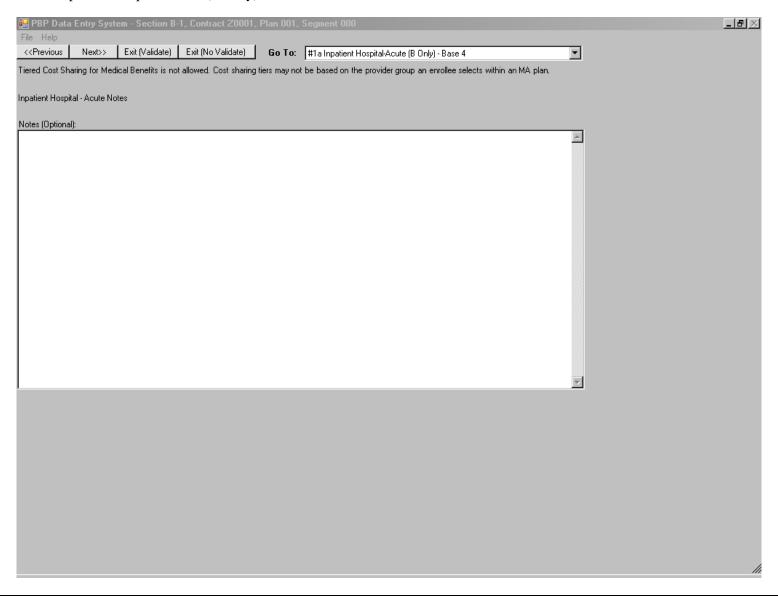
🔛 PBP Data Entry System - Section B-1, Contract Z0001, I	Plan 001,	, Segment 000	_ 6
File Help			
< <pre>&lt;<pre></pre></pre>	Go To:	#1a Inpatient Hospital-Acute (B Only) - Base 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		Indicate the number of day intervals for the stay:	
C Yes C No		C Zero (No Coinsurance per Day) C One	
		O Two	
Indicate the Maximum Enrollee Out-of-Pocket Cost amount:		○ Three	
		Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:		(enter "999" if unlimited days are offered; e.g., 1 to 999);	
C Every year		Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
C Every six months			
C Every three months			
Is there an enrollee Coinsurance?		Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
C Yes			
O No		Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
Indicate Coinsurance percentage per stay:			
mulcate consular ce percentage per stay.			

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

🔛 PBP Data Entry System - Section B-1, Contract Z0001, F	Plan 001,	Segment 000	_B×
File Help			
< <pre>&lt;<pre> </pre> <pre></pre></pre>	Go To:	#1a Inpatient Hospital-Acute (B Only) - Base 3	▼
Is there an enrollee Deductible?		Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):	
© Yes			
O No		Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
Indicate Deductible Amount:			
		Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
		Sognification and the	
Is there an enrollee Copayment?			
O Yes		Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
○ No			
Indicate Copayment amount per stay:	_		
		rollee must receive Authorization from one or more of the following:  None	
		Primary Care Physician (Internist/Family Practice, General Practice)	
Indicate the number of day intervals for the stay:	. 🗀	Physician Specialist	
C Zero (No Copayment per Day) C One	무	Organization Medical Director/Utilization Management/Utilization Review Other, describe	
O Two		Uther, describe	
O Three		a referral required for Inpatient Hospital - Acute Services?	_
		Yes	
	C	No	

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



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

Fu Associates, Ltd.

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001,		_ <u>- B ×</u>
File Help		
< <pre>&lt;<pre>&lt;<pre></pre></pre></pre>	#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?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
O Yes	O Yes	
O No	O No	
Select enhanced benefit:		
Additional Days	Select the Maximum Enrollee Out-of-Pocket Cost type:	
☐ Non-Medicare-covered Stay	C Covered under Inpatient Hospital Services Category 1a C Plan-specified amount per period	
Select type of benefit for Additional Days:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
C Mandatory C Optional		
S optional		
Is this benefit unlimited for Additional Days?	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Yes	C Every year C Every six months	
C No, indicate number	C Every three months	
Indicate number of Additional Days per benefit period:		
indicate number of Additional Days per benefit period.		
Select type of benefit for Non-Medicare-covered stay:		
C Mandatory		
O Optional		

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

🖳 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000	_ B ×
File Help	
< <pre>&lt;<pre>&lt;</pre> Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 2</pre>	
Is there an enrollee Coinsurance?	
© Yes	
O 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:	
C Zero (No Coinsurance per Day) C One T Two	
○ Three	
Indicate the coinsurance percentage and day interval(s) for the Medicare -covered stay (e.g., 1 to 30; 31 to 90):	
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	

Section B – 1B - Inpatient Hospital Psychiatric – Base 3 Screen

🔛 PBP Data Entry System - Section B-1, Contract Z0001, I	Plan 001, Segment 000	_ B ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre></pre></pre>	Go To: #1b Inpatient Hospital Psychiatric - Base 3	
Indicate the number of day intervals for the Medicare-covered Lifetime	Reserve Days:	
C Zero (No Coinsurance per Day)		
© One		
C Two C Three		
Indicate the coinsurance percentage and day interval(s) for the 60 M Days (i.e., 1 - 60):	edicare-covered Lifetime Reserve	
Coinsurance % Interval 1: Lifetime Reserve Begin Day Interval 1:	Lifetime Reserve End Day Interval 1:	
Coinsurance % Interval 2: Lifetime Reserve Begin Day Interval 2:	Lifetime Reserve End Day Interval 2:	
Coinsurance % Interval 3: Lifetime Reserve Begin Day Interval 3:	Lifetime Reserve End Day Interval 3:	

Section B – 1B - Inpatient Hospital Psychiatric – Base 4 Screen

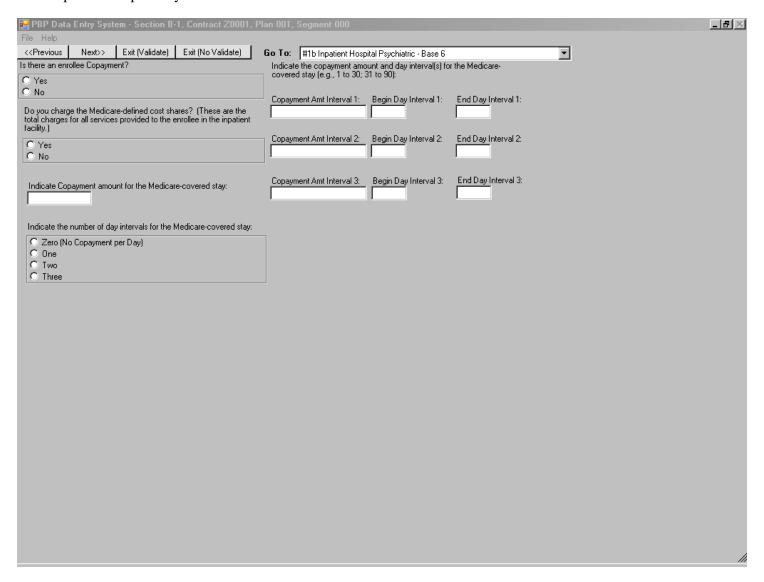
🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000	_ B ×
File Help	
< <pre></pre>	
Indicate the number of day intervals for Additional Days:	
C Zero (No Coinsurance per Day)	
C One C Two	
© Three	
Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999);	
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
	li.

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Section B – 1B - Inpatient Hospital Psychiatric – Base 5 Screen

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001,		_ 8 ×
File Help		
< <pre>&lt;<pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To:</pre></pre>	#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?	Is there an enrollee Deductible?	
C Yes	O Yes O No	
C No	NO NO	
Indicate Coinsurance percentage for the Non-Medicare-covered stay:	Indicate Deductible Amount:	
Indicate the number of day intervals for the Non-Medicare-covered stay:		
C Zero (No Coinsurance per Day)		
C One		
C 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:		
		11.

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



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

🔐 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000	<u>_ &amp; </u>
File Help	
< <pre>&lt;<pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital P</pre></pre>	sychiatric - Base 7
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	
C Zero (No Copayment per Day) C One C Two C 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 Interva	1:
Copayment Amt Interval 2: Lifetime Reserve Begin Day Interval 2: Lifetime Reserve End Day Interval	2:
Copayment Amt Interval 3: Lifetime Reserve Begin Day Interval 3: Lifetime Reserve End Day Interval	3:

Section B – 1B - Inpatient Hospital Psychiatric – Base 8 Screen

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000	<u>_ 8 × </u>
File Help	
< <pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To: #1b Inpatient</pre>	Hospital Psychiatric - Base 8
Indicate the number of day intervals for Additional Days:	
C Zero (No Copayment per Day) C One C Two	
O Three	
Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999);	
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
	li de la companya de

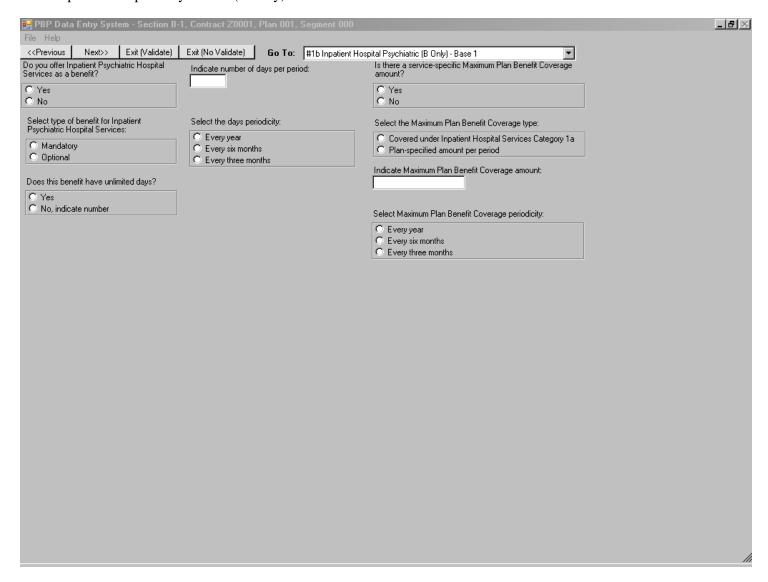
Section B – 1B - Inpatient Hospital Psychiatric – Base 9 Screen

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001,		_ B ×
File Help		
< <pre>&lt;<pre>revious</pre></pre>	#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?  C. Yes C. No	Enrollee must receive Authorization from one or more of the following:  None Primary Care Physician (Internist/Family Practice, General Practice)	
Indicate Copayment amount for the Non-Medicare-covered stay:	□ Physician Specialist     □ Organization Medical Director/Utilization Management/Utilization Review     □ Other, describe	
Indicate the number of day intervals for the Non-Medicare-covered stay:  C Zero (No Copayment per Day)  O One  O Two  O Three	Is a referral required for Inpatient Psychiatric Hospital Services?  C Yes C No	
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:		

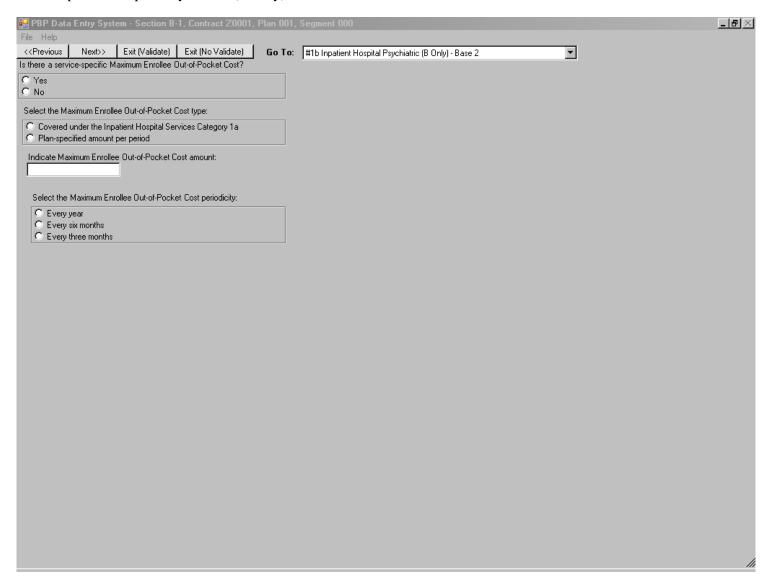
Section B – 1B - Inpatient Hospital Psychiatric – Base 10 Screen



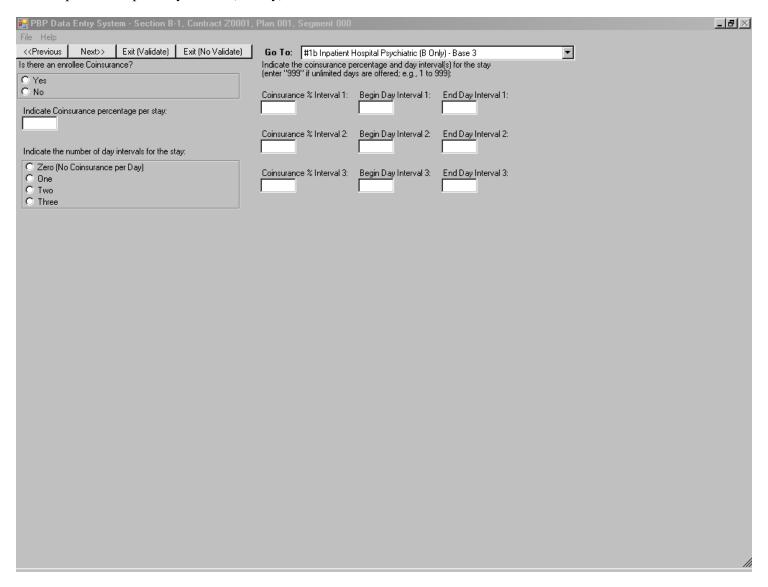
Section B – 1B - Inpatient Hospital Psychiatric (B Only) – Base 1 Screen



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



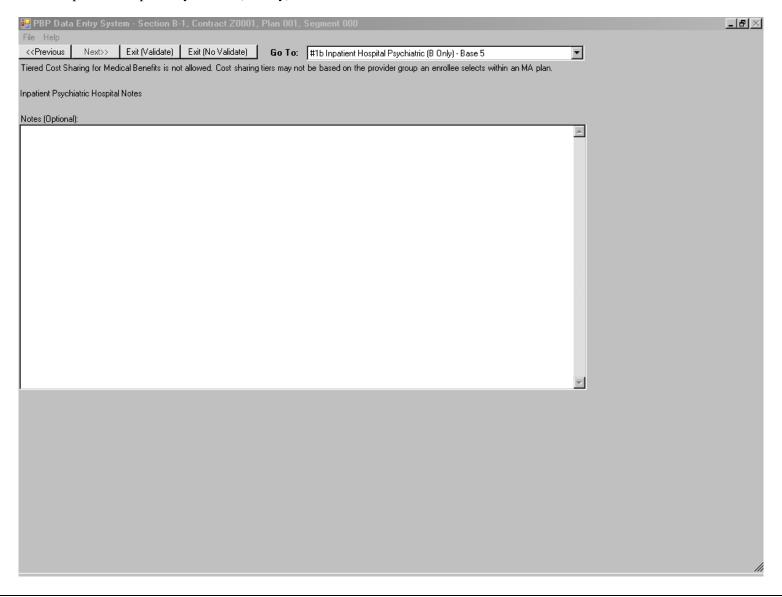
Section B – 1B - Inpatient Hospital Psychiatric (B Only) – Base 3 Screen



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

📴 PBP Data Entry System - Section B-1, Contract Z0001, I	Plan 001, Segment 000	_ B ×
File Help		
< <pre>&lt;<pre> </pre> Next&gt;&gt; Exit (Validate) Exit (No Validate)</pre>	Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 4	
Is there an enrollee Deductible?	Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999);	
○ Yes		
○ No	Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
Indicate Deductible Amount:		
	0	
	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
Is there an enrollee Copayment?		
C Yes	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
○ No		
Indicate Copayment amount per stay:		
	Enrollee must receive Authorization from one or more of the following:	
	☐ None ☐ Primary Care Physician (Internist/Family Practice, General Practice)	
Indicate the number of day intervals for the stay:	Physician Specialist	
C Zero (No Copayment per Day)	☐ Organization Medical Director/Utilization Management/Utilization Review	
© One	☐ Other, describe	
C Two C Three	Is a referral required for Inpatient Psychiatric Hospital Services?	
O Three	C Yes	
	Č 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 Z0001, Plan 001,	Segment 000	_ 8 ×
File Help		
< <pre> </pre>	#2 SNF - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Do you allow less than 3 day hospital stay prior to SNF admission?	
Do you offer any Mandatory or Optional Supplemental Benefits?	C Yes C No	
© Yes		
© No	Indicate the Number of Hospital Days Required Prior to SNF Admission [0-2]:	
Select enhanced benefits:	© Zero	
Additional days beyond Medicare-covered	O One	
Non-Medicare-covered stay	C Two	
Select type of benefit for Additional Days beyond Medicare-covered:	Maximum Plan Benefit Coverage is not applicable for this Service  Category.	
O Mandatory	_ Category.	
C Optional		
Is this benefit unlimited for Additional Days?		
O Yes		
O 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:		
O Mandatory		
C Optional		

# Section B – 2 - SNF – Base 2 Screen

🚂 PBP Data Entry System - Section B-2, Contract Z0001, F	Plan 001, Segment 000		_ l
File Help			
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #2 SNF - Base 2		<u> </u>
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the number of day intervals	s for the Medicare-covered stay:	
C Yes	💆 Zero (No Coinsurance per Day)		
C No	O One		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	C Three		
Select the Maximum Enrollee Dut-of-Pocket Cost periodicity:	Indicate the coinsurance percenta covered stay (e.g.; 1 to 20; 21 to 1	age and day interval(s) for Medicare- 100):	
	Coinsurance % Interval 1: Begi	in Day Interval 1: End Day Interval 1:	
C Every year C Every six months			
C Every three months	Science & Interval 2 Pari	- Devilational 2	
Is there an enrollee Coinsurance?	Coinsurance % Interval 2: Begi	in Day Interval 2: End Day Interval 2:	
C Yes			
C No	Coinsurance % Interval 3: Begi	in Day Interval 3: End Day Interval 3:	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)			
© Yes	7		
○ No			
Indicate Coinsurance percentage for the Medicare-covered stay:			
			//

# Section B – 2 - SNF – Base 3 Screen

	_ 8 ×
File Help	
< <pre> &gt; Exit (Validate) Exit (No Validate) Go To: #2 SNF ⋅ Base 3  ▼</pre>	
Indicate the number of day intervals for Additional Days:	
© Zero (No Coinsurance per Day)	
O One	
O Two O Three	
Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999):	
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	

# Section B – 2 - SNF – Base 4 Screen

🔛 PBP Data Entry System - Section B-2, Contract Z0001, Plan 001	, Segment 000	
File Help		
< <pre>&lt;<pre> </pre> <pre></pre></pre>	: #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?	Is there an enrollee Deductible?	
C Yes	O No	
○ No		
Indicate Coinsurance percentage for the Non-Medicare-covered stay:	Indicate Deductible Amount:	
Indicate the number of day intervals for the Non-Medicare-covered stay:		
C Zero (No Coinsurance per Day)		
○ One		
C Two		
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:		

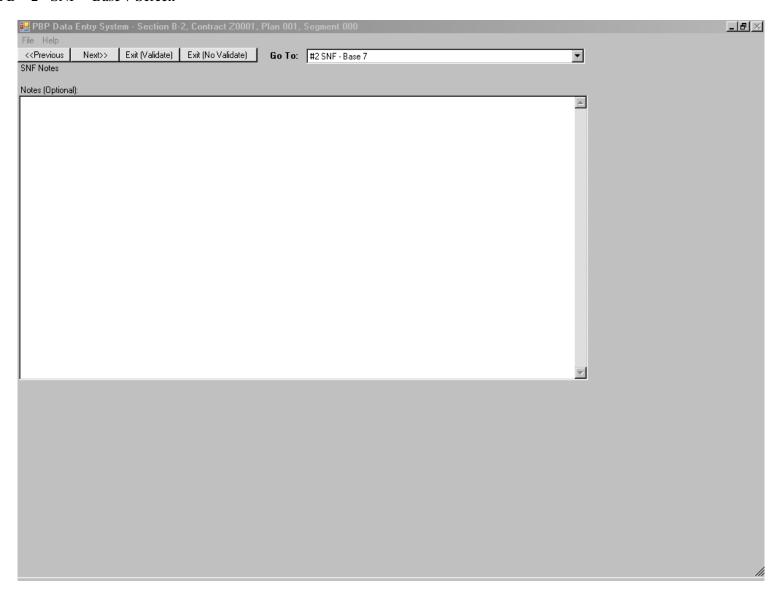
# Section B – 2 - SNF – Base 5 Screen

🖳 PBP Data Entry System - Section B-2, Contract Z0001, Plan 001, S	Segment 000	_ B ×
File Help		
	#2 SNF - Base 5	
Is there an enrollee Copayment?	Indicate the number of day intervals for Additional Days:	
C Yes	C Zero (No Copayment per Day) C One	
	O Two	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	C Three	
C Yes C No	Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999):	
Indicate Copayment amount for Medicare-covered stay:	Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
Indicate the number of day intervals for the Medicare-covered stay:  C Zero (No Copayment per Day)	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
O One		
C Two	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
○ 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:		
		//

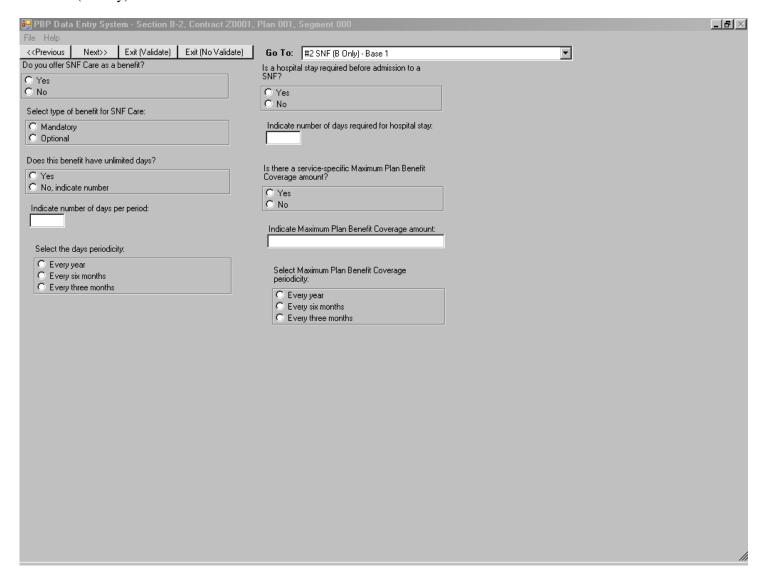
# Section B – 2 - SNF – Base 6 Screen

🔐 PBP Data Entry System - Section B-2, Contract Z0001, Plan 001,	, Segment 000	X
File Help		
	#2 SNF - 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 SNF Services?	
Indicate the number of day intervals for the Non-Medicare-covered stay:	C Yes	
C Zero (No Copayment per Day) C One C Two C 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:		
		//

# Section B – 2 - SNF – Base 7 Screen



#### Section B – 2 – SNF (B Only) – Base 1 Screen



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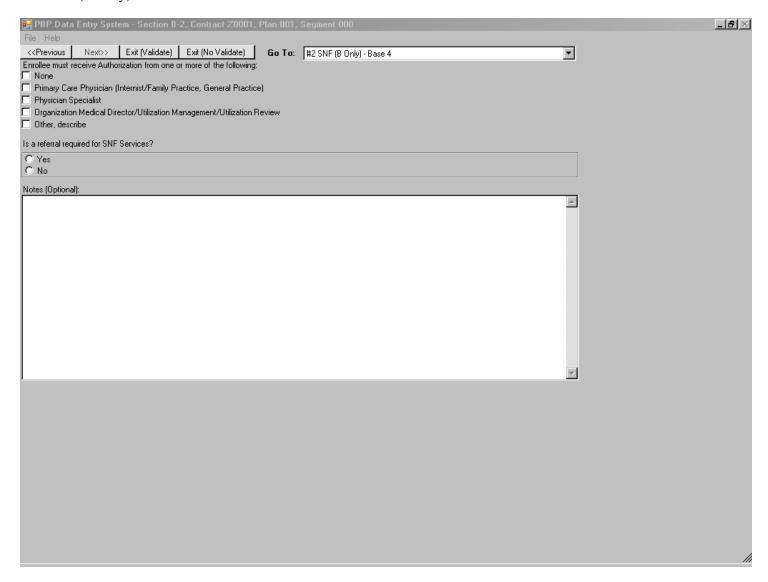
# Section B – 2 – SNF (B Only) – Base 2 Screen

🔛 PBP Data Entry System - Section B-2, Contract Z0001, F	Plan 001, Segment 000				_ 5 ×
File Help					
< <pre>&lt;<pre>&lt;<pre>revious</pre></pre></pre>	Go To: #2 SNF (B Only) - Bas			▼	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the number of day i	<u> </u>			
O Yes	C Zero (No Coinsurance p	er Day)			
C No	O One O Two				
Indicate amount for Maximum Enrollee Out-of-Pocket Cost:	C Three				
	Indicate the coinsurance of	ercentage and day interv	val(s) for the stau		
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate the coinsurance p (enter "999" if unlimited da	ys are offered; e.g.; 1 to 9	999):		
	Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:		
C Every year C Every six months	Comission is the second in the	- Dogin Day mortain.	Ena Bay Interval 1.		
© Every three months					
	Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:		
Is there an enrollee Coinsurance?					
C Yes C No	Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:		
I No	Coinsurance & Interval 3:	Begin Day Interval 3:	End Day Interval 3:		
Indicate Coinsurance percentage:					
					ll.

# Section B – 2 – SNF (B Only) – Base 3 Screen

🔛 PBP Data Entry System - Section B-2, Contract Z0001, F	Plan 001, Segment 000		_ & ×
File Help			
< <pre>&lt;<pre>&lt;<pre>vious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #2 SNF (B Only) - Base 3	▼	
Is there an enrollee Deductible?	Indicate the copayment amount and day interval(s) for if unlimited days are offered; e.g., 1 to 999):	or the stay (enter "999"	
O Yes			
C No	Copayment Amt Interval 1: Begin Day Interval 1:	End Day Interval 1:	
Indicate Deductible Amount:			
	Copayment Amt Interval 2: Begin Day Interval 2:	End Day Interval 2:	
	Copayment Ank Interval 2. Begin Day Interval 2.	End Day Interval 2.	
Is there an enrollee Copayment?			
C Yes	Copayment Amt Interval 3: Begin Day Interval 3:	End Day Interval 3:	
C No			
Indicate Copayment amount per Stay:			
Indicate the number of day intervals for the stay:			
C Zero (No Copayment per Day)			
○ One ○ Two			
O Three			
			//

#### Section B – 2 – SNF (B Only) – Base 4 Screen



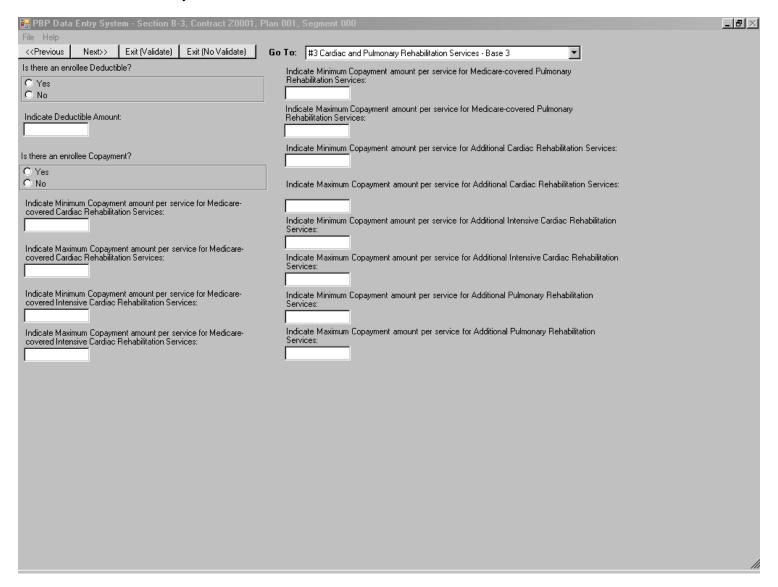
Section B – 3 – Cardiac and Pulmonary Rehabilitation Services – Base 1 Screen

🔛 PBP Data Entry System - Section B-3, Contract Z0001, Plan 001,		_ <u>_ P ×</u>
File Help		
< <pre>&lt;<pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To:</pre></pre>	#3 Cardiac and Pulmonary Rehabilitation Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Do you offer any Mandatory or Optional Supplemental Benefits?	Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services?  © Yes	
O Yes	O No, indicate number	
○ No	Indicate number of visits for Additional Intensive Cardiac Rehabilitation	
Select enhanced benefit:	Services:	
Additional Intensive Cardiac Rehabilitation Services		
Additional Pulmonary Rehabilitation Services	Select the Additional Intensive Cardiac Rehabilitation Services periodicity:	
Select type of benefit for Additional Cardiac Rehabilitation Services:	C Every year	
O Mandatory	© Every six months	
O Optional	© Every three months	
Is this benefit unlimited for Additional Cardiac Rehabilitation Services?	Select type of benefit for Additional Pulmonary Rehabilitation Services:	
© Yes	O Mandatory	
O No, indicate number	C Optional	
Indicate number of visits for Additional Cardiac Rehabilitation Services:	Is this benefit unlimited for Additional Pulmonary Rehabilitation Services?	
	© Yes	
Select the Additional Cardiac Rehabilitation Services periodicity:	C No, indicate number	
C Every year	Indicate number of visits for Additional Pulmonary Rehabilitation Services:	
C Every six months C Every three months		
Select type of benefit for Additional Intensive Cardiac Rehabilitation Services:	Select the Additional Pulmonary Rehabilitation Services periodicity:	
	C Every year	
○ Mandatory ○ Optional	O Every six months	
S Optional	C Every three months	

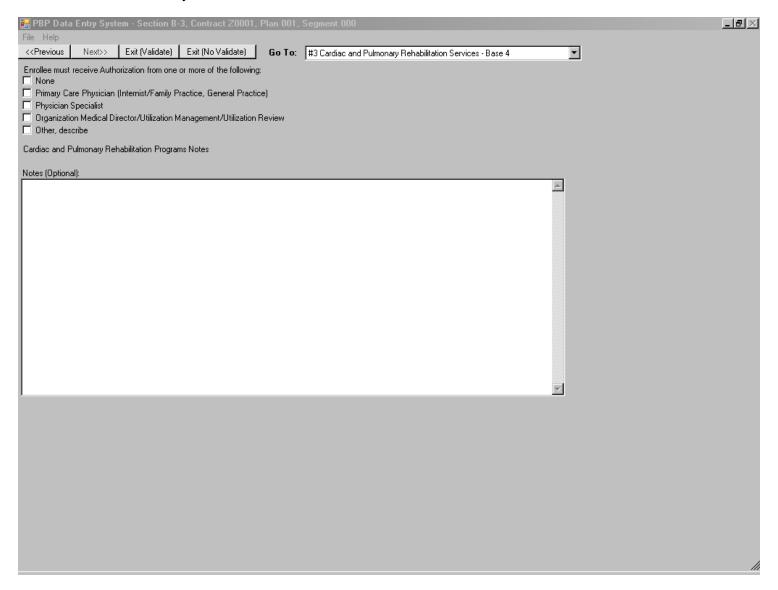
# Section B – 3 – Cardiac and Pulmonary Rehabilitation Services – Base 2 Screen

🖳 PBP Data Entry System - Section B-3, Contract Z0001, Plan 0	01, Segment 000
File Help	
< <pre>&lt;<pre>&lt;<pre>revious</pre> Next&gt;&gt;</pre> Exit (Validate) Exit (No Validate) Go 1</pre>	o: #3 Cardiac and Pulmonary Rehabilitation Services - Base 2
Maximum Plan Benefit Coverage is not applicable for this Service Category	Indicate Minimum Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services:
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
C Yes C No	Indicate Maximum Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services:
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Minimum Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Maximum Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:
C Every six months Every three months	Indicate Minimum Coinsurance percentage for Additional Cardiac Rehabilitation Services:
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.	Indicate Maximum Coinsurance percentage for Additional Cardiac Rehabilitation Services:
Is there an enrollee Coinsurance?  C Yes C No	Indicate Minimum Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:
Indicate Minimum Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services:	Indicate Maximum Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:
Indicate Maximum Coinsurance percentage for Medicare-covered 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

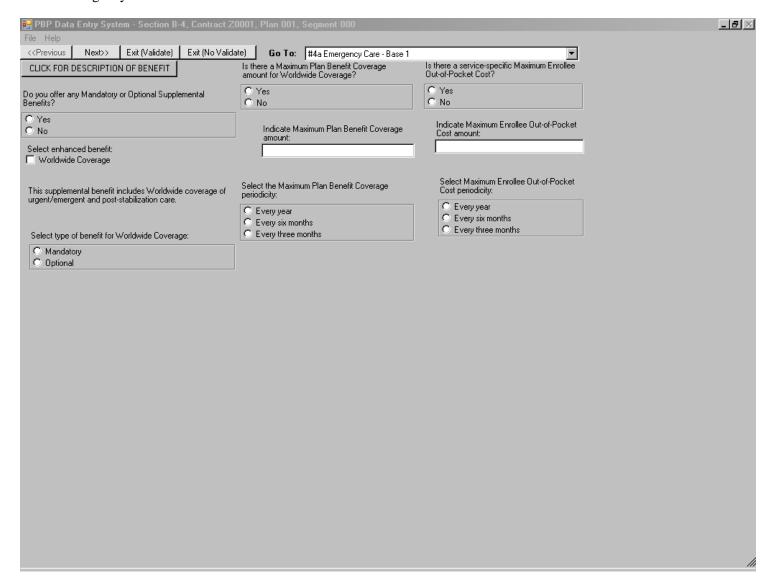


Section B – 3 – Cardiac and Pulmonary Rehabilitation Services – Base 4 Screen



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

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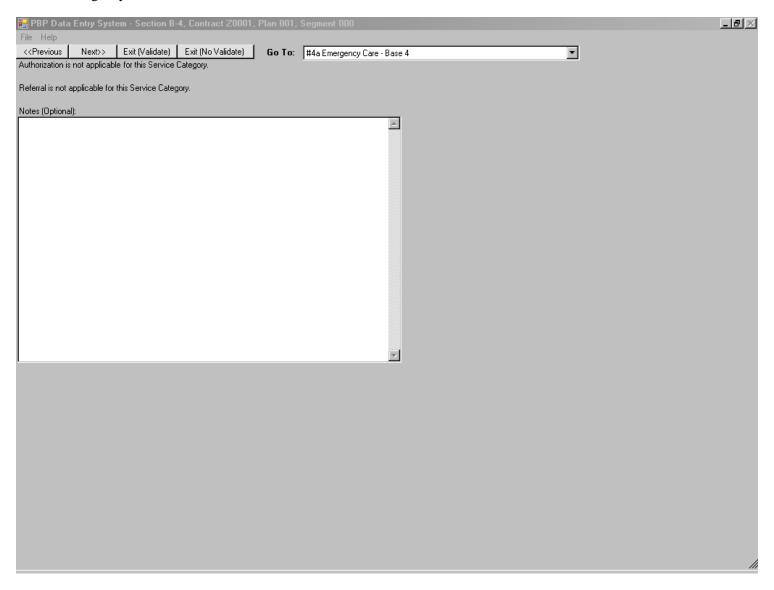
# Section B – 4A – Emergency Care – Base 2 Screen

🔛 PBP Data Entry System - Section B-4, Contract Z0001,	Plan 001, Segment 000	_   &   ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To:   #4a Emergency Care - Base 2  ▼	
Is there an enrollee Coinsurance?	Indicate Coinsurance percentage for Worldwide Coverage:	
O Yes		
© No		
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Is this Coinsurance waived for Worldwide Coverage if admitted to hospital?  C Yes  C No	
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Is there an enrollee Deductible?  C Yes C No	
Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?	Indicate Deductible Amount:	
C Yes C No		
Select either Days or Hours within which admission must occur for waiver:		
C Days O Hours		
Enter number of Days or Hours:		
		,

# Section B – 4A – Emergency Care – Base 3 Screen

🔛 PBP Data Entry System - Section B-4, Con		_ <i>- - -</i> ×
File Help		
< <pre>&lt;<pre>&lt;<pre>c</pre></pre><pre>Next&gt;&gt;</pre><pre>Exit (Validate)</pre><pre>Exit (I</pre></pre>	(No Validate) Go To: #4a Emergency Care - Base 3	
Is there an enrollee Copayment?	Indicate Copayment amount for Worldwide	
O Yes	Coverage:	
O 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?  C Yes  No  Select either Days or Hours within which admission must occur for waiver:  C Days C Hours  Enter number of Days or Hours:	Is this Copayment for Worldwide Coverage waived if admitted to hospital?  C Yes No  Does ER cost sharing count towards any plan-level deductibles?  C Yes No  Indicate the plan-level deductibles where ER cost sharing counts: In-Network only Out-of-Network only Combined (In-Network and Out-of-Network)	
		//

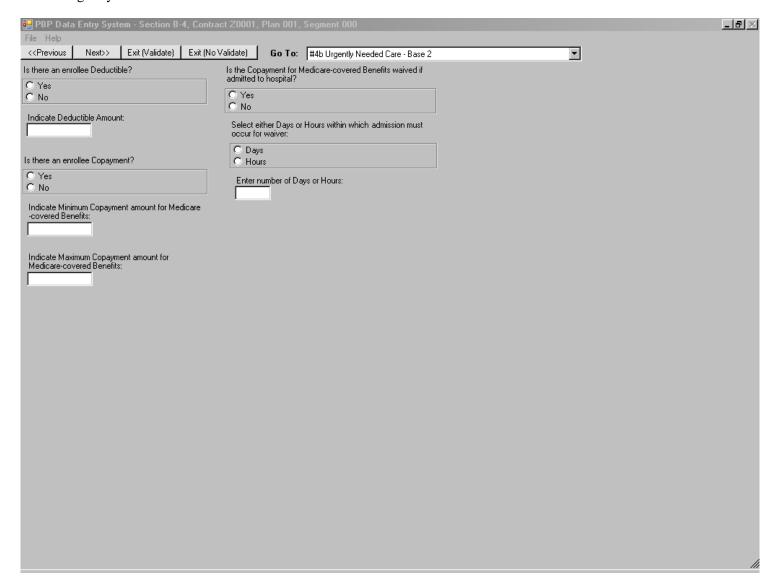
Section B – 4A – Emergency Care – Base 4 Screen



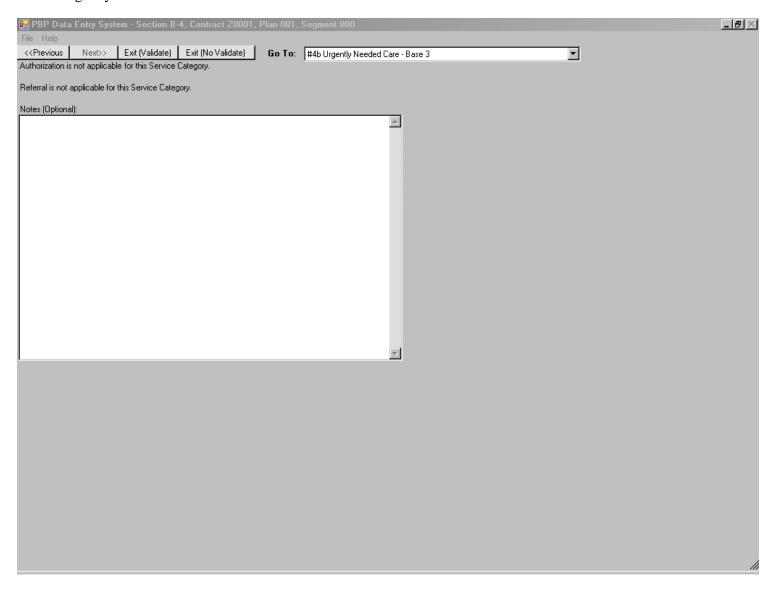
Section B – 4B – Urgently Needed Care – Base 1 Screen

🔛 PBP Data Entry System - Section B-4, Contract Z00	01, Plan 001, Segment 000		_ <b>.</b> .
File Help			
< <pre>&lt;<pre>&lt;<pre>revious</pre></pre></pre>	Go To: #4b Urgently Needed Care		
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?	
Urgently needed services means covered services that are not emergency services provided when an enrollee is temporarily absent from the MA plan's service (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible! when the services are Maximum Plan Benefit Coverage is not applicable for this Service Category.  Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  C Yes  No  Select the Maximum Enrollee Out-of-Pocket Cost type:  C Covered under Emergency Care Service Category 4a  C Plan-specified amount per period		waived if admitted to hospital?  C Yes  No  Select either Days or Hours within which admission must occur for waiver:  Days Hours  Enter number of Days or Hours:	
			<i></i>

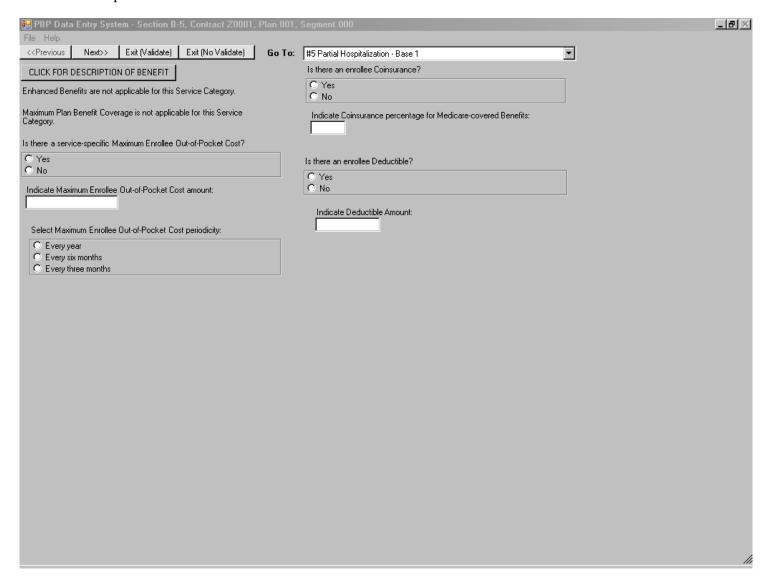
Section B – 4B – Urgently Needed Care – Base 2 Screen



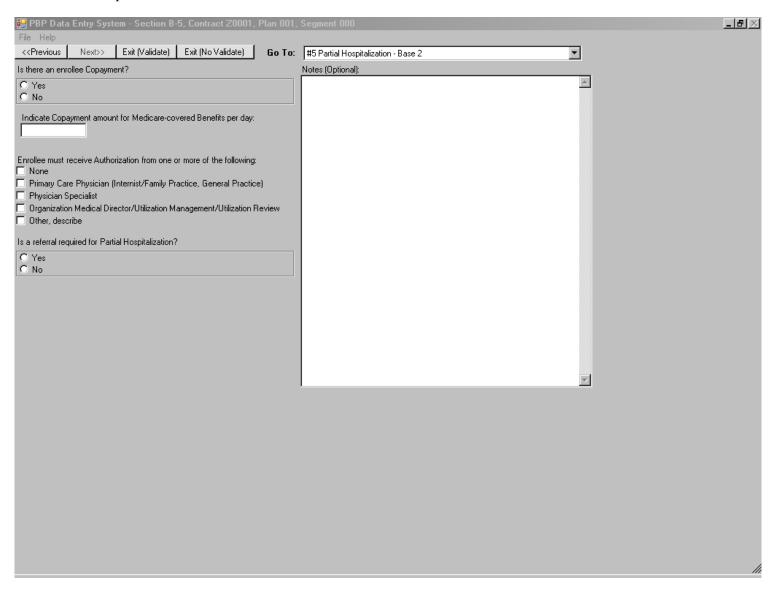
Section B – 4B – Urgently Needed Care – Base 3 Screen



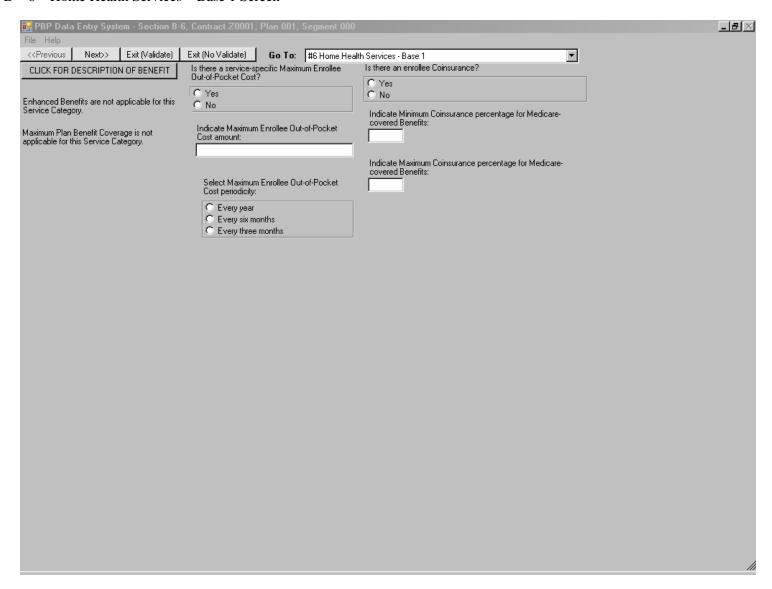
Section B – 5 – Partial Hospitalization – Base 1 Screen



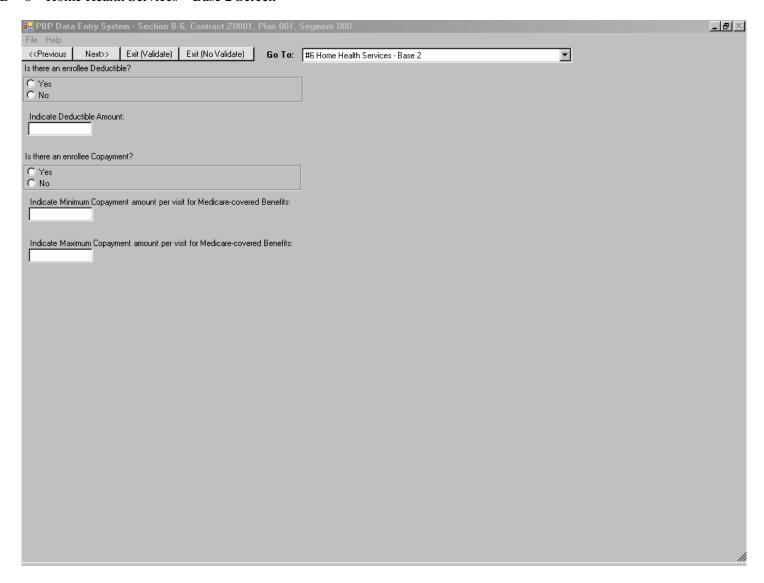
Section B – 5 – Partial Hospitalization – Base 2 Screen



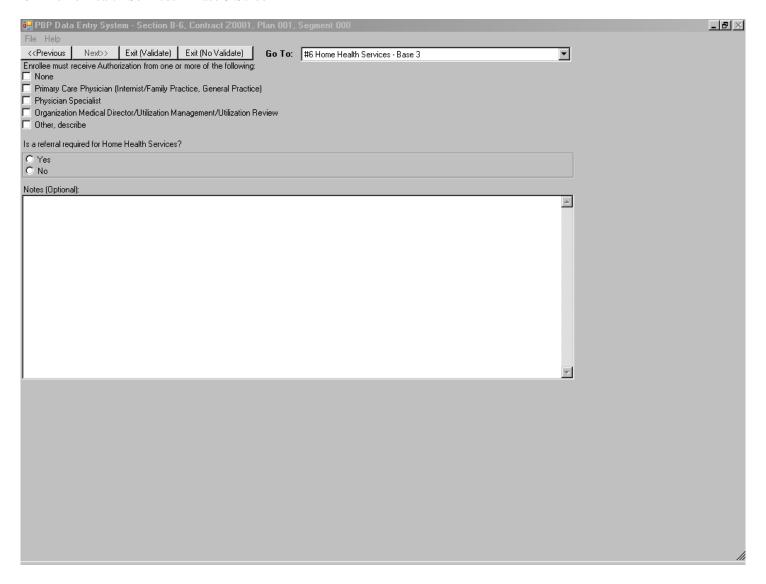
#### Section B – 6 – Home Health Services – Base 1 Screen



#### Section B – 6 – Home Health Services – Base 2 Screen



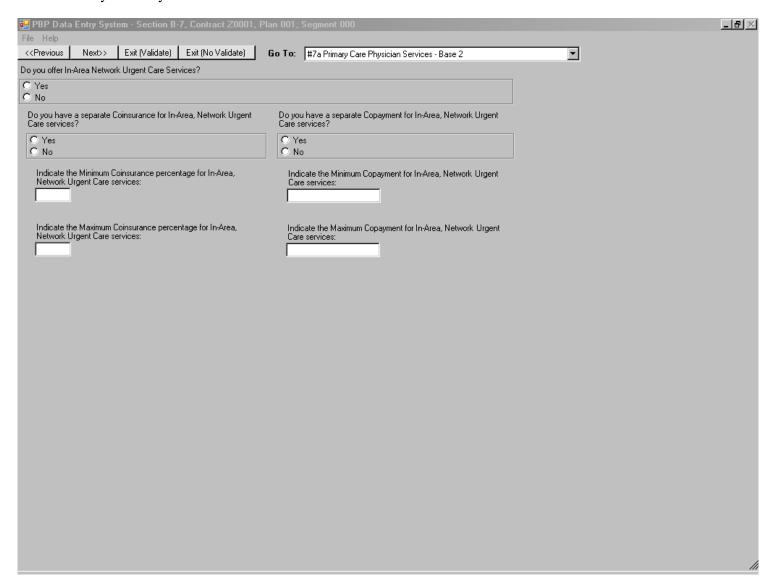
Section B – 6 – Home Health Services – Base 3 Screen



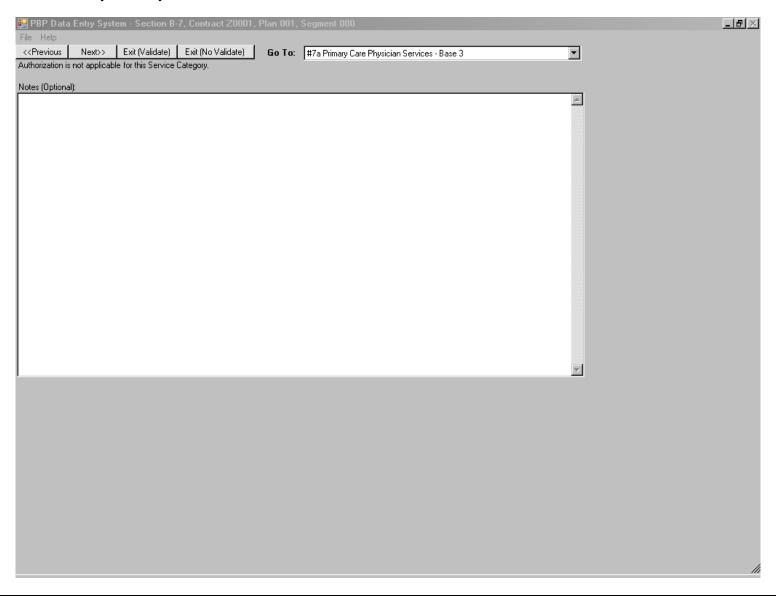
# Section B – 7A – Primary Care Physician Services – Base 1 Screen

🔛 PBP Data Entry System - Section B-7, Contract Z0001	, Plan 001, Segment 000	_ B ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #7a Primary Care Physician Services - Base 1	<b>T</b>
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	_
	O Yes	
If your plan offers in-network coverage such as through walk-in	○ No	
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.	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
If cost sharing for this benefit is not the same as primary care, reflect the cost sharing in the range.	<del></del>	
	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Maximum Plan Benefit Coverage is not applicable for this Service Category.		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Deductible?	
C Yes	O Yes	
C No	C No	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Deductible Amount:	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Copayment?	
C Every year	C Yes	
C Every six months C Every three months	C No	
C Every tribe months	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
		li.

Section B – 7A – Primary Care Physician Services – Base 2 Screen



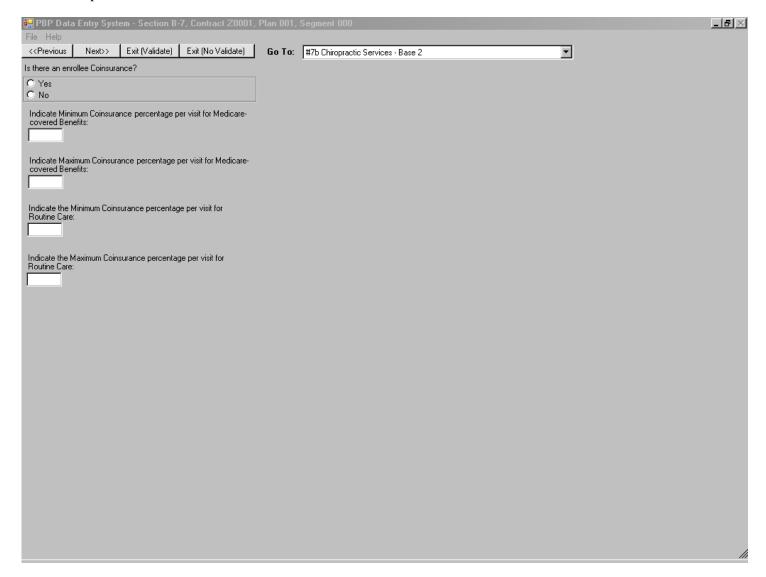
Section B – 7A – Primary Care Physician Services – Base 3 Screen



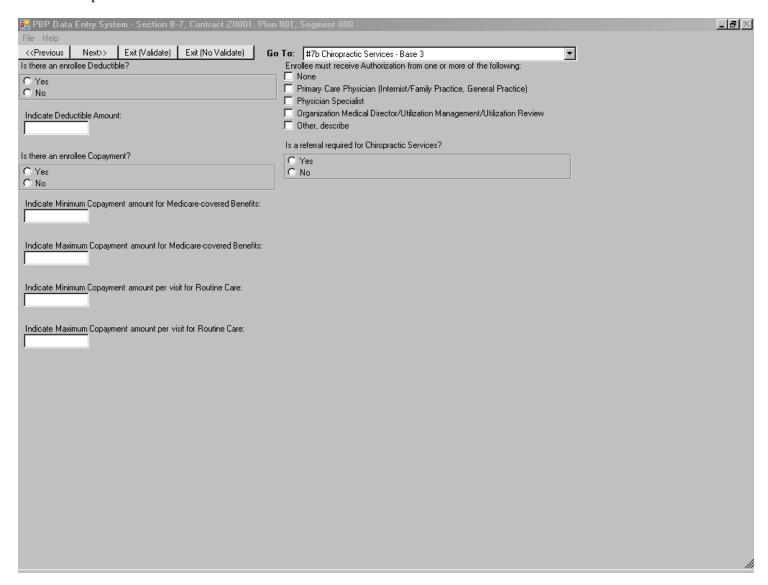
Section B – 7B – Chiropractic Services – Base 1 Screen

🔛 PBP Data Entry System - Section B-7	, Contract Z0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre>&lt;<pre>&lt;&lt; Previous</pre></pre>	Exit (No Validate) Go To: #7b Chiropractic Ser		
CLICK FOR DESCRIPTION OF BENEFIT	Select Routine Care periodicity:	Is there a service-specific Maximum Enrollee Out-of- Pocket Cost?	
Do you offer any Mandatory or Optional Supplemental Benefits?	C Every year C Every six months C Every three months	C Yes	
O Yes O No		Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select enhanced benefit: ☐ Routine Care	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select the Maximum Enrollee Out-of-Pocket Cost	
Select type of benefit for Routine Care:	C Yes C No	periodicity:	
Mandatory     Optional	Indicate Maximum Plan Benefit Coverage amount:	C Every year C Every six months C Every three months	
Is this benefit unlimited for Routine Care?			
C Yes	Select Maximum Plan Benefit Coverage periodicity:		
C No, indicate number	C Every year		
Indicate number of visits for Routine Care:	C Every six months C Every three months		

Section B – 7B – Chiropractic Services – Base 2 Screen



Section B – 7B – Chiropractic Services – Base 3 Screen



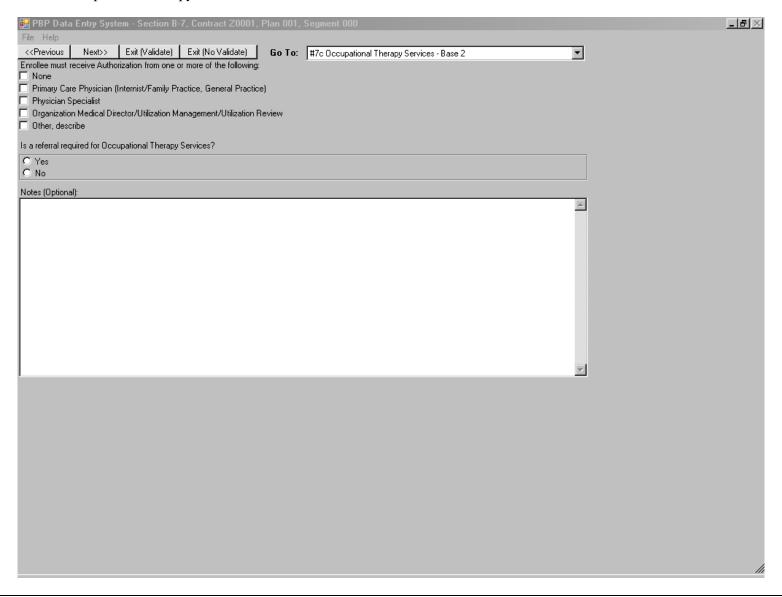
Section B – 7B – Chiropractic Services – Base 4 Screen



Section B – 7C – Occupational Therapy Services – Base 1 Screen

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.  Enhanced Benefit Coverage is not applicable for this Service Category.  Maximum Plan Benefit Coverage is not applicable for this Service Category.  Do you apply the Medicare coverage limit?  O you must include total cost sharing, to the beneficiary, including any facility cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.  O you must include total 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.  O Yes  O Yes  Is there an enrollee Copayment?	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  Enhanced Benefits are not applicable for this Service Category.  Maximum Plan Benefit Coverage is not applicable for this Service Category.  Maximum Plan Benefit Coverage is not applicable for this Service Category.  Do you apply the Medicare coverage limit?  You must include total 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 Deductible?  Yes  Is there an enrollee Deductible?  Yes  Is there an enrollee Deductible?  Yes	
Enhanced Benefits are not applicable for this Service Category.  C Every year C Every yisk months C Every three months  Maximum Plan Benefit Coverage is not applicable for this Service Category.  Do you apply the Medicare coverage limit?  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 Copayment?  Yes	
Enhanced Benefits are not applicable for this Service Category.  C Every year C Every year C Every six months C Every six months Indicate Deductible Amount:  You must include total cost sharing to the beneficiary, including any facility cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.  C Yes  C Yes  C No Indicate Deductible Amount:  Is there an enrollee Copayment?  C Yes	
Do you apply the Medicare coverage limit?  Do you apply the Medicare coverage limit?  O yes  Is there an enrollee Copayment?  O yes	
O Yes and highest cost sharing that a beneficiary may pay.	
○ W-	
Is there an enrollee Coinsurance?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Indicate Copayment amount per visit for Medicare- covered Benefits:	
C Yes Indicate Coinsurance percentage for Medicare- covered Benefits per visit:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	

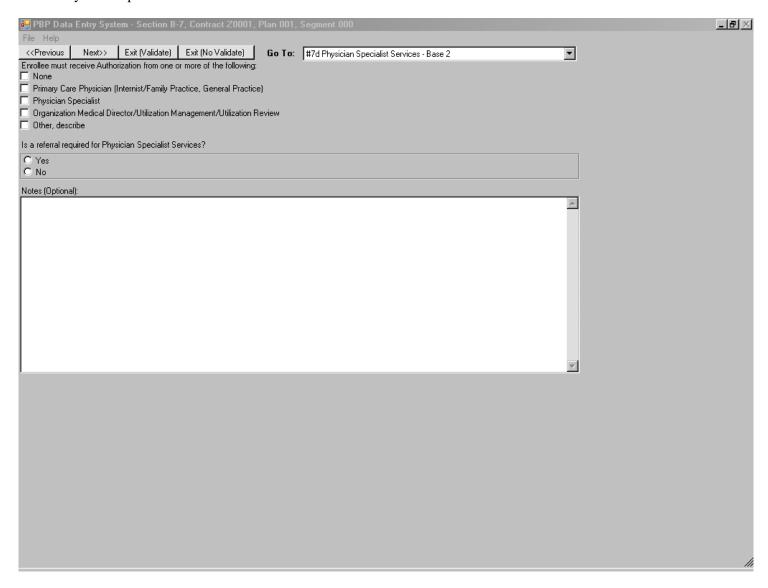
Section B – 7C – Occupational Therapy Services – Base 2 Screen



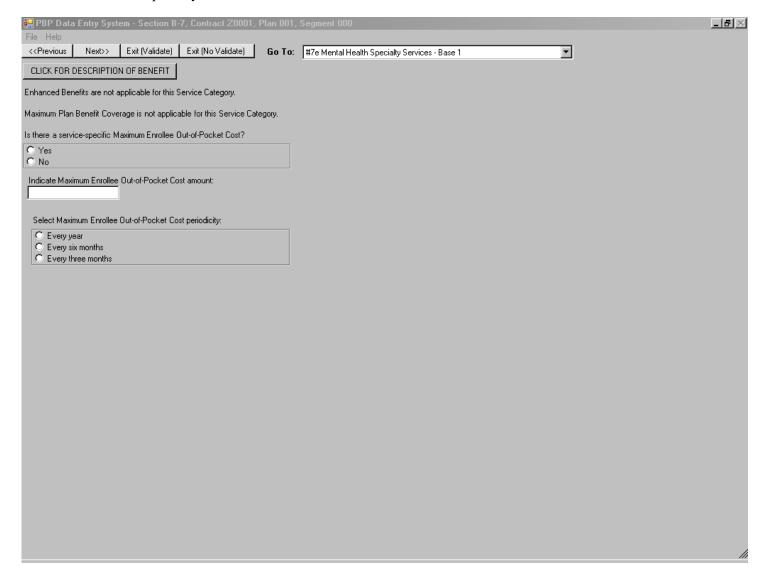
Section B – 7D – Physician Specialist Services – Base 1 Screen

🚂 PBP Data Ei	ntry System	- Section B-7	, Contract Z0001	, Plan 001, Segment 000						_ B ×
File Help										
< <pre>&lt;&lt; Previous</pre>	Next>> E	xit (Validate)	Exit (No Validate)	Go To: #7d Physician S	Specialist 9	iervices - Base 1		▼		
CLICK FOR DES	SCRIPTION (	F BENEFIT				Is there an enrollee Dedu	ictible?			
						C Yes				
Enhanced Benefit Service Category.	ts are not app	licable for this	Select the Ma	ximum Enrollee Out-of-Pocket C	Cost	C No				
			C Every yea			Indicate Deductible Am	ount:			
Maximum Plan Benefit Coverage is not applicable for this Service Category.		C Every six								
			C Every thre	ee months		Is there an enrollee Copa	ument?			
Is there a service- Out-of-Pocket Cos	specific Maxii st?	num Enrollee	Is there an en	rollee Coinsurance?		C Yes	<u> </u>			
C Yes			C Yes			O No				
○ No			O No			Indicate Minimum Copa for Medicare-covered B	yment amount per visi	t		
Indicate Maximu	m Enrollee Οι	ıt-of-Pocket	Indicate Min	imum Coinsurance percentage fo vered Benefits:	for	for Medicare-covered B	enefits:			
Cost amount:			Medicare-co	vered Benefits:						
						Indicate Mavimum Cons	sumant amount par vis	.i.		
			landin aka kita	.i C.i	- 6	Indicate Maximum Copa for Medicare-covered B	enefits:	oic .		
			Medicare-co	ximum Coinsurance percentage I overed Benefits:	e ror					
										//

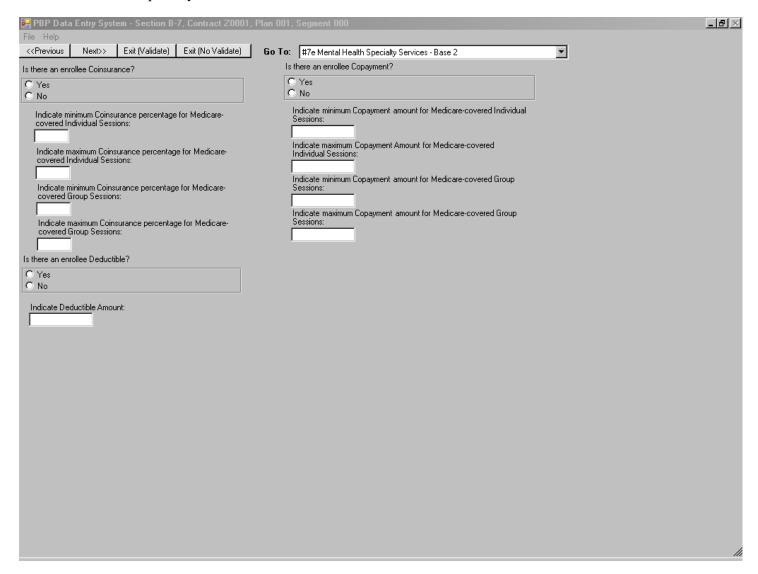
Section B – 7D – Physician Specialist Services – Base 2 Screen



Section B – 7E – Mental Health Specialty Services – Base 1 Screen



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



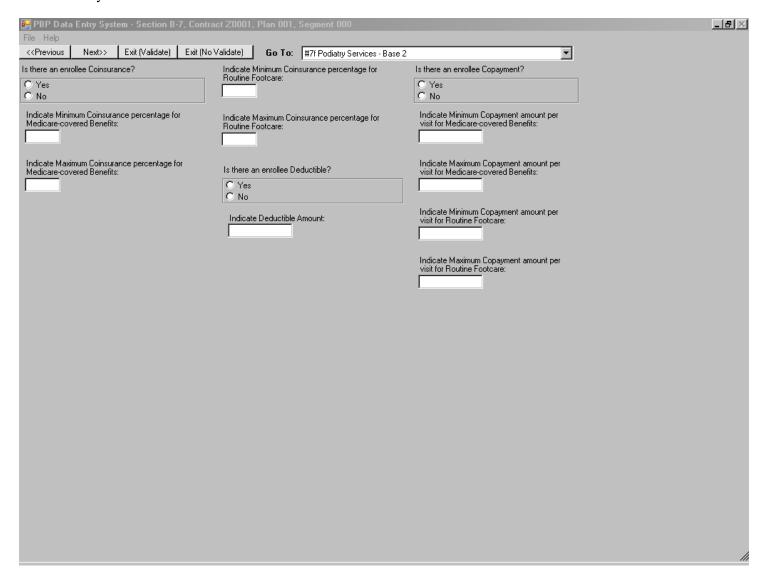
Section B – 7E – Mental Health Specialty Services – Base 3	Screen	
Fu Associates, Ltd.	CY 2012 PBP – Section B	Page 70 of 199



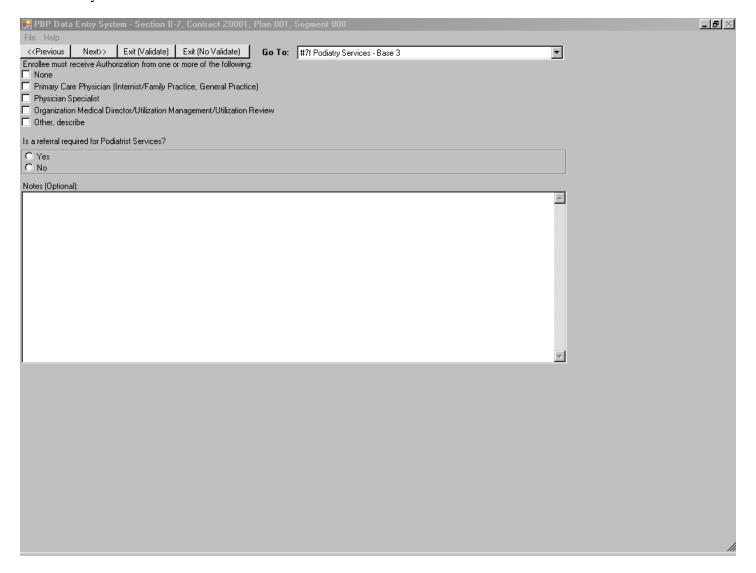
# Section B – 7F – Podiatry Services – Base 1 Screen

🔛 PBP Data Entry System - Section B-7, Co	ntract Z0001, Plan 001, Segment 000		_ <b>5</b> ×
File Help			
< <pre>&lt;<pre>&lt;<pre>c<pre>vious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit</pre></pre></pre></pre>	(No Validate) Go To: #7f Podiatry Services - Base	e1 <b>▼</b>	
CLICK FOR DESCRIPTION OF BENEFIT	Select the Routine Footcare periodicity:	Is there a service-specific Maximum Enrollee Out- of-Pocket Cost?	
Do you offer any Mandatory or Optional Supplemental Benefits?	C Every six months Every three months	C Yes C No	
O Yes O No	Is there a service-specific Maximum Plan Benefit Coverage amount?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select enhanced benefits:  Routine Footcare	C Yes C No		
Select type of benefit for Routine Footcare:	Indicate Maximum Plan Benefit Coverage amount:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Mandatory C Optional	Select Maximum Plan Benefit Coverage periodicity:	C Every year C Every six months	
Is this benefit unlimited for Routine Footcare?	C Every year C Every six months	© Every three months	
○ No	C Every three months		
Indicate number of Routine Footcare visits:			
			,

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



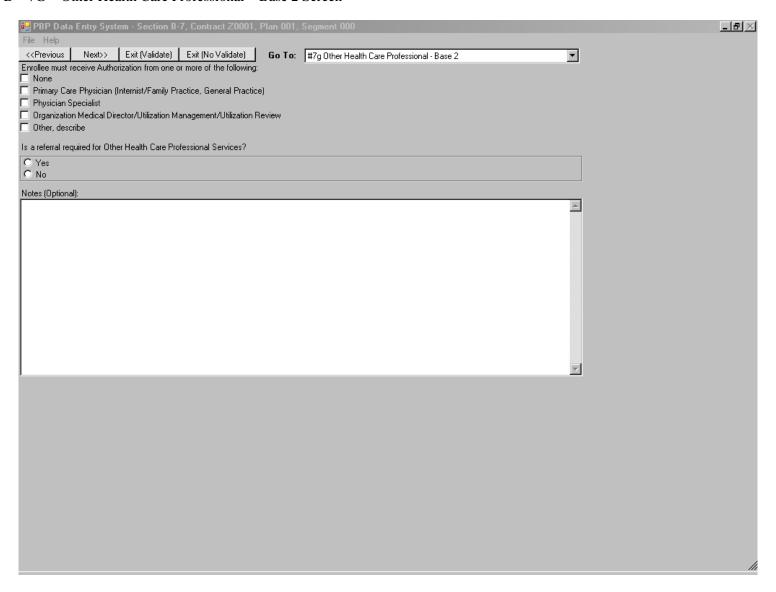
Section B – 7F – Podiatry Services – Base 3 Screen



# Section B – 7G – Other Health Care Professional – Base 1 Screen

🔛 PBP Data Entry System - Section B-7, Con	tract Z0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre>&lt;<pre>&lt;<pre>c</pre></pre><pre>Next&gt;&gt;</pre><pre>Exit (Validate)</pre><pre>Exit (Next)</pre></pre>	No Validate) Go To: #7g Other Health Care Pro	ofessional - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	1
Enhanced Benefits are not applicable for this Service Category.	C Every year C Every six months C Every three months	No Indicate Deductible Amount:	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Is there an enrollee Coinsurance?		
Is there a service-specific Maximum Enrollee Out-of- Pocket Cost?	○ Yes ○ No	Is there an enrollee Copayment?  C Yes C No	
C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	J
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	

Section B – 7G – Other Health Care Professional – Base 2 Screen



Section B – 7H – Psychiatric Services – Base 1 Screen

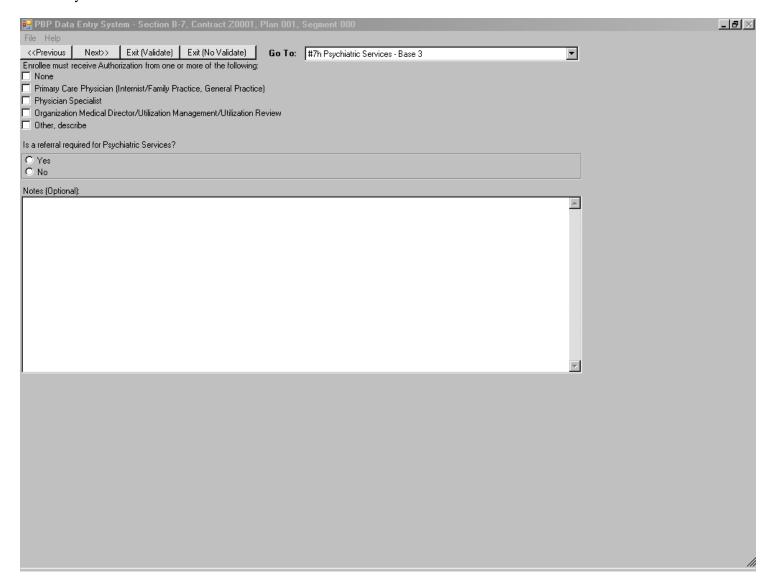
🖳 PBP Data Entry System - Section B-7, Contract Z0001, Plan O	1, Segment 000	_ B ×
File Help		
< <pre>&lt;<pre> </pre> <pre></pre></pre>	o: #7h Psychiatric Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT		
Enhanced Benefits are not applicable for this Service Category.		
Maximum Plan Benefit Coverage is not applicable for this Service Category.		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
O Yes		
○ No		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:		
O Every year		
© Every six months		
C Every three months		

Section B – 7H – Psychiatric Services – Base 2 Screen

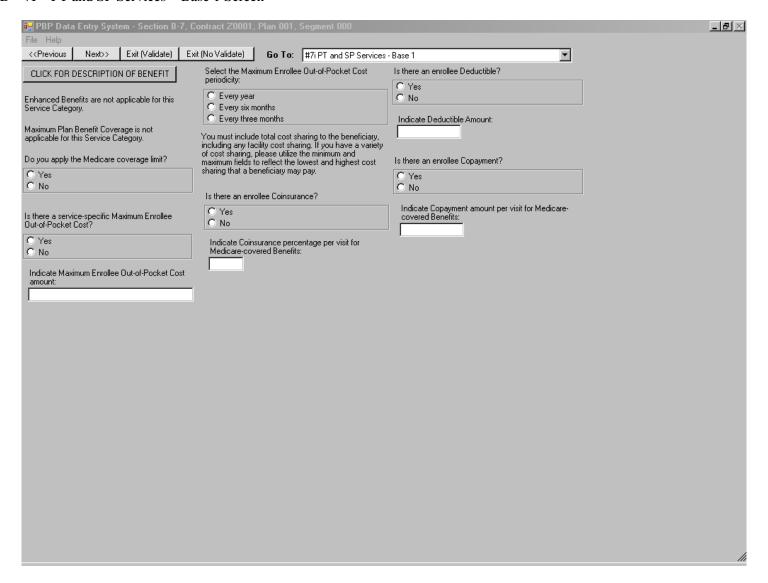
🔛 PBP Data Entry System - Section B-7, Contract Z0001, Pla	001, Segment 000	_ B ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre></pre></pre>	To: #7h Psychiatric Services - Base 2	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
O Yes	C Yes	
○ No	O No	
Indicate minimum Coinsurance percentage for Medicare-covered Individual Sessions:	Indicate minimum Copayment amount for Medicare-covered Individual Sessions:	
Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:	Indicate maximum Copayment amount for Medicare-covered Individual Sessions:	
Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:	Indicate minimum Copayment amount for Medicare-covered Group Sessions:	
Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:	Indicate maximum Copayment amount for Medicare-covered Group Sessions:	
Is there an enrollee Deductible?		
O Yes		
● No		
Indicate Deductible Amount:		
		li.

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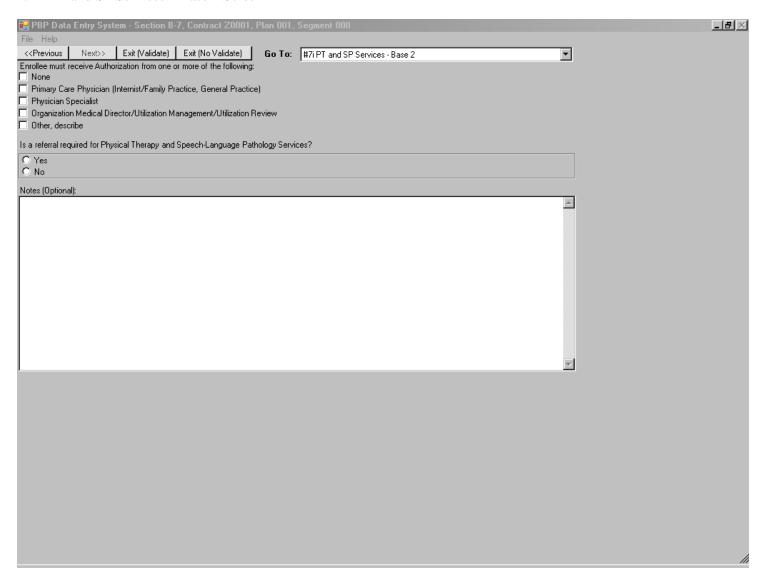
Section B – 7H – Psychiatric Services – Base 3 Screen



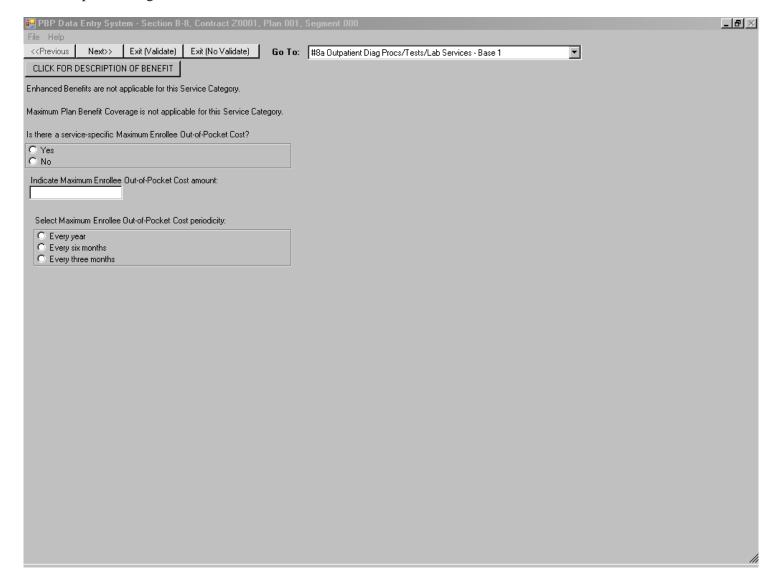
### Section B – 7I – PT and SP Services – Base 1 Screen



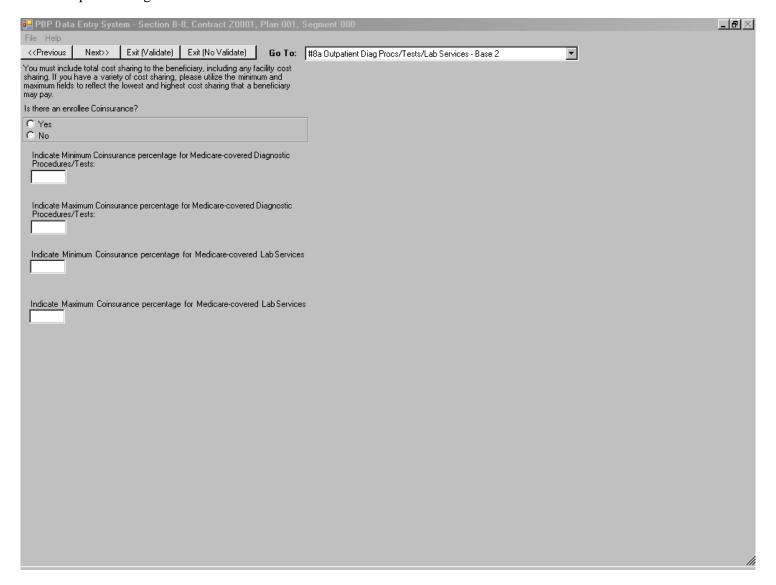
### Section B – 7I – PT and SP Services – Base 2 Screen



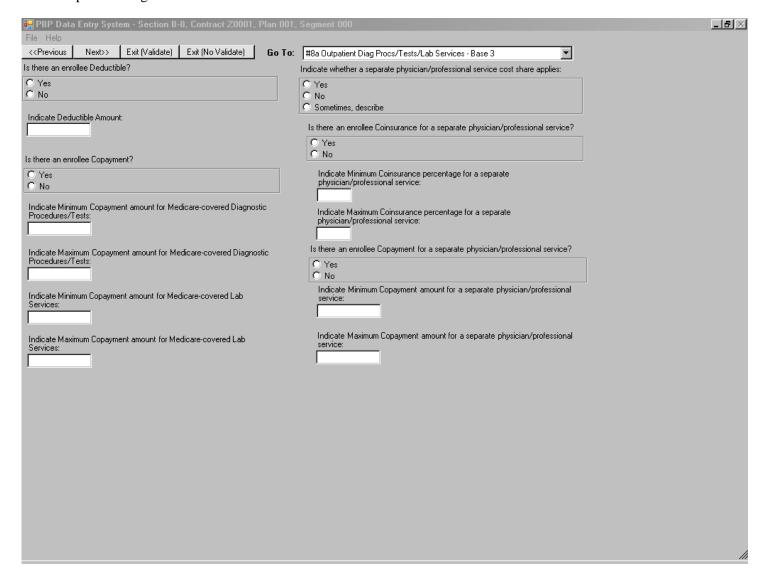
Section B – 8A– Outpatient Diag Procs/Tests/Lab Services – Base 1 Screen



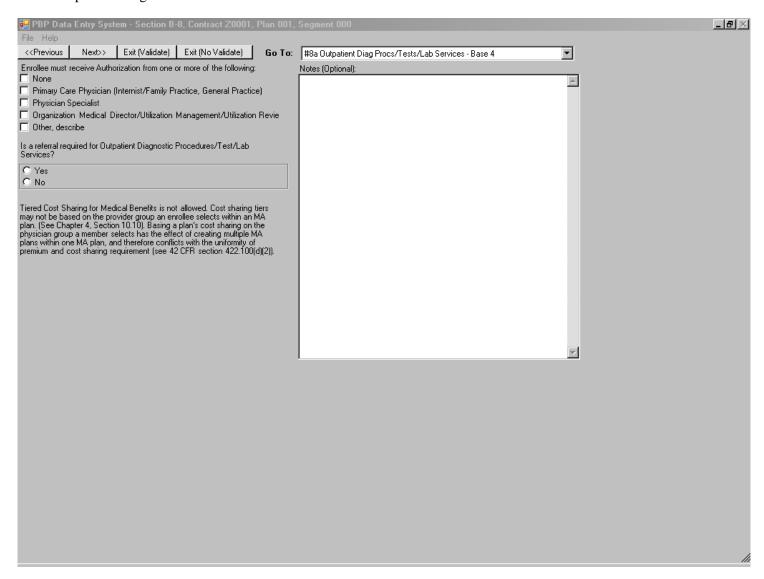
Section B – 8A– Outpatient Diag Procs/Tests/Lab Services – Base 2 Screen



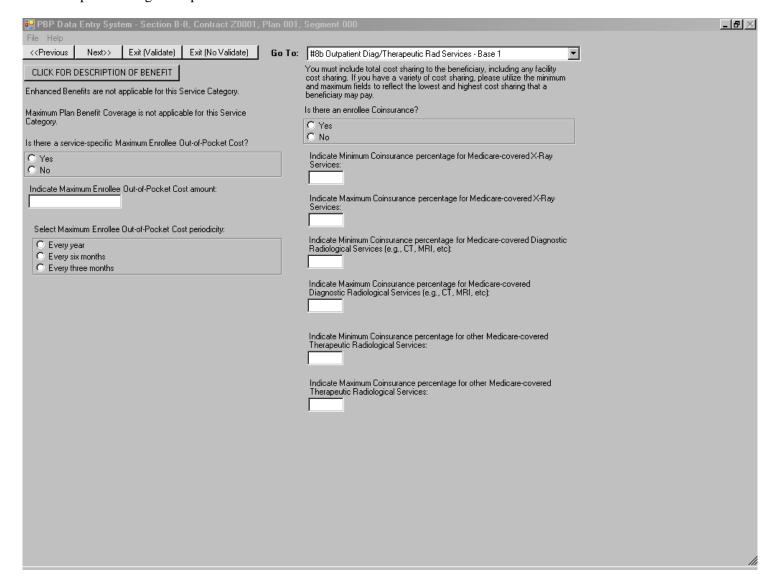
Section B – 8A– Outpatient Diag Procs/Tests/Lab Services – Base 3 Screen



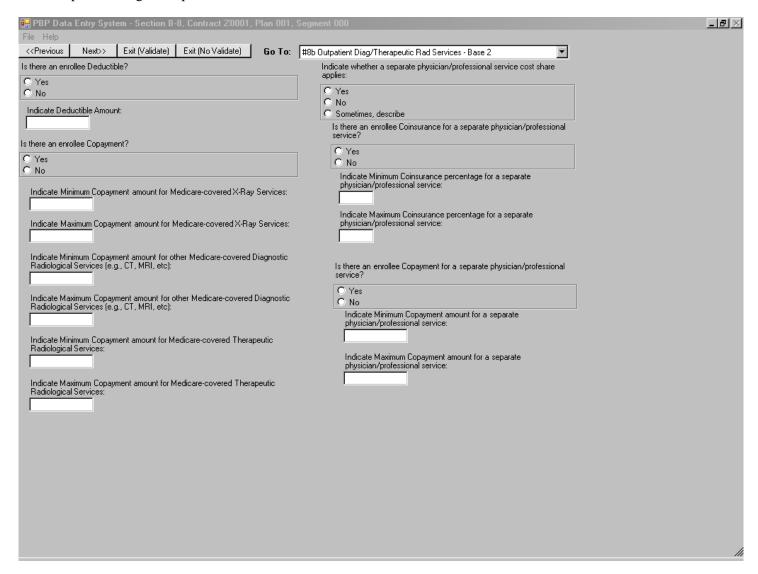
Section B – 8A– Outpatient Diag Procs/Tests/Lab Services – Base 4 Screen



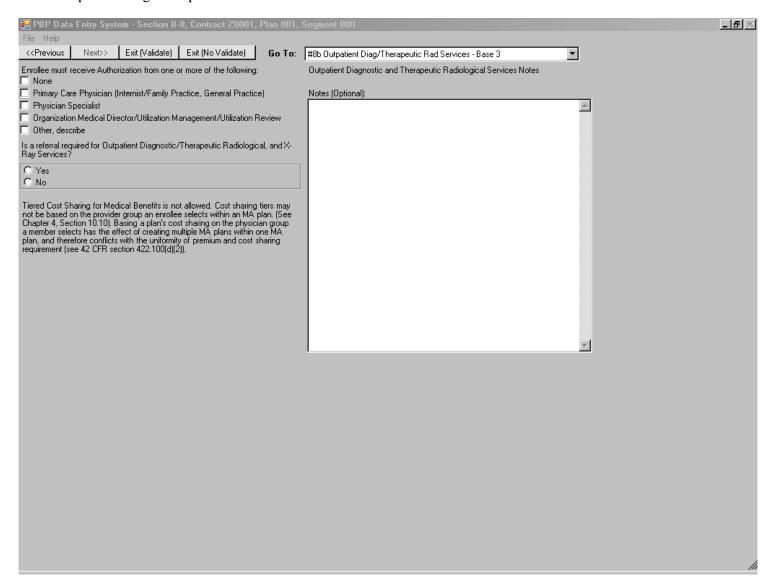
Section B – 8B– Outpatient Diag/Therapeutic Rad Services – Base 1 Screen



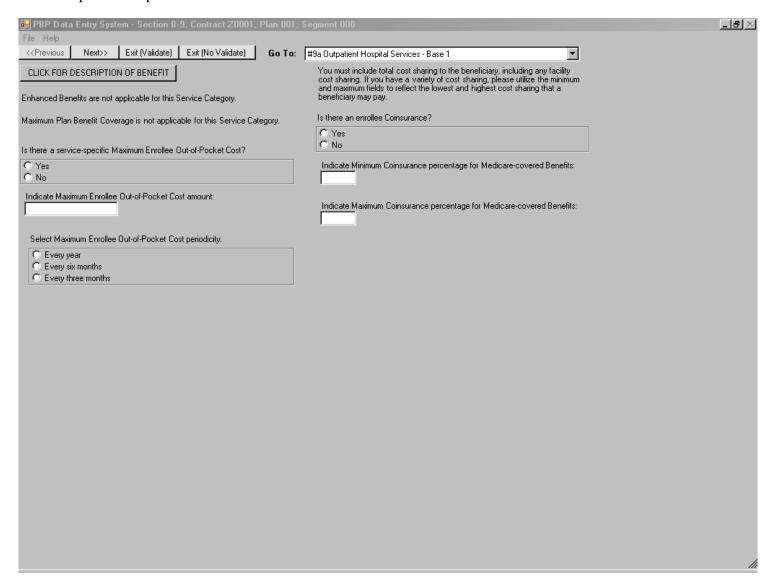
Section B – 8B– Outpatient Diag/Therapeutic Rad Services – Base 2 Screen



Section B – 8B– Outpatient Diag/Therapeutic Rad Services – Base 3 Screen



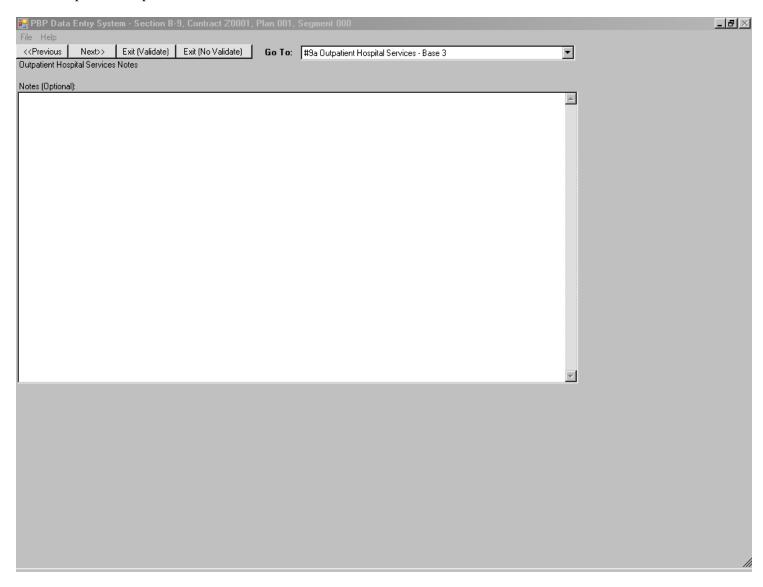
Section B – 9A– Outpatient Hospital Services – Base 1 Screen



Section B – 9A– Outpatient Hospital Services – Base 2 Screen

🔛 PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segmer	nt 000	_ & ×
File Help		
⟨Previous Next>⟩ Exit (Validate) Exit (No Validate) Go To: #9a Out    #9a Out   #	utpatient Hospital Services - Base 2	
File Help	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

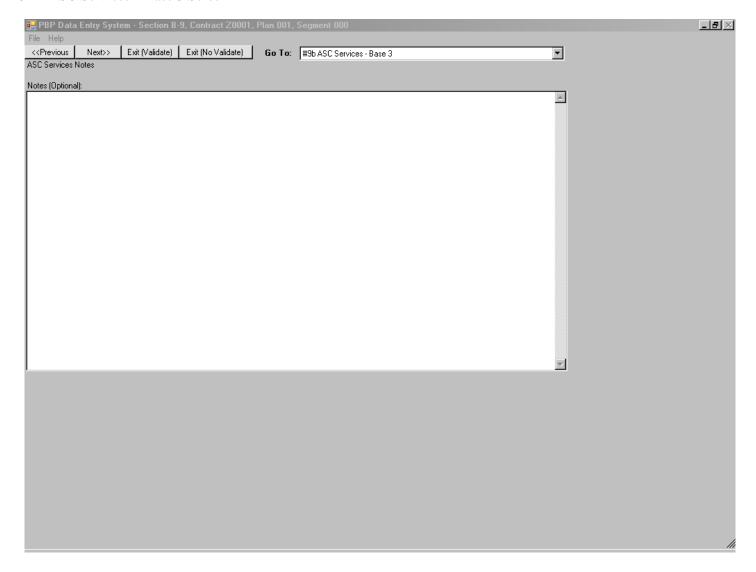
🔛 PBP Data Entry System - Section B-9, Contract Z0001, Plan 001,	Segment 000	_ 8 ×
File Help		
< <pre>&lt;<pre>revious  Next&gt;&gt;  Exit (Validate)  Exit (No Validate)  Go To:</pre></pre>	#9b ASC Services - Base 1	<u> </u>
CLICK FOR DESCRIPTION OF BENEFIT  Enhanced Benefits are not applicable for this Service Category.  Maximum Plan Benefit Coverage is not applicable for this Service Category.	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?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	C Yes	
C Yes C No Select the Maximum Enrollee Out-of-Pocket Cost type:	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
C. 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:  C Every year C Every six months C Every three months	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	

# Section B – 9B– ASC Services – Base 2 Screen

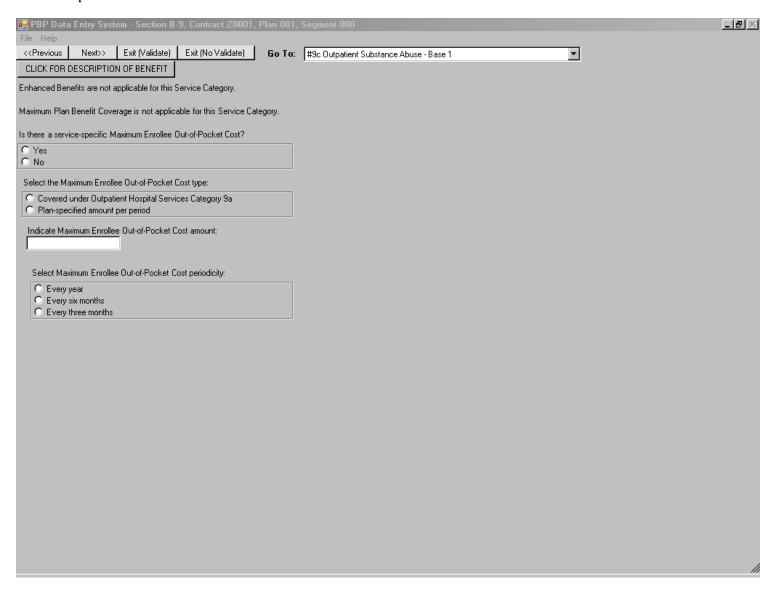
📴 PBP Data Entry System - Section B-9, Contract Z0001, F	Plan 001, Segment 000	_ & ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #9b ASC Services - Base 2  ▼	
Is there an enrollee Deductible?  C Yes C 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	
Is there an enrollee Copayment?	☐ Other, describe  Is a referral required for Ambulatory Surgical Center Services?  C Yes	
C Yes C No	© No	
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:		
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:		
		II.

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# Section B – 9B– ASC Services – Base 3 Screen



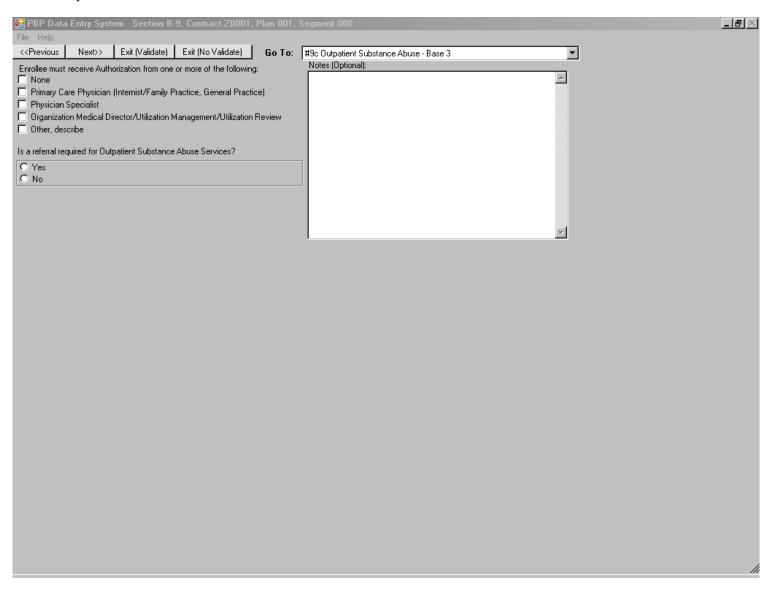
Section B – 9C– Outpatient Substance Abuse – Base 1 Screen



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

🚂 PBP Data	Entry Syst	em - Section B-	9, Contract Z0001,	Plan 001,	Segment 000	_ B ×
File Help						
< <pre>revious</pre>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#9c Outpatient Substance Abuse - Base 2	
You must inclu cost sharing. If minimum and r sharing that a l	naximum fields	to reflect the low	eficiary, including any fa ing, please utilize the est and highest cost	cility	Is there an enrollee Copayment?  C Yes C No	
Is there an enr	ollee Coinsura	nce?			Indicate minimum Copayment amount for Medicare-covered	
C Yes C No					Individual Sessions	
Individual S	essions:		for Medicare-covered		Indicate maximum Copayment amount for Medicare-covered Individual Sessions:	
Individual S	essions: imum Coinsur		for Medicare-covered		Indicate maximum Copayment amount for Medicare-covered Group Sessions:	
Indicate may Group Sessi	ons:		for Medicare-covered			
C Yes						
	ductible Amou	nt:				
						//

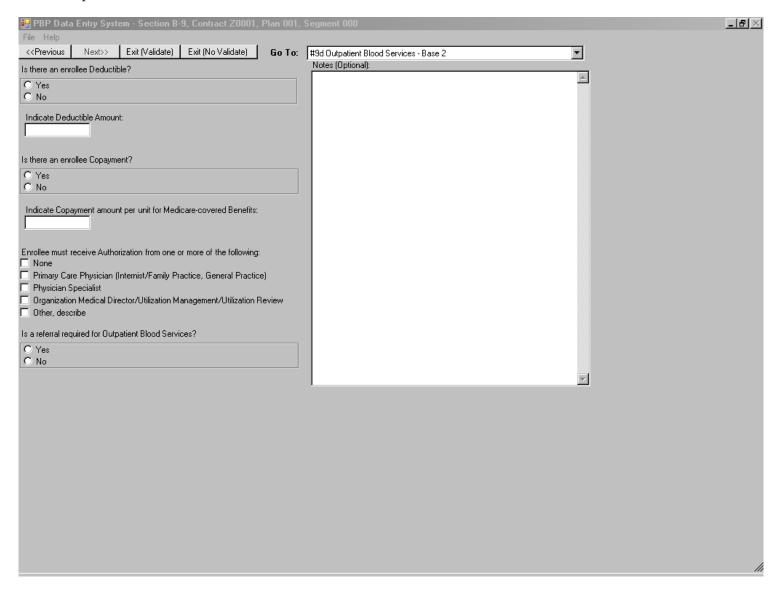
Section B – 9C– Outpatient Substance Abuse – Base 3 Screen



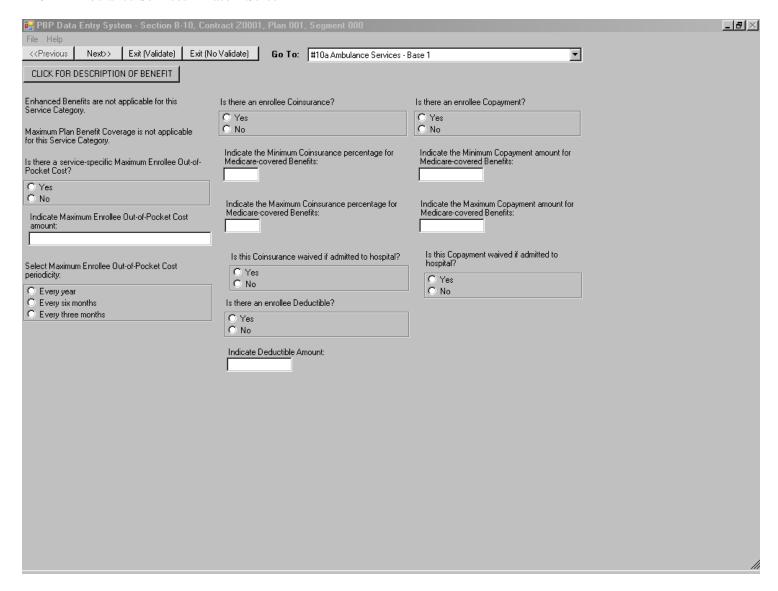
# Section B – 9D– Outpatient Blood Services – Base 1 Screen

🔛 PBP Data Entry System - Section B-9, Contract Z0001, Plan 001	, Segment 000	_ B ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre> <pre>Go To:</pre></pre></pre>	#9d Outpatient Blood Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
	C Every year	
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.	C Every six months	
	C Every three months	
Do you offer any Mandatory or Optional Supplemental Benefits?	Is there an enrollee Coinsurance?	
C Yes C No	C Yes	
	○ No	
Select enhanced benefit:  Three (3) pint deductible waived	Indicate Coinsurance percentage per unit for Medicare-covered Benefits:	
Trilee (3) pirit deductible walved		
Select type of benefit for Three (3) Pint Deductible Waived:		
O Mandatory		
O Optional		
Maximum Plan Benefit Coverage is not applicable for this Service Category.		
maximum r farr benefit coverage is not applicable for this pervice category.		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
C Yes		
C No		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
		li.

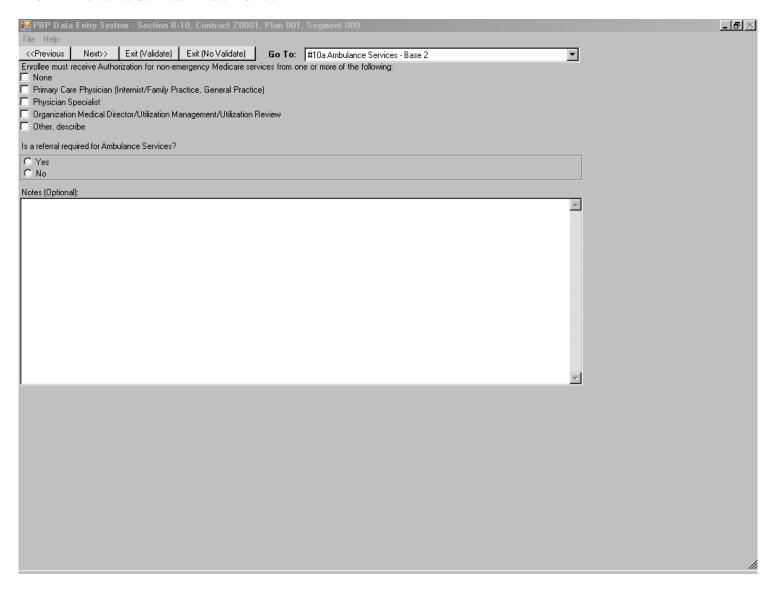
Section B – 9D– Outpatient Blood Services – Base 2 Screen



#### Section B – 10A– Ambulance Services – Base 1 Screen



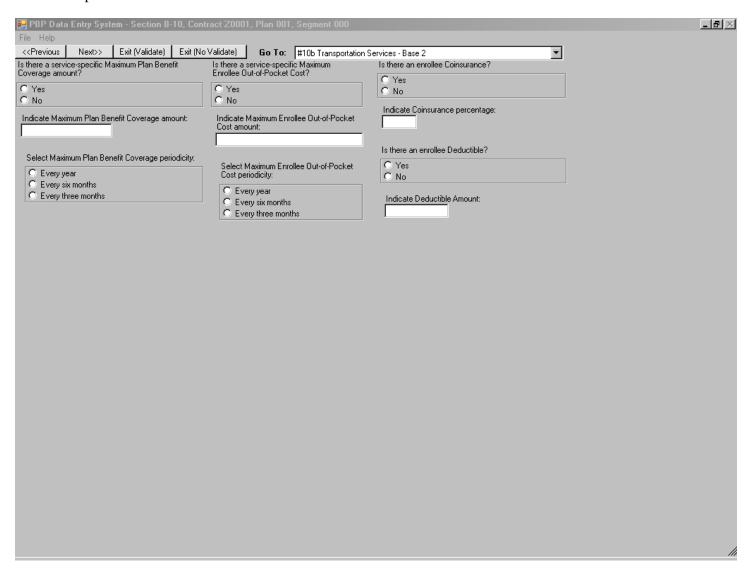
### Section B – 10A– Ambulance Services – Base 2 Screen



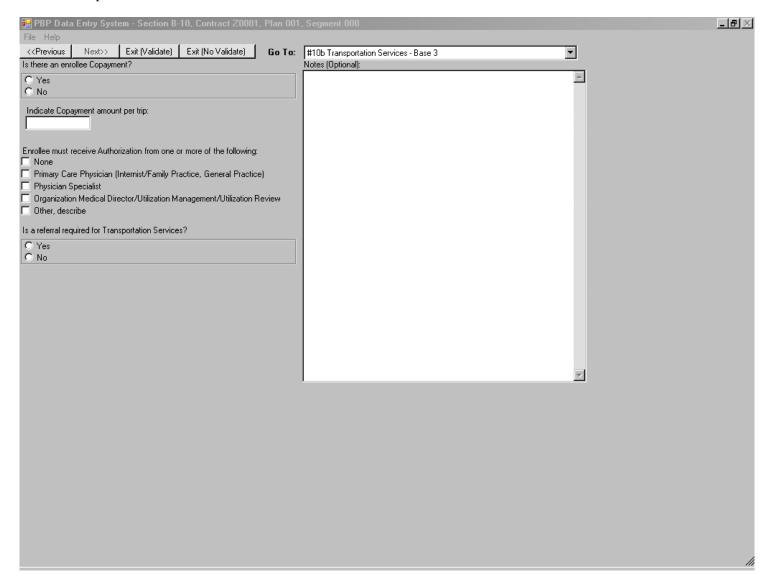
# Section B – 10B– Transportation Services – Base 1 Screen

🔛 PBP Data Entry System - Section B-10, Con	tract Z0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre>&lt;<pre>&lt;<pre>revious</pre></pre></pre>	o Validate) Go To: #10b Transportation Servi	ices - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select Type of Transportation for Plan-approved Location:	Indicate number of trips for Any Location:	
Do you offer any Mandatory or Optional Supplemental Benefits?	C One-way C Round Trip C Days	Select Any Location Trips periodicity:	
O No	Other, describe	C Every year	
Select enhanced benefit:	Indicate number of days for Plan-approved Location:	C Every six months C Every three months	
Plan-approved Location     Any Location		Select Type of Transportation for Any Location:	
Select type of benefit for Plan-approved Location:  C Mandatory C Optional	Select Mode of Transportation for Plan-approved Location:  Taxi Bus/Subway	C One-way C Round Trip C Days C Other, describe	
Is this benefit unlimited for number of trips for Plan- approved Location?	☐ Van ☐ Other, describe	Indicate number of days for Any Location:	
C Yes C No	Select type of benefit for Any Location:		
Indicate number of trips for Plan-approved Location:	C Mandatory C Optional	Select Mode of Transportation for Any Location:  Taxi Bus/Subway	
	Is this benefit unlimited for number of trips for Any Location?	☐ Van ☐ Other, describe	
Select Plan-approved Location Trips periodicity:  C Every year C Every six months C Every three months	C Yes C No		
			//

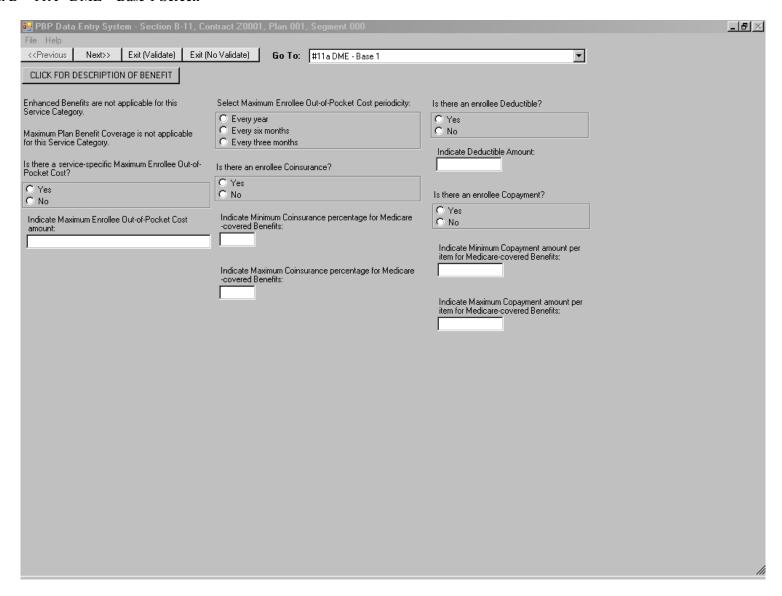
Section B – 10B– Transportation Services – Base 2 Screen



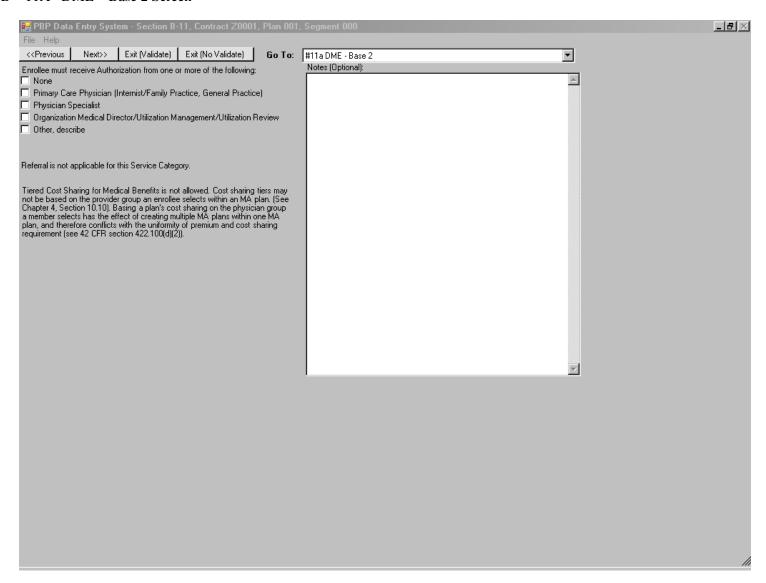
Section B – 10B– Transportation Services – Base 3 Screen



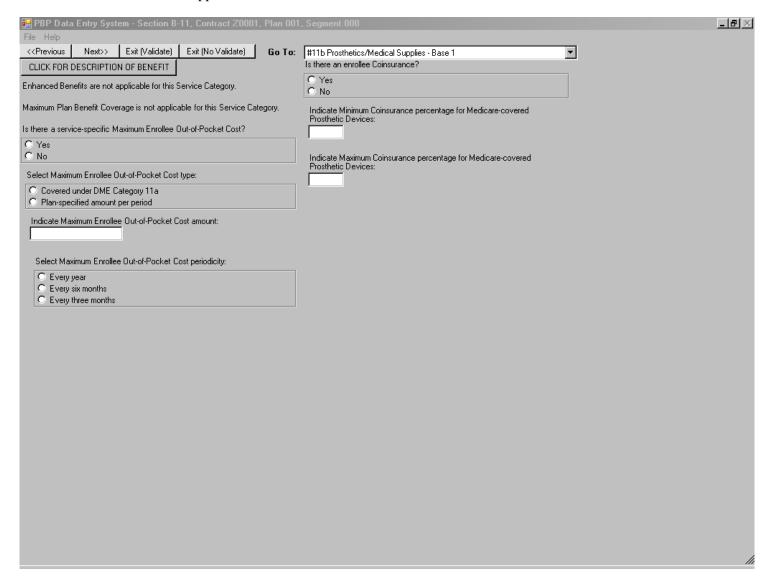
#### Section B – 11A– DME – Base 1 Screen



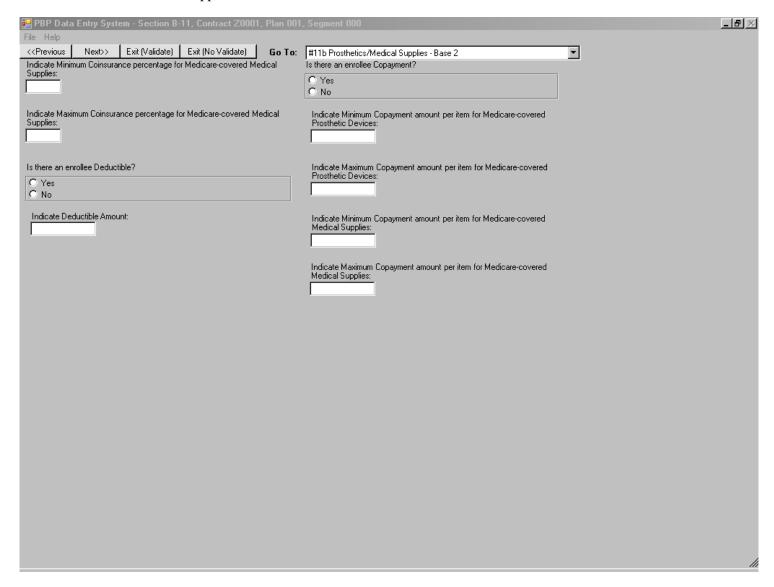
#### Section B – 11A– DME – Base 2 Screen



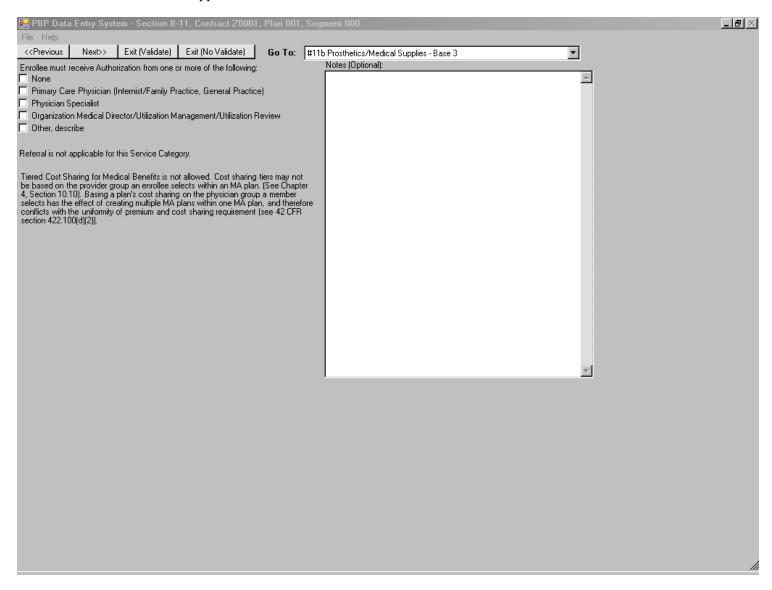
# Section B – 11B– Prosthetics/Medical Supplies – Base 1 Screen



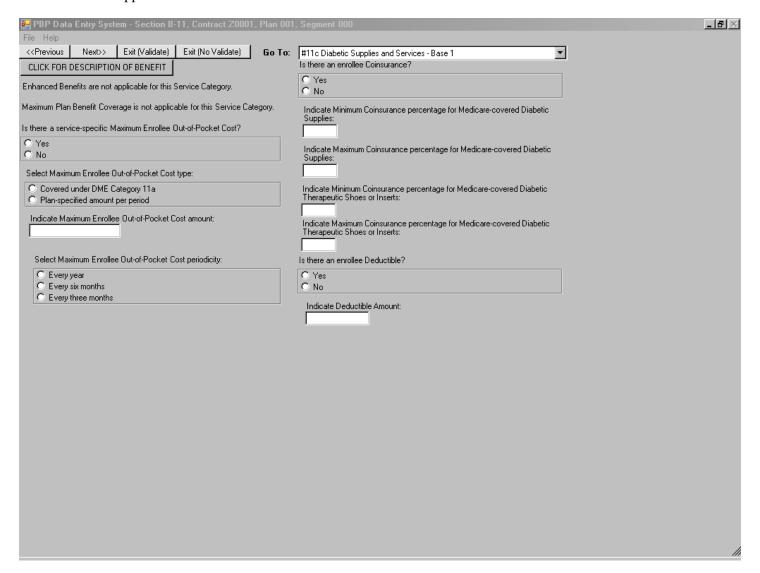
# Section B – 11B– Prosthetics/Medical Supplies – Base 2 Screen



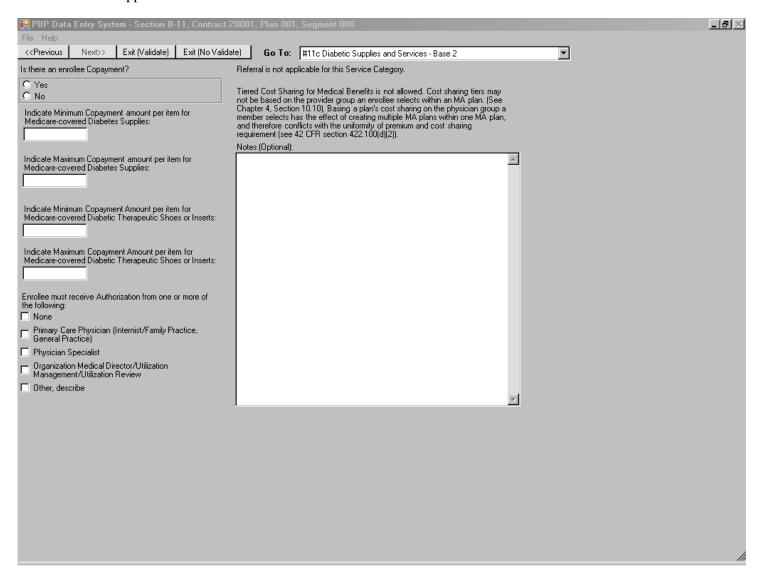
## Section B – 11B– Prosthetics/Medical Supplies – Base 3 Screen



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

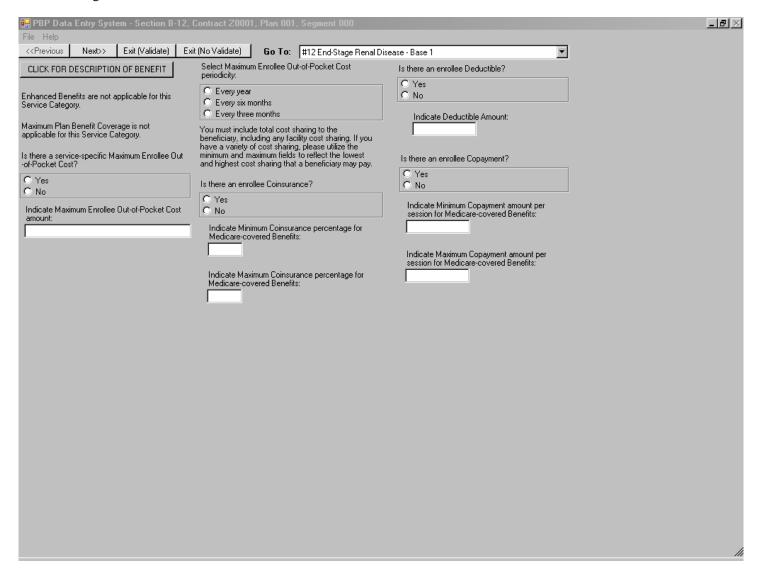


Section B – 11C– Diabetic Supplies and Services – Base 2 Screen

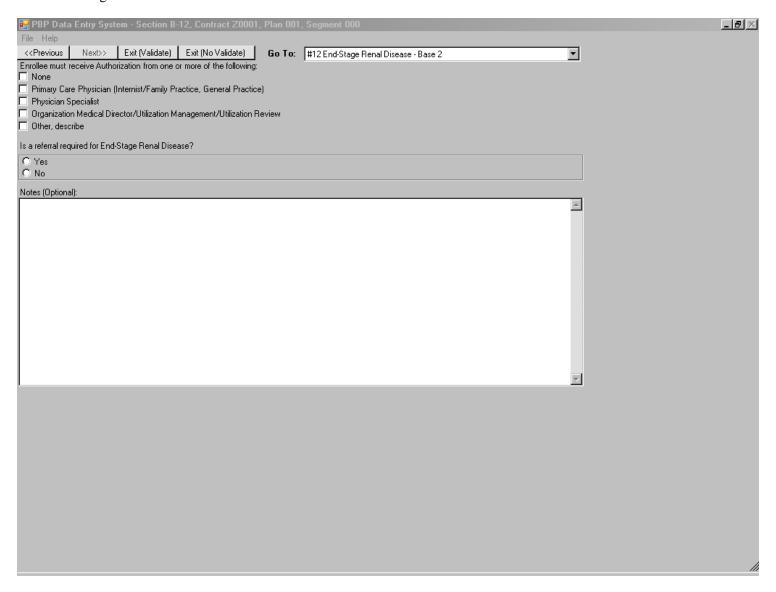


#### Section B – 12– End Stage Renal Disease – Base 1 Screen

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## Section B – 12– End Stage Renal Disease – Base 2 Screen



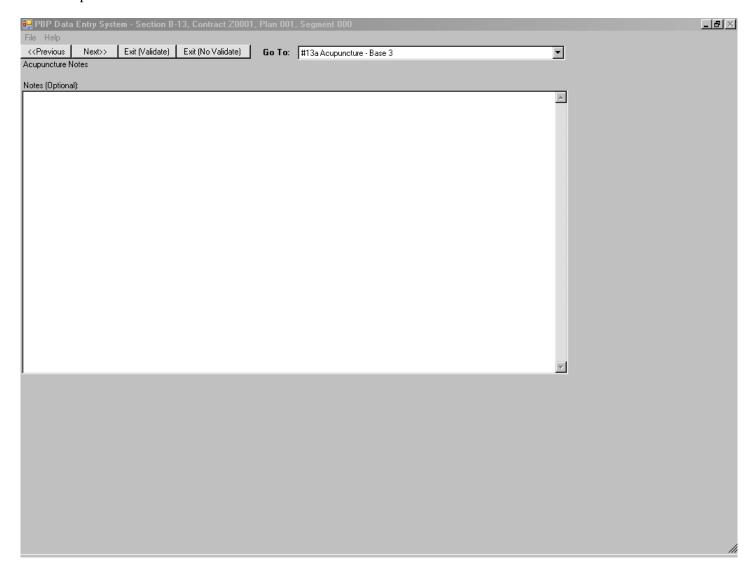
# Section B – 13A– Acupuncture – Base 1 Screen

🔛 PBP Data Entry System - Section B-13, Cont	tract Z0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No</pre></pre></pre>	Validate) Go To: #13a Acupuncture - Bas	e1 🔻	
CLICK FOR DESCRIPTION OF BENEFIT	Indicate limit for Number of Treatments:	Is there a service-specific Maximum Enrollee Out-of- Pocket Cost?	
Do you offer any Mandatory or Optional Supplemental Benefits?	Indicate Number of Treatments periodicity:	C Yes C No	
O Yes O No	C Every year	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select enhanced benefit:	C Every three months		
Number of Treatments	Is there a service-specific Maximum Plan Benefit Coverage amount?	Indicate Maximum Enrollee Out-of-Pocket Cost	
Select type of benefit for Number of Treatments:	C Yes	periodicity:	
○ Mandatory ○ Optional	○ No	C Every year C Every six months	
— Ориона	Indicate Maximum Plan Benefit Coverage amount:	C Every three months	
1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
Is this benefit unlimited for Number of Treatments?  C Yes	1		
⊙ No	Indicate Maximum Plan Benefit Coverage periodicity:		
	C Every year C Every six months		
	C Every three months		
		_	
			li.

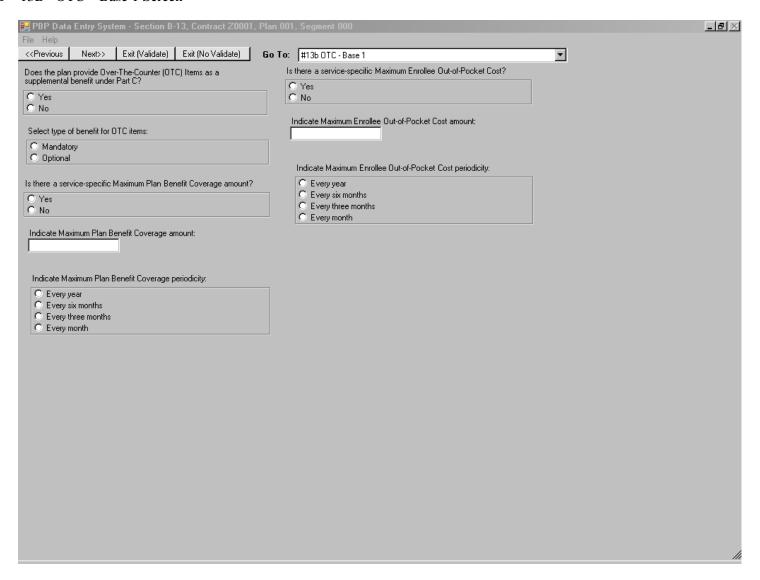
# Section B – 13A– Acupuncture – Base 2 Screen

🔛 PBP Data Entry System - Section B-13, Contract	t Z0001, Plan 001, Segment 000	<u>_6</u> ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre></pre></pre>	date) Go To: #13a Acupuncture - Base 2	<u> </u>
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
O Yes	O Yes	
○ No	○ No	
Indicate Coinsurance percentage:	Indicate Copayment amount per treatment:	
Is there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:  ☐ None	
C Yes	☐ Primary Care Physician (Internist/Family Practice, General Practice)	
	Physician Specialist	
Indicate Deductible Amount:	Organization Medical Director/Utilization Management/Utilization Review	
maicate Deductible Amount.	Other, describe	
	Is a referral required for Acupuncture Services?	
	O Yes	
	○ No	
		//

Section B – 13A– Acupuncture – Base 3 Screen



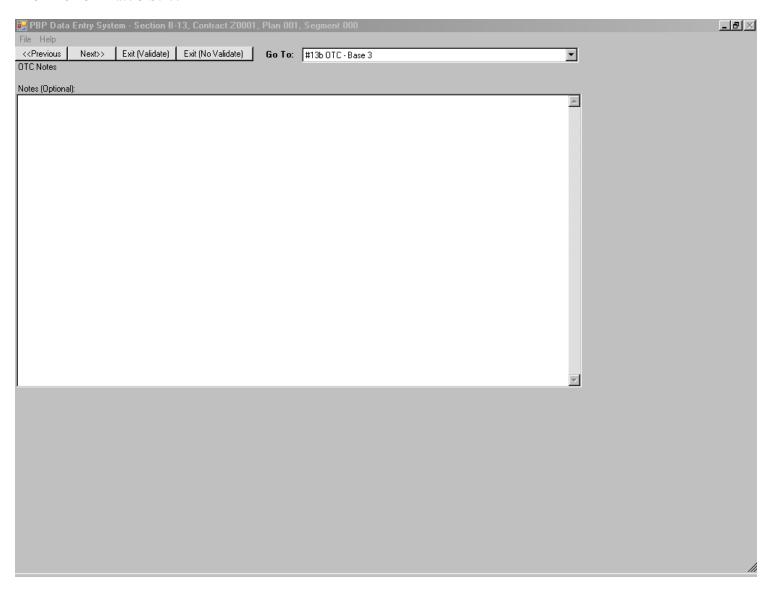
#### Section B – 13B– OTC – Base 1 Screen



## Section B – 13B– OTC – Base 2 Screen

₽ PBP Data Entry System - Section B-13, Contract	Z0001, Plan 001, Segment 000
File Help	
< <pre>&lt;<pre>c</pre></pre> Next>> Exit (Validate) Exit (No Validate)	
Is there an enrollee Coinsurance?	Does this cover all of the CMS OTC list?
O Yes	C Yes C No
C No	
Indicate Coinsurance percentage:	Authorization is not applicable for this service category.
	Referral is not applicable for this service category.
Is there an enrollee Deductible?	
O Yes O No	
Indicate Deductible Amount:	
Is there an enrollee Copayment?	
O Yes O No	
O No	
Indicate Copayment amount:	
	li de la companya de

## Section B – 13B– OTC – Base 3 Screen



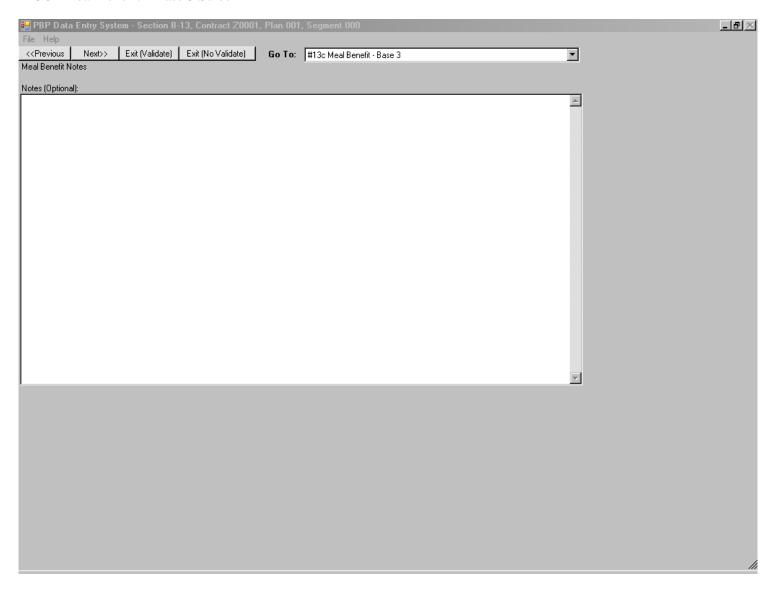
## Section B – 13C– Meal Benefit – Base 1 Screen

🔛 PBP Data Entry System - Section B-13, Contract Z0001,	Plan 001, Segment 000	_ & ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #13c Meal Benefit - Base 1	▼
Does the plan provide a Meal Benefit as a supplemental benefit under Part C?  C Yes C No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  C Yes C No	
Select type of benefit:  C Mandatory C Optional  Is there a service-specific Maximum Plan Benefit Coverage amount?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:  © Every year © Every six months	
C Yes	© Every three months	
Indicate Maximum Plan Benefit Coverage amount:  Indicate Maximum Plan Benefit Coverage periodicity:  C Every year C Every six months C Every three months		

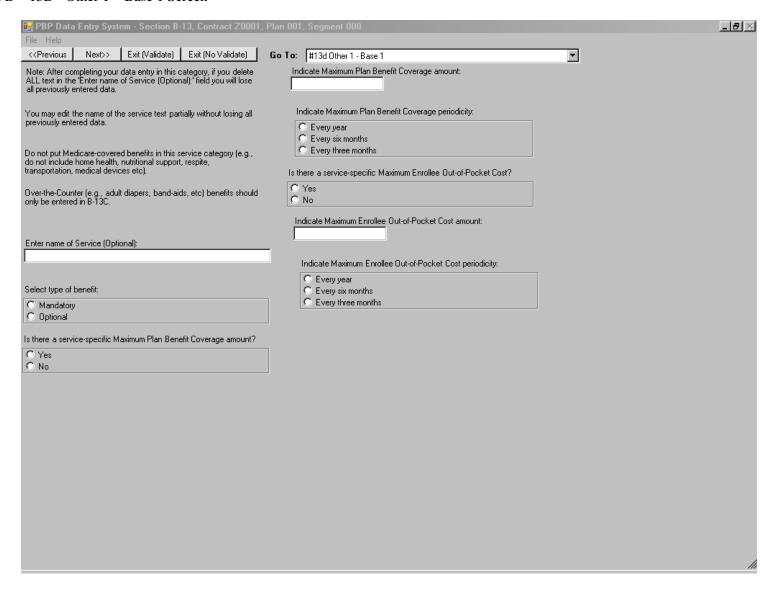
## Section B – 13C– Meal Benefit – Base 2 Screen

🔛 PBP Data Entry System - Section B-13, Contract Z0001	, Plan 001, Segment 000	_ B ×
File Help		
< <pre>&lt;<pre>&lt;<pre>c</pre></pre> Next&gt;&gt; <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre>	Go To: #13c Meal Benefit - Base 2	▼
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes	O Yes	
○ No	O No	
Indicate Coinsurance percentage:	Indicate Copayment amount:	
	Face Harmon & A. Alania diag (care and a care of the fall and a	
Is there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:	
C Yes C No	Primary Care Physician (Internist/Family Practice, General Practice)	
	☐ Physician Specialist☐ Organization Medical Director/Utilization Management/Utilization Review	
Indicate Deductible Amount:	Other, describe	
	Is a referral required for the Meal Benefit?  © Yes	7
	O No	
		_

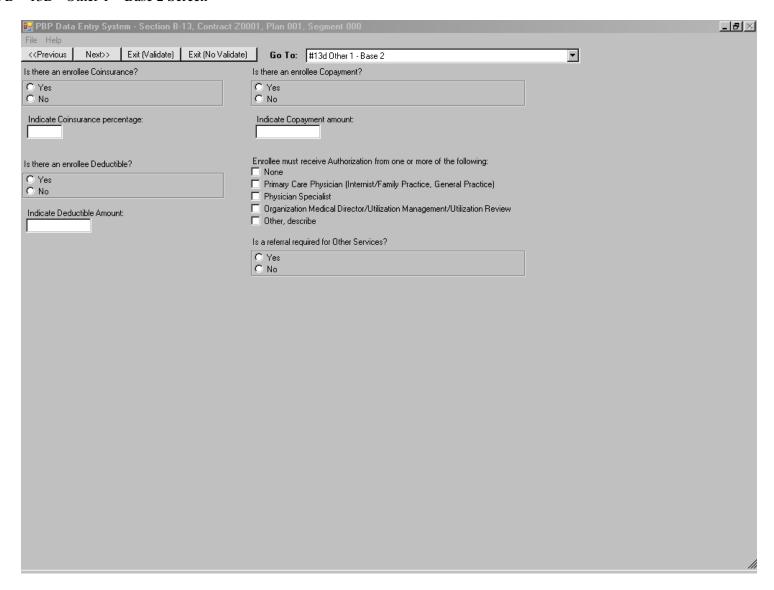
## Section B – 13C– Meal Benefit – Base 3 Screen



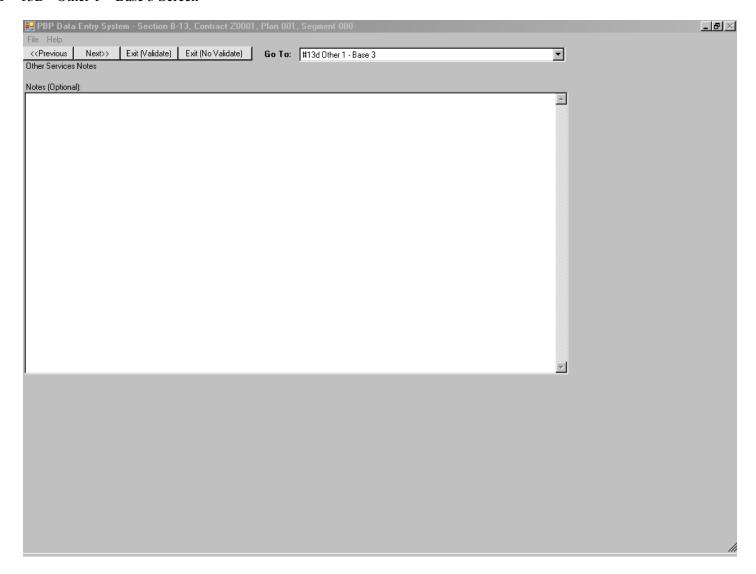
#### Section B – 13D– Other 1 – Base 1 Screen



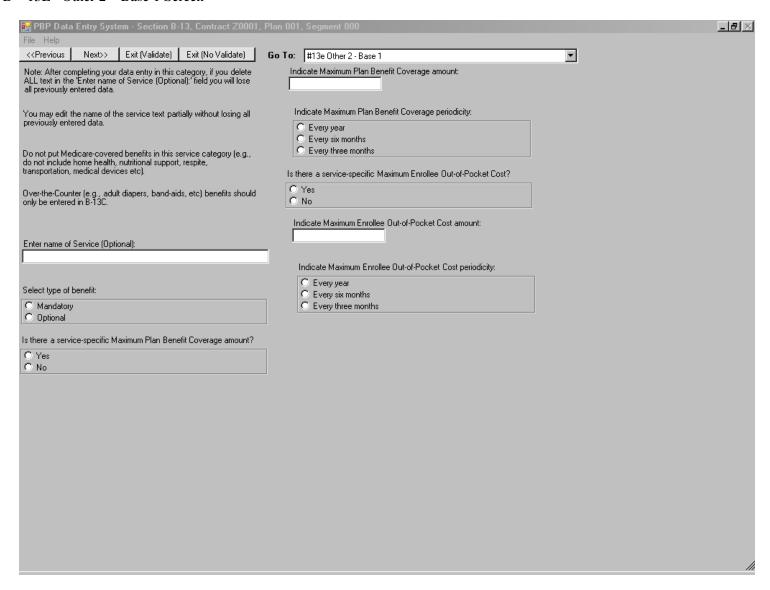
#### Section B – 13D– Other 1 – Base 2 Screen



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



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

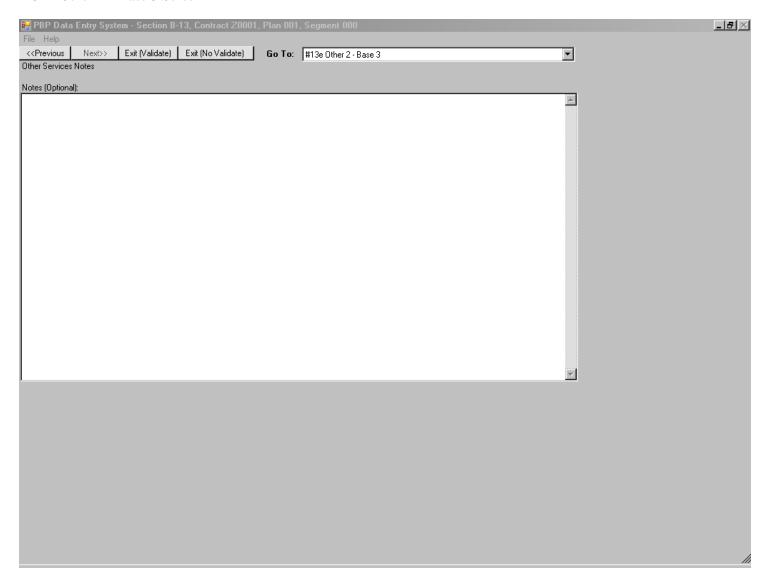


## Section B – 13E– Other 2 – Base 2 Screen

₽ PBP Data Entry System - Section B-13, Contract Z(	0001, Plan 001, Segment 000	_	a ×
File Help			
< <pre>&lt;<pre>&lt;<pre>revious   Next&gt;&gt;   Exit (Validate)   Exit (No Validate)</pre></pre></pre>	e) Go To: #13e Other 2 - Base 2	▼	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?		
C Yes	O Yes		
○ No	○ No		
Indicate Coinsurance percentage:	Indicate Copayment amount:		
	Enrollee must receive Authorization from one or more of the following:		
Is there an enrollee Deductible?	None		
○ Yes ○ No	Primary Care Physician (Internist/Family Practice, General Practice)		
	Physician Specialist Organization Medical Director/Utilization Management/Utilization Review		
Indicate Deductible Amount:	Other, describe		
	Is a referral required for Other Services?		
	C Yes		
	O No		

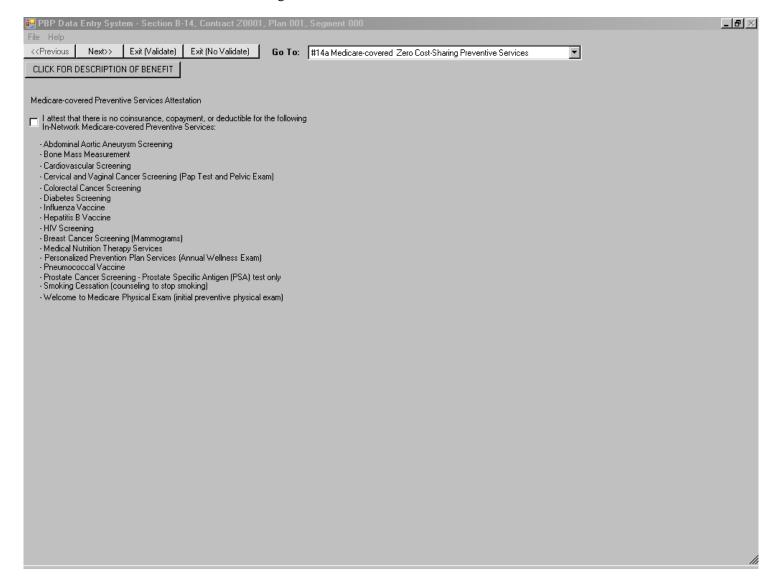
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## Section B – 13E– Other 2 – Base 3 Screen



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

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

🔛 PBP Data Entry System - Section B-14, Contract Z0001, Plan O	01, Segment 000	_ & ×
File Help		
<pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre> <pre>Go To</pre></pre></pre>	p: #14b Supplemental Preventive Health Services - Base 1	
Do you offer any Mandatory or Optional Supplemental Preventive Benefits?	Is this benefit unlimited for Additional Physical Exams?	
O Yes	O Yes	
○ No	O No, indicate number	
Select enhanced benefit:  Other Immunizations  Additional Physical Exams  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	Indicate limit for Additional Physical Exams:  Select the Additional Physical Exams periodicity:  C Every year C Every six months C 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	_ B ×
File Help		
< <pre>&lt;<pre>&lt;<pre>c<pre>vious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre></pre>	Go To: #14b Supplemental Preventive Health Services - Base 2	
Select type of benefit for Additional Pap Smears:	Select type of benefit for Additional Pelvic Exams:	
○ Mandatory	C Mandatory	
O Optional	○ Optional	
1.41.1.22.12.14.11.12.12.0		
Is this benefit unlimited for Additional Pap Smears?	Is this benefit unlimited for Additional Pelvic Exams?	
C Yes C No, indicate number	C Yes C No, indicate number	
o 110, indicate named	2 HO, INDICAGO HAMBON	
Indicate number of Additional Pap Smears:	Indicate number of Additional Pelvic Exams:	
Select the Additional Pap Smears periodicity:	Select the Additional Pelvic Exams periodicity:	
C Every year	C Every year	
C Every six months	C Every six months	
C Every three months	© Every three months	

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

🔛 PBP Data Entry System - Section B-14, Contract Z0001	l , Plan 001, Segment 000	_ & ×
File Help		
< <pre>&lt;<pre>&lt;<pre>evious</pre> Next&gt;&gt; Exit (Validate) Exit (No Validate)</pre></pre>	Go To: #14b Supplemental Preventive Health Services - Base 3	
Select type of benefit for Additional Prostate Exams:	Select type of benefit for Additional Colorectal Exams:	
○ Mandatory	○ Mandatory	
O Optional	○ Optional	
Is this benefit unlimited for Additional Prostate Exams?	Is this benefit unlimited for Additional Colorectal Exams?	
C Yes	C Yes C No, indicate number	
C No, indicate number		
Indicate number of Additional Prostate Exams:	Indicate number of Additional Colorectal Screenings:	
Select the Additional Prostate Exams periodicity:	Select the Additional Colorectal Exams periodicity:	
C Every year C Every six months	C Every year C Every six months	
© Every three months	© Every three months	

Section B – 14B– Supplemental Preventative Health Services – Base 4 Screen

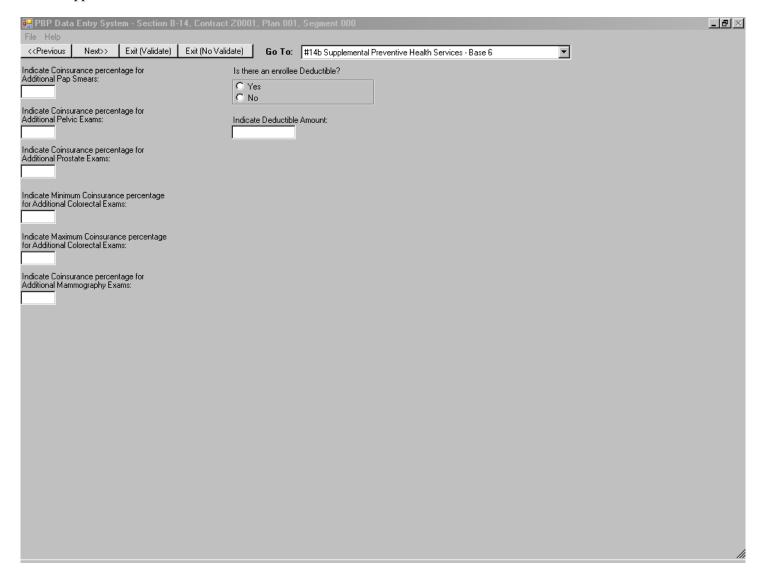
🔛 PBP Data Entry System - Section B-14, Contract Z0001,	, Plan 001	, Segment 000	_BX
File Help			
< <pre>&lt;<pre>&lt;<pre></pre></pre></pre>	Go To:	#14b Supplemental Preventive Health Services - Base 4	
Select type of benefit for Additional Mammography Exams:		Is there a service-specific Maximum Plan Benefit Coverage amount?	
O Mandatory		O Yes	
C Optional		C No	
Is this benefit unlimited for Additional Mammography Exams?	-	Indicate Manipular Disc Danieli Comment	
C Yes C No, indicate number		Indicate Maximum Plan Benefit Coverage amount:	
Indicate number of Additional Mammography Exams:		Select the Maximum Plan Benefit Coverage periodicity:	
		C Every year	
Select the Additional Additional Mammography Exams periodicity:		C Every six months C Every three months	
C Every year	7	S Every three months	
© Every six months			
C Every three months			

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Section B – 14B– Supplemental Preventative Health Services – Base 5 Screen

🔛 PBP Data Entry System - Section B-14, Contract Z0001, Plan 00	1, Segment 000	_ B ×
File Help		
< <pre> </pre> Next>> Exit (Validate) Exit (No Validate) Go To:	#14b Supplemental Preventive Health Services - Base 5	<b></b>
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Minimum Coinsurance percentage for Other Immunizations:	
C Yes		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Other Immunizations:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Coinsurance percentage for Additional Physical Exams:	
C Every year		
C Every six months C 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?		
O Yes		
Select which Supplemental Preventive Health Services have a Coinsurance (Select all that apply):  Other Immunizations  Additional Physical Exams  Additional Pelvic Exams  Additional Perstate Exams  Additional Colorectal Exams  Additional Mammography Exams		

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



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

🔛 PBP Data	Entry Syst	em - Section B-	·14, Contract Z000	1, Plan 001	, Segme	ent 000						_ 8 ×
File Help												
< <pre>revious</pre>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#14b St	upplemental Prev	entive Health S	ervices - Base	: 7	▼		
Is there an enro	llee Copaym	ent?		Indicate Cor	avment ar	mount per Additio	nal					
C Yes				Pap Smear:	aymonk an	mount por ridakio						
C No												
Select which Services have Services have Other Imm Additional Additional Additional Additional Additional Indicate Other Im Other Im	unizations Physical Exa Pap Smears Pelvic Exam: Prostate Exa Colorectal Ex Mammograpi Minimum Col munizations: Maximum Col munizations:	s ms tams	or Or	Pelvic Exam  Indicate Cop Prostate Exa  Indicate Mini Additional Co  Indicate Max Additional Co	ayment an ms: mum Copa lorectal Ex imum Cop inium Cop	mount per Addition ayment amount for  xams: mount for Addition	nal or					
												//

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Section B – 14B– Supplemental Preventative Health Services – Base 8 Screen

📴 PBP Data Entry System - Section B-14, Contract Z0001, Plan 001	, Segment 000	_ <b>5</b> ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre> <pre>Go To:</pre></pre>	#14b Supplemental Preventive Health Services - Base 8	
Indicate whether a separate physician/professional service cost share applies:	Is there a separate Coinsurance for Physician/Professional Services applied during Additional Mammography Exams?	
© Yes		
© No	O Yes	
O Sometimes, describe	○ No	
Is there a separate Coinsurance for Physician/Professional Services applied during Additional Colorectal Exams?	Indicate Minimum Coinsurance percentage for Physician/Professional Services applied during Additional Mammography Exams:	
C Yes C 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 Mammography Exams:	
Indicate Maximum Coinsurance percentage for Physician/Professional Services applied during Additional Colorectal Exams:		

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



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



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

🔛 PBP Data Entry System - Section B-14, Contract	t Z0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	date) Go To: #14c Supplemental Educat	ion/Wellness Programs - Base 1	
Do you offer any Mandatory or Optional Supplemental Educational/Wellness Programs?	Select type of benefit for Written Health Education Materials, incl. Newsletters:	Select type of benefit for Membership in Health Club/Fitness Classes:	
C Yes	○ Mandatory	O Mandatory	
C No	O Optional	O Optional	
Select enhanced benefit (Select all that apply):  Written Health Education Materials, incl. Newsletters	Select type of benefit for Nutritional Benefit:	Select type of benefit for Nursing Hotline:	
Nutritional Benefit	O Mandatory	○ Mandatory	
☐ Additional Smoking Cessation ☐ Membership in Health Club/Fitness Classes	O Optional	O Optional	
Nursing Hotline	Select type of benefit for Additional Smoking Cessation:		
	C Mandatory		
	O Optional		

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

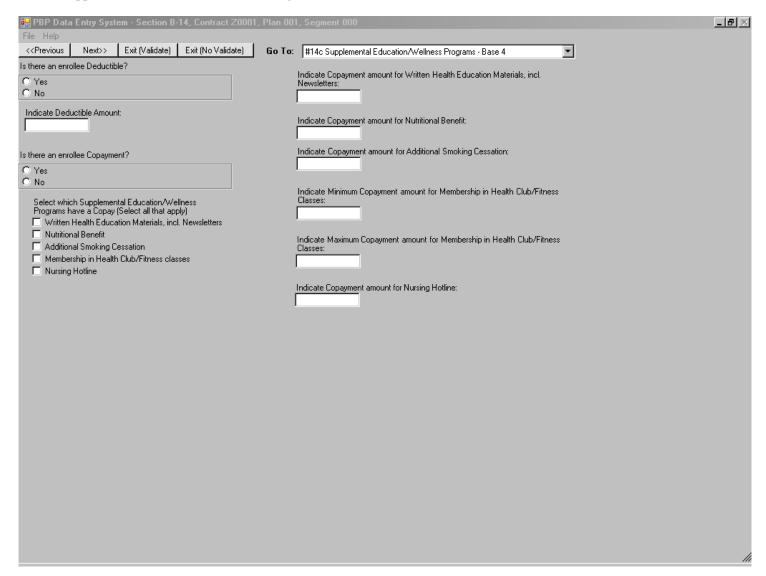
🔛 PBP Data Entry System - Section B-14, Con	ntract Z0001, Plan 001, Segment 000	_ & ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious Next&gt;&gt; Exit (Validate) Exit (Note)</pre></pre></pre>	Io Validate) Go To: #14c Supplemental Education/Wellness Programs - Base 2 ▼	
Is there a service-specific Maximum Plan Benefit Coverage amount for Supplemental Education/Wellness Programs?	Is there a service-specific Maximum Enrollee Out- of-Pocket Cost for Supplemental Education/Wellness Programs?	
O Yes O No	◯ Yes ◯ No	
Indicate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select the Maximum Plan Benefit Coverage periodicity:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
© Every year	C Every year	
C Every six months C Every three months	C Every six months	
Every triee months	C Every three months	

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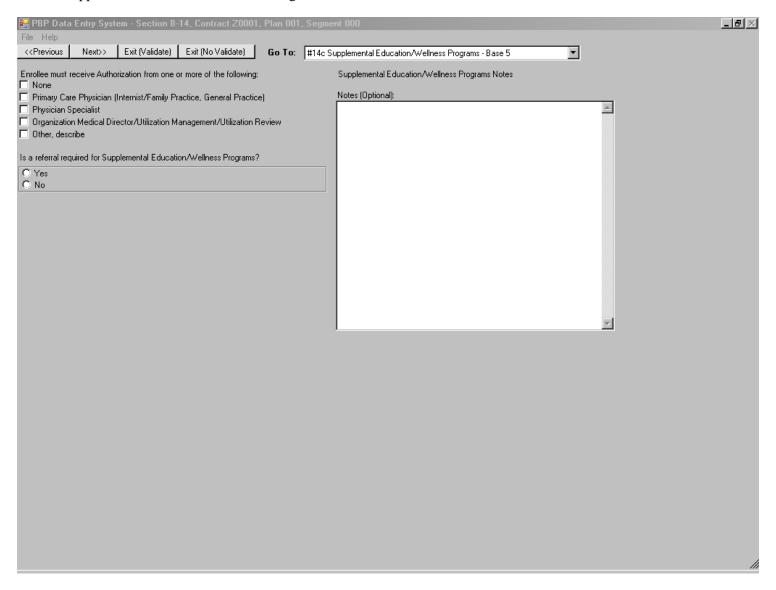
# Section B – 14C– Supplemental Education/Wellness Programs – Base 3 Screen

🔛 PBP Data Entry System - Section B-14, Contract Z0001,		_ B ×
File Help		
< <pre>&lt;<pre>revious</pre></pre>	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.	Indicate Coinsurance percentage for Nutritional Benefit:	
Is there an enrollee Coinsurance?	Indicate Coinsurance percentage for Additional Smoking Cessation:	
C Yes		
Select which Supplemental Education/Wellness Programs have a Coinsurance (Select all that apply)  Written Health Education Materials, incl. Newsletters  Nutritional Benefit  Additional Smoking Cessation	Indicate Minimum Coinsurance percentage for Membership in Health Club/Fitness Classes:  Indicate Maximum Coinsurance percentage for Membership in	
☐ Membership in Health Club/Fitness classes☐ Nursing Hotline	Health Club/Fitness Classes:	
Indicate Minimum Coinsurance percentage for Written Health Education Materials, incl. Newsletters:	Indicate Coinsurance percentage for Nursing Hotline:	
Indicate Maximum Coinsurance percentage for Written Health Education Materials, Incl. Newsletters:		
		li.

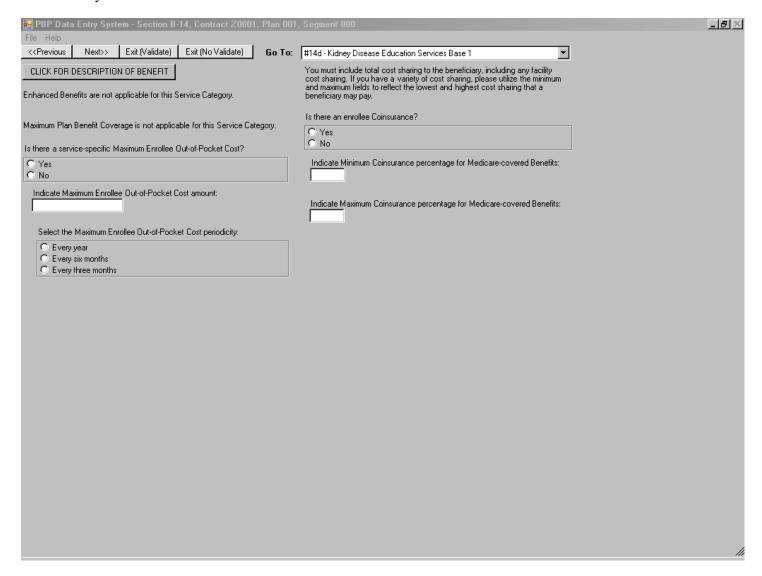
Section B – 14C– Supplemental Education/Wellness Programs – Base 4 Screen



Section B – 14C– Supplemental Education/Wellness Programs – Base 5 Screen



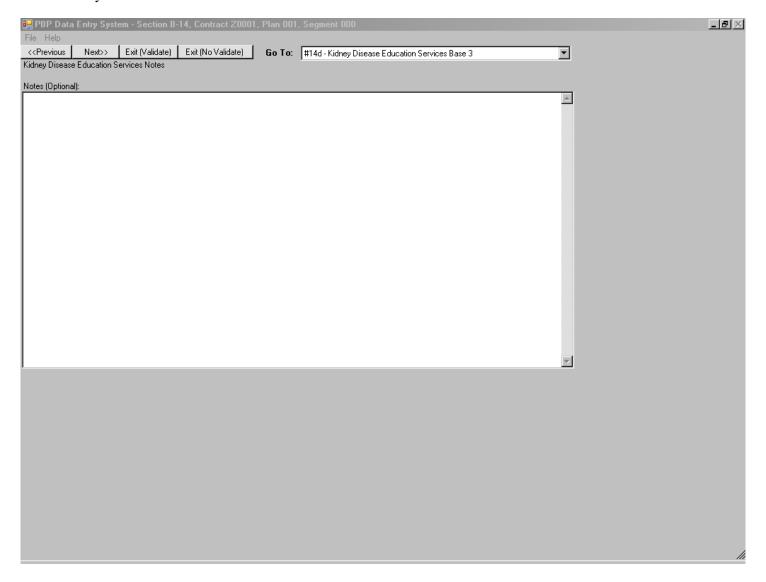
#### Section B – 14D– Kidney Disease Education Services – Base 1 Screen



Section B – 14D– Kidney Disease Education Services – Base 2 Screen

🖳 PBP Data Entry System - Section B-14, Contract Z0001, I	Plan 001, Segment 000	_ <i>- 18</i> ×
File Help		
< <pre>&lt;<pre>&lt;<pre>evious</pre> Next&gt;&gt;</pre></pre>	Go To: #14d - Kidney Disease Education Services Base 2 ▼	
Is there an enrollee Deductible?  C Yes C 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 there an enrollee Copayment?	Is a referral required for Kidney Disease Education Services?	
C Yes C No	C Yes C No	
Indicate Minimum Copayment amount for Medicare-covered Benefits:  Indicate Maximum Copayment amount for Medicare-covered Benefits:		
		li.

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



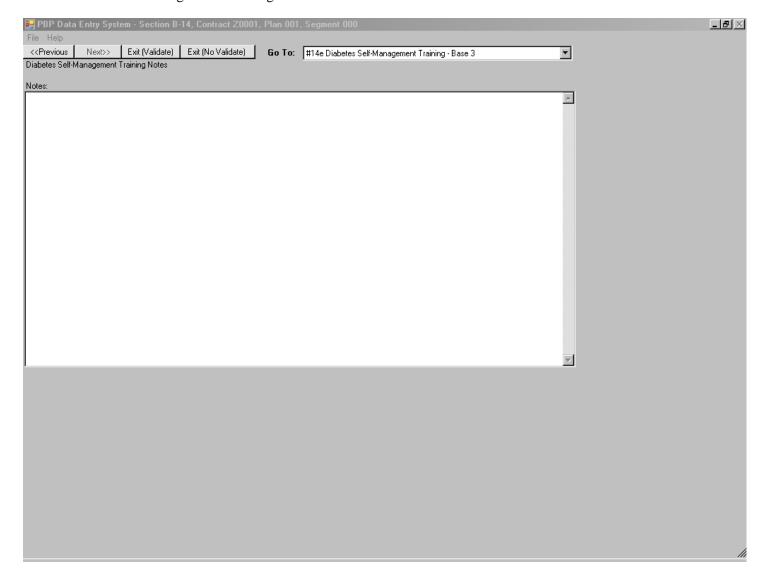
Section B – 14E– Diabetes Self-Management Training – Base 1 Screen

CEUCK 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  Indicate Maximum Enrollee Out-of-Pocket Cost amount.  Indicate Maximum Enrollee Out-of-Pocket Cost amount.  Select the Maximum Enrollee Out-of-Pocket Cost periodicity.  E very wear in the Maximum Enrollee Out-of-Pocket Cost periodicity.  E very where months  Indicate Deductible Amount:	🔛 PBP Data Entry System - Section B-14, Contract Z0001, Plan 001,	Segment 000	_ & ×
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?  C Yes C No  Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Is there an enrollee Coinsurance?  C Yes C No  Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:  Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Is there an enrollee Deductible?  C Yes C No  Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Is there an enrollee Deductible?  C Yes C No  Every year C Every year C Every year C Every year months	File Help		
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?  Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Is there an enrollee Deductible?  Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  C Yes  No  Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  C Every year  C Every year	<pre>&lt;<pre>revious</pre> Next&gt;&gt;</pre> Exit (Validate) Exit (No Validate) Go To:	#14e Diabetes Self-Management Training - Base 1	
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?  Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:  Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Is there an enrollee Deductible?  Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  Every year	CLICK FOR DESCRIPTION OF BENEFIT		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:  Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Is there an enrollee Deductible?  Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  C Every year C Every year C Every six months	Enhanced Benefits are not applicable for this Service Category.		
C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Is there an enrollee Deductible?  Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  C Every year C Every six months		Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Is there an enrollee Deductible?  Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  C Every year C Every six months	· · · · · · · · · · · · · · · · · · ·		
Is there an enrollee Deductible?  Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  C Every year C Every six months		Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  C Yes C No C Every year C Every six months	Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  © Every year © Every six months			
C Every six months			
	C Every six months	Indicate Deductible Amount:	
	2 E Toly Wilde Months		

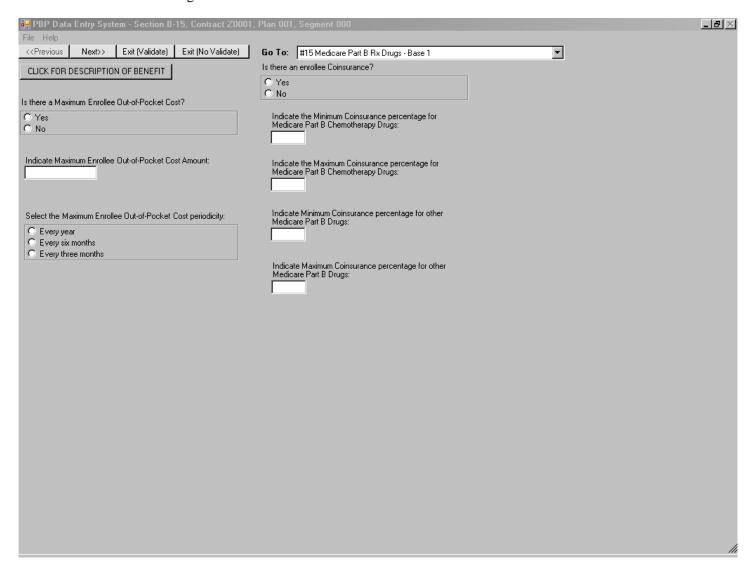
Section B – 14E– Diabetes Self-Management Training – Base 2 Screen

🔛 PBP Data Entry System - Section B-14, Contract Z0001, I	Plan 001, Segment 000	_ & ×
File Help  >   Exit (Validate)   Exit (No Validate)	Go To: #14e Diabetes Self-Management Training - Base 2	
Is there an enrollee Copayment?	Go To: #14e Diabetes Self-Management Training - Base 2  Is there an enrollee Copayment for a separate physician/professional service?	
C Yes	O Yes	
O No	O No	
Indicate Minimum Copayment amount for Medicare-covered Benefits:	Indicate Minimum Copayment amount for a separate physician/professional service:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	Indicate Maximum Copayment amount for a separate physician/professional service:	
Indicate whether a separate physician/professional service cost share applies:	Enrollee must receive Authorization from one or more of the following:  ☐ None	
○ Yes	☐ Primary Care Physician (Internist/Family Practice, General Practice) ☐ Physician Specialist	
○ No ○ Sometimes, describe	Organization Medical Director/Utilization Management/Utilization Review	
Is there an enrollee Coinsurance for a separate physician/professional service?	Other, describe	
C Yes	Is a referral required for Diabetes Self-Management Training?	
C No Indicate Minimum Coinsurance percentage for a separate	C Yes	
physician/professional service:		
Indicate Maximum Coinsurance percentage for a separate physician/professional service:		
		//

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



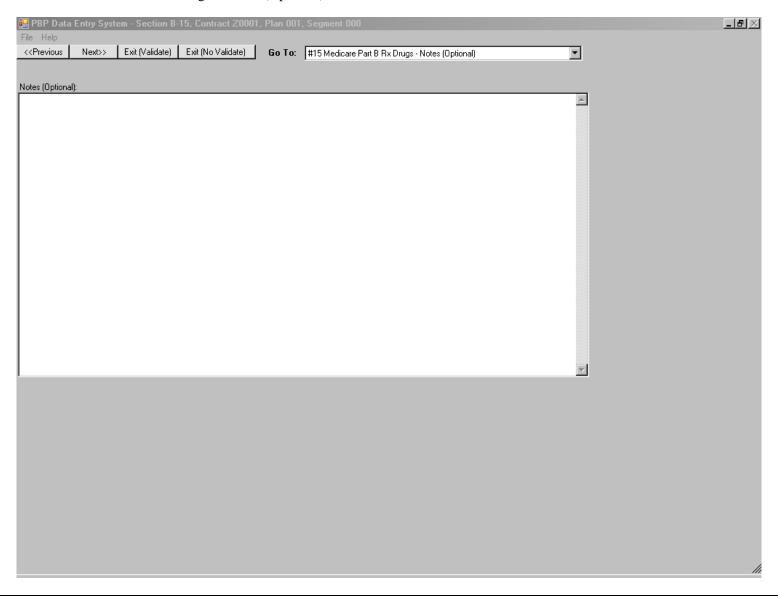
Section B – 15– Medicare Part B Rx Drugs – Base 1 Screen



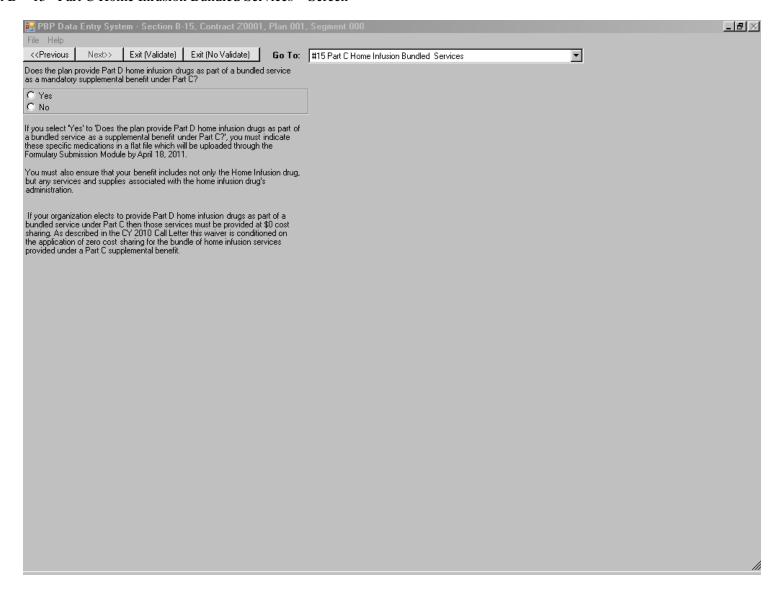
Section B – 15– Medicare Part B Rx Drugs – Base 2 Screen

🔛 PBP Data Entry System - Section B-15, Contract Z00	001, Plan 001, Segment 000	_ # ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #15 Medicare Part B Rx Drugs - Base 2	<u> </u>
Is there an enrollee Deductible?	Is Authorization Required?	
C Yes	C Yes	
C No	○ No	
Indicate Deductible Amount:		
Is there an enrollee Copayment?		
O 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



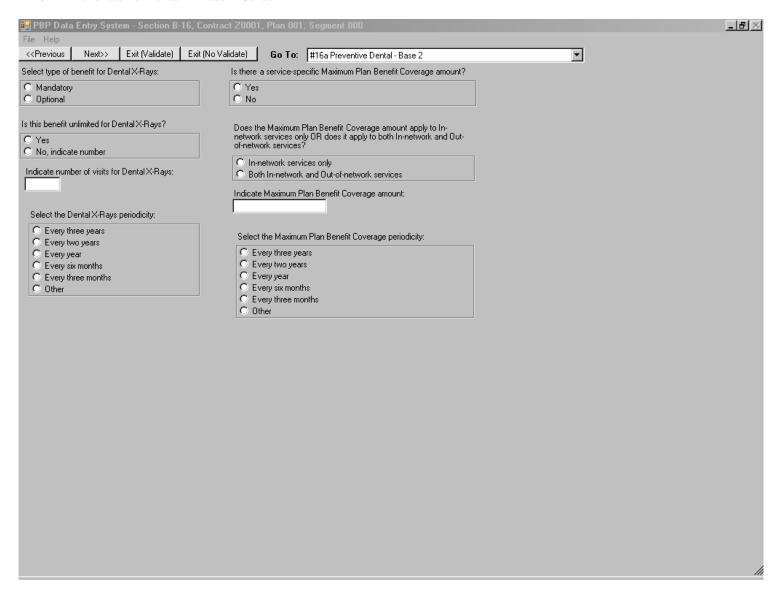
#### Section B – 15– Part C Home Infusion Bundled Services – Screen



### Section B – 16A– Preventative Dental – Base 1 Screen

🔛 PBP Data Entry System - Section B-16, Con	tract Z0001, Plan 001, Segment 000		_ B ×
File Help			
	o Validate) Go To: #16a Preventive Dental - Ba		
CLICK FOR DESCRIPTION OF BENEFIT	Select the Oral Exams periodicity:	Select type of benefit for Fluoride Treatment:	
Do you offer any Mandatory or Optional Supplemental Benefits?	C Every three years C Every two years C Every year C Every six months	C Mandatory C Optional  Is this benefit unlimited for Fluoride Treatment?	
○ No	C Every three months	O Yes	
Select enhanced benefits:	O Other  Select type of benefit for Prophylaxis (Cleaning):	O No, indicate number	
☐ Oral Exams ☐ Prophylaxis (Cleaning) ☐ Fluoride Treatment	C Mandatory C Optional	Indicate number of visits for Fluoride Treatment:	
☐ Dental X-Rays	Is this benefit unlimited for Prophylaxis (Cleaning)?	Select the Fluoride Treatment periodicity:	
Select type of benefit for Oral Exams:	C Yes C No, indicate number	C Every three years C Every two years	
C Optional  Is this benefit unlimited for Oral Exams?	Indicate number of visits for Prophylaxis (Cleaning):	C Every year C Every six months C Every three months	
O Yes O No, indicate number	Select the Prophylaxis (Cleaning) periodicity:	Other	
Indicate number of visits for Oral Exams:	C Every three years C Every two years C Every year C Every six months C Every three months C Other		
			//

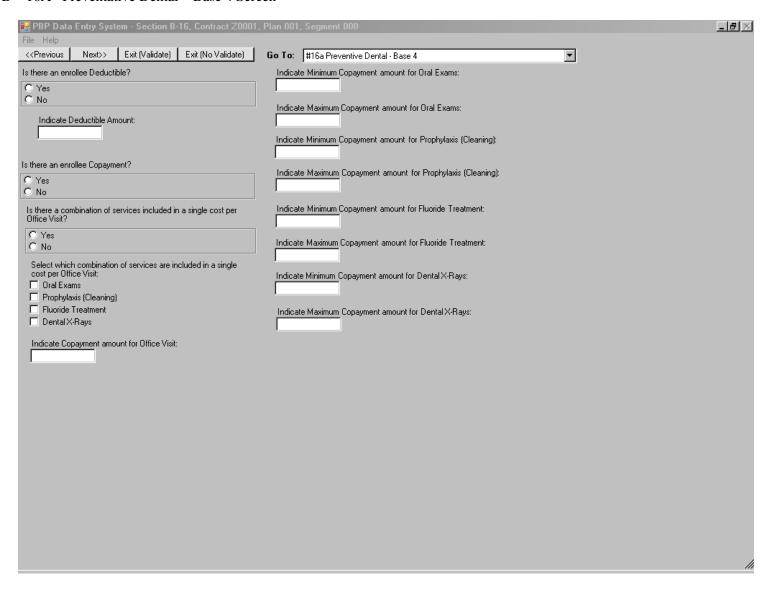
#### Section B – 16A– Preventative Dental – Base 2 Screen



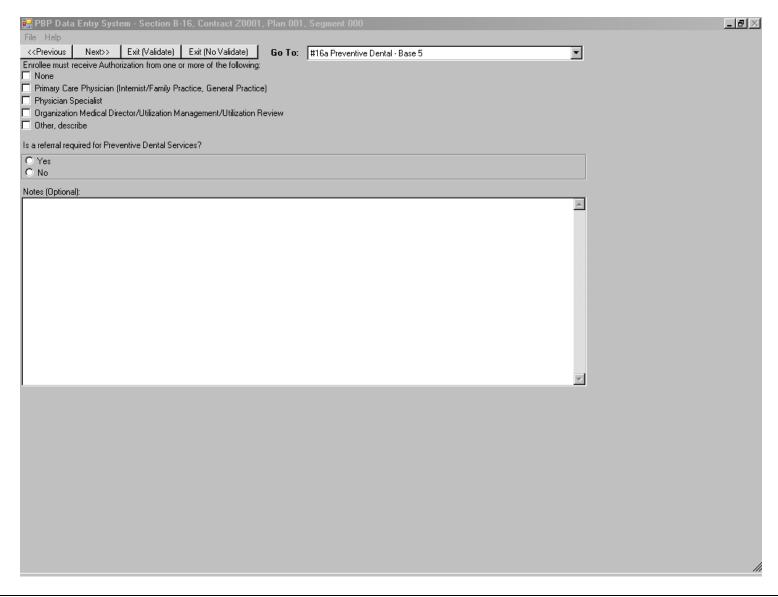
### Section B – 16A– Preventative Dental – Base 3 Screen

		_ B ×
Go To: #16a Preventive Dental - Base 3	▼	
Is there a combination of services included in a single cost per Office Visit?  C Yes C No	Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):	
Select which combination of services are included in a single cost per Office Visit:  Oral Exams Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays	Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):  Indicate Minimum Coinsurance percentage for Fluoride Treatment:  Indicate Maximum Coinsurance percentage for Fluoride Treatment:	
malcate comsularice percentage for office visit.		
Indicate Minimum Coinsurance percentage for Oral Exams: Indicate Maximum Coinsurance percentage for Oral Exams:	Indicate Minimum Coinsurance percentage for Dental X-Rays:  Indicate Maximum Coinsurance percentage for Dental X-Rays:	
	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	Is there a combination of services included in a single cost per Office Visit?  Prophylaxis (Cleaning):  Oral Exams Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays  Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):  Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):  Indicate Minimum Coinsurance percentage for Fluoride Treatment:  Indicate Minimum Coinsurance percentage for Fluoride Treatment:  Indicate Minimum Coinsurance percentage for Oral Exams:  Indicate Minimum Coinsurance percentage for Oral Indicate Minimum Coinsurance percentage for Dental X-Rays:  Indicate Maximum Coinsurance percentage for Oral Indicate Minimum Coinsurance percentage for Dental X-Rays:  Indicate Maximum Coinsurance percentage for Oral Indicate Maximum Coinsurance percentage for Dental X-Rays:  Indicate Maximum Coinsurance percentage for Oral Indicate Maximum Coinsurance percentage for Dental X-Rays:  Indicate Maximum Coinsurance percentage for Oral Indicate Maximum Coinsurance percentage for Dental X-Rays:

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



#### Section B – 16A– Preventative Dental – Base 5 Screen



Section B – 16B– Comprehensive Dental – Base 1 Screen

🔛 PBP Data Entry System - Section B-16, Contract Z0001, I	Plan 001, Segment 000		_ & ×
File Help			
< <pre>&lt;<pre> <pre></pre></pre></pre>	Go To: #16b Comprehensive Dental - Base	e 1 🔽	
CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Non-routine Services:	Select type of benefit for Diagnostic Services:	
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	C Mandatory C Optional	Mandatory     Optional	
Do you offer any Mandatory or Optional Supplemental Benefits?	Is this benefit unlimited for Non-routine Services?	Is this benefit unlimited for Diagnostic Services?	
O No	O Yes O No, indicate number	O Yes O No, indicate number	
Select enhanced benefits:  Non-routine Services Diagnostic Services Restorative Services	Indicate number of visits for Non-routine Services:	Indicate number of visits for Diagnostic Services:	
☐ Endodontics/Periodontics/Extractions ☐ Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	Select the Non-routine Services periodicity:	Select the Diagnostic Services periodicity:	
	C Every three years C Every two years C Every year C Every six months	C Every three years C Every two years C Every year C Every six months	
	© Every three months	C Every three months C Other	

Section B – 16B– Comprehensive Dental – Base 2 Screen

🔛 PBP Data Entry System - Section B-16, (	Contract Z0001, Plan 001, Segment 000		
File Help			
< <pre>&lt;<pre>&lt;<pre>c<pre>vious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit</pre></pre></pre></pre>	t (No Validate) Go To: #16b Comprehensive	Dental - Base 2	
Select type of benefit for Restorative Services:	Select type of benefit for Endodontics/Periodontics/Extractions:	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
© Optional	C Mandatory C Optional	C Mandatory C Optional	
Is this benefit unlimited for Restorative Services?	Is this benefit unlimited for Endodontics/Periodontics/Extractions?	Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	
O No, indicate number	© Yes	C Yes	
Indicate number of visits for Restorative Services:	C No, indicate number  Indicate number of visits for Endodontics/Peridontics/Extractions:	C No, indicate number  Indicate number of visits for Prosthodontics, 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:  C	Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:  C 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 0	001, Segment 000	_
File Help  < <pre> &lt;<pre> File Help  &lt;<pre> </pre> <pre> File Help  </pre>  <pre> File Help  </pre>  <pre> File Help  </pre>  <pre> File Help  </pre>  <pre> File Help  </pre>  <pre> File Help  </pre>  <pre> File Help  </pre>  <pre> File Help  </pre>  <pre> File Help  </pre>  <pre> File Help  </pre>  <pre> File Help  </pre>   <pre> File Help  </pre>  <pre> File Help  </pre>  <pre> File Hel</pre></pre></pre>		
Is there a service-specific Maximum Plan Benefit Coverage amount?	o: #16b Comprehensive Dental - Base 3  Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
© Yes	C Yes	
O No	O No	
Select the Maximum Plan Benefit Coverage type:	Select the Maximum Enrollee Dut-of-Pocket Cost type:	
C Covered under Preventive Dental Category 16a	C Covered under Preventive Dental Category 16a	
C Plan-specified amount per period	C 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?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:  Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
n-network services only	© Every three years	
C Both In-network and Out-of-network services	C Every two years	
Indicate Maximum Plan Benefit Coverage amount:	C Every year C Every six months	
	C Every three months	
Select the Maximum Plan Benefit Coverage periodicity:	O Other	
© Every three years		
C Every two years		
C Every year C Every six months		
© Every three months		
O Other		

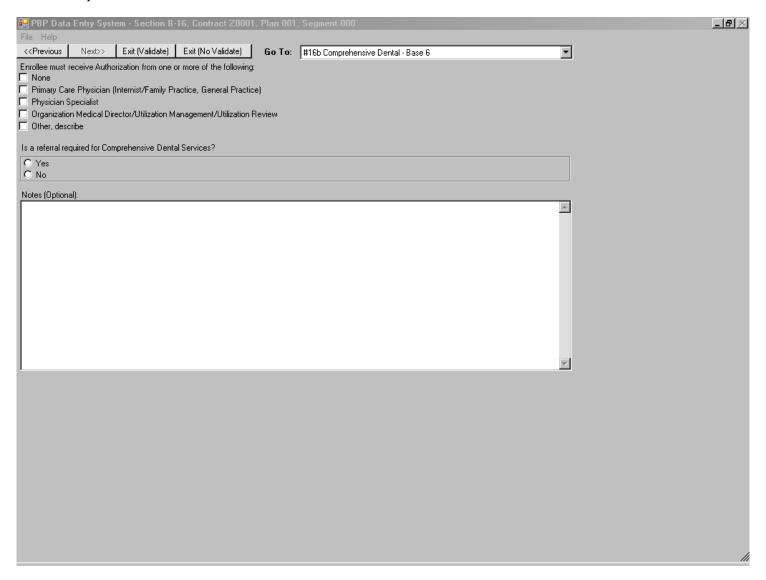
# Section B – 16B– Comprehensive Dental – Base 4 Screen

🔛 PBP Data Entry System - Section B-16, Contract Z0001, Pk	an 001, Segment 000	_ 8 ×
File Help		
< <pre>&lt;<pre> </pre> <pre>Next&gt;&gt; Exit (Validate)</pre></pre>	o To: #16b Comprehensive Dental - Base 4	
Is there an enrollee Coinsurance?	Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions:	
C Yes	Endodonics/Fellodonics/Exitactions.	
C No		
Indicate the Minimum Coinsurance percentage for Medicare-covered Ber	nefits: Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:	
Indicate the Maximum Coinsurance percentage for Medicare-covered Ber	nefits:	
	Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Minimum Coinsurance percentage for Non-routine Services:		
Indicate Maximum Coinsurance percentage for Non-routine Services:	Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Minimum Coinsurance percentage for Diagnostic Services:	Is there an enrollee Deductible?	
Later Mariner Crimeron and the Control	C Yes C No	
Indicate Maximum Coinsurance percentage for Diagnostic Services:	Indicate Deductible Amount:	
Indicate Minimum Coinsurance percentage for Restorative Services:		
muicate minimum coinsulance percentage for nestorative services.		
Indicate Maximum Coinsurance percentage for Restorative Services:		
		/

# Section B – 16B– Comprehensive Dental – Base 5 Screen

🔛 PBP Data Entry System - Section B-16, Con	ntract Z0001, Plan 001, Segment 000	_ 8 ×
File Help		
<pre>&lt;<pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (Next)</pre></pre></pre></pre>	o Validate) Go To: #16b Comprehensive Dental - Base 5	
Is there an enrollee Copayment?	Indicate Minimum Copayment amount for Restorative Services:	
○ Yes	nestulative Scivices.	
C No		
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 Maximum 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



# Section B – 17A– Eye Exams – Base 1 Screen

🔛 PBP Data Entry System - Section B-17, Conti	ract Z0001, Plan 001, Segment 000		_ & ×
File Help			
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No</pre></pre></pre>	Validate) Go To: #17a Eye Exams - Base 1	▼	
CLICK FOR DESCRIPTION OF BENEF	Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of- Pocket Cost?	
Do you offer any Mandatory or Optional Supplemental Benefits?	C Yes C No	C Yes C No	
O Yes O 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?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	_
Select enhanced benefit:  Routine Eye Exams	O In-network services only	 	
Select type of benefit for Routine Eye Exams:	Both In-network and Out-of-network services	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Mandatory C Optional	Indicate Maximum Plan Benefit Coverage amount:	C Every three years C Every two years	
Is this benefit unlimited for Routine Eye Exams?	Select the Maximum Plan Benefit Coverage	C Every year C Every six months	
C Yes C No, indicate number	periodicity:  © Every three years	C Every three months C Other	
Indicate number of exams for Routine Eye Exams:	C Every two years C Every year C Every six months C Every three months		
Select the Routine Eye Exams periodicity:	C Other		
C Every three years C Every two years C Every year C Every six months C Every three months C Other			

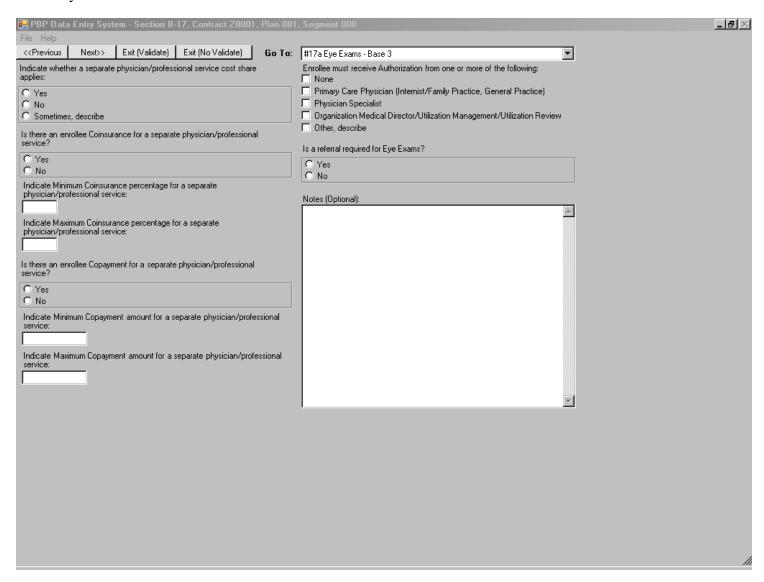
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# Section B – 17A– Eye Exams – Base 2 Screen

🔛 PBP Data Entry System - Section B-17, Contract Z0001,	. Plan 001	, Segment 000	_ B >
File Help			
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To:	#17a Eye Exams - Base 2	▼
Is there an enrollee Coinsurance?		Is there an enrollee Copayment?	
○ Yes		O Yes	
○ No		O No	
Indicate Minimum Coinsurance percentage for Medicare- covered Benefits:		Indicate Minimum Copayment amount for Medicare-covered Benefits:	
Indicate Maximum Coinsurance percentage for Medicare-			
covered Benefits:		Indicate Maximum Copayment amount for Medicare-covered Benefits:	
Indicate Minimum Coinsurance percentage for Routine Eye		Laffact Military Comment and Burfac For Form	
Exams:		Indicate Minimum Copayment amount per Routine Eye Exam:	
Indicate Maximum Coinsurance percentage for Routine Eye			
Exams:		Indicate Maximum Copayment amount per Routine Eye Exam:	
Is there an enrollee Deductible?			
C Yes			
O No			
Indicate Deductible Amount:			
maicate Deductible Amount.			
·			

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#### Section B – 17A– Eye Exams – Base 3 Screen



#### Section B – 17B– Eye Wear – Base 1 Screen



# Section B – 17B– Eye Wear – Base 2 Screen

🔛 PBP Data Entry System - Section B-17, Contract Z0	001, Plan 001, Segment 000 8	X
File Help		
< <pre>&lt;<pre>revious</pre></pre>	<b>Go To</b> : #17b Eye Wear · Base 2 ▼	
Select type of benefit for Eye Glass Lenses:	Select type of benefit for Eye Glass Frames:	
© Mandatory	© Mandatory	
C Optional	© Optional	
Is this benefit unlimited for Eye Glass Lenses?	Is this benefit unlimited for Eye Glass Frames?	
O Yes	O Yes	
C No, indicate number	No, indicate number	
Indicate quantity (number of pairs) for Eye Glass Lenses:	Indicate quantity for Eye Glass Frames:	
Select Eye Glass Lenses periodicity:	Select Eye Glass Frames periodicity:	
C Every three years	© Every three years	
© Every two years	C Every two years C Every year	
C Every year C Every six months	C Every six months	
C Every three months	C Every three months C Other	
○ Other	Select type of benefit for Upgrades:	
	○ Mandatory	
	C Optional	
		//

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# Section B – 17B– Eye Wear – Base 3 Screen

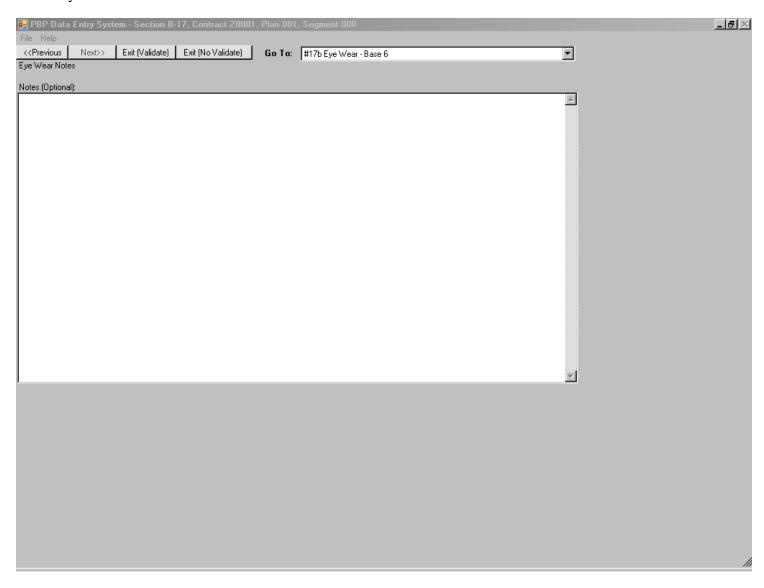
# Section B – 17B– Eye Wear – Base 4 Screen

🔛 PBP Data Entry System - Section B-17, Contract Z0001,	, Plan 001, Segment 000	_ & ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre></pre></pre>	Go To: #17b Eye Wear - Base 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?	
C Yes	© Yes	
○ No	○ No	
Select the Maximum Enrollee Out-of-Pocket Cost type:	Indicate Coinsurance percentage for Medicare-covered Benefits:	
C Covered under Eye Exams Category 17a C Plan-specified amount per period		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Coinsurance percentage for Contact Lenses:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Coinsurance percentage for Eye Glasses (Lenses and Frames):	
C Every three years C Every two years C Every year C Every six months C Every three months O Other	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

	_ 6 ×
l o z lwas v s s	
Indicate Copayment amount for Eye Glass Frames:	
Indicate Copayment amount for Upgrades:	
Enrollee must receive Authorization from one or more of the following:	
☐ None	
Physician Specialist	
O Yes	
C No	
h.	
j.	
):	Go To: #17b Eye Wear - Base 5 Indicate Copayment amount for Eye Glass Frames:  Indicate Copayment amount for Upgrades:  Enrollee must receive Authorization from one or more of the following:  None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for Eye Wear?  Yes No

### Section B – 17B– Eye Wear – Base 6 Screen

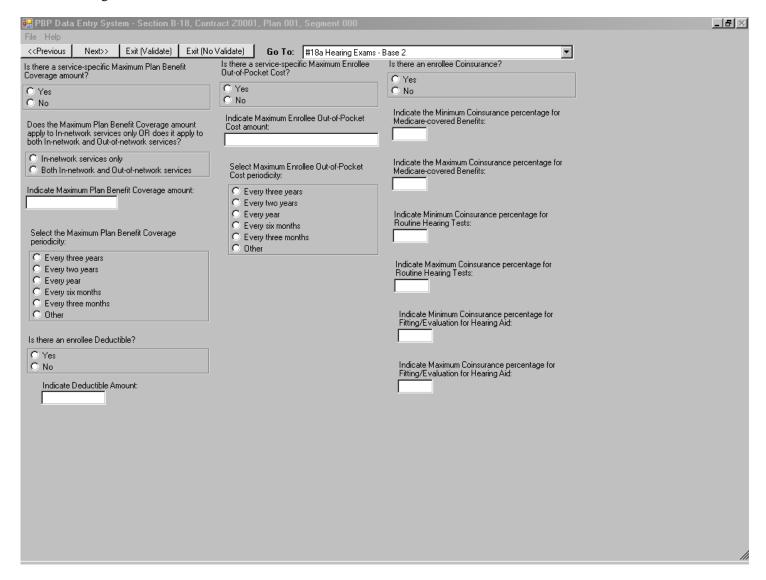


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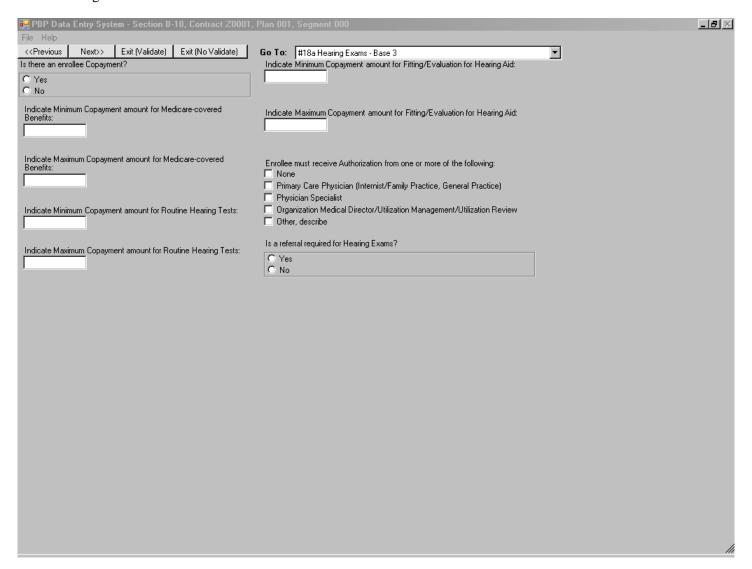
# Section B – 18A– Hearing Exams – Base 1 Screen

🔛 PBP Data Entry System - Section B-18, Contract Z000	01, Plan 001, Segment 000	_ & ×
File Help		
<pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #18a Hearing Exams - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select Routine Hearing Tests periodicity:	
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	C Every three years C Every two years C Every year C Every six months C Every three months O Other	
Do you offer any Mandatory or Optional Supplemental Benefits?  C Yes	Select type of benefit for Fitting/Evaluation for Hearing Aid:	
C No	C Mandatory C Optional	
Select enhanced benefits:  Routine Hearing Tests Fitting/Evaluation for Hearing Aid	Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	
Select type of benefit for Routine Hearing Tests:	C Yes C No, indicate number	
○ Mandatory ○ Optional	Indicate number for Fitting/Evaluation for Hearing Aid:	
Is this benefit unlimited for Routine Hearing Tests?		
© Yes	Select Fitting/Evaluation for Hearing Aid periodicity:	
O No, indicate number	© Every three years	
Indicate number for Routine Hearing Tests:	C Every two years	
Trades to the treatment of the treatment	© Every year	
	C Every six months C Every three months	
	O Other	
		//

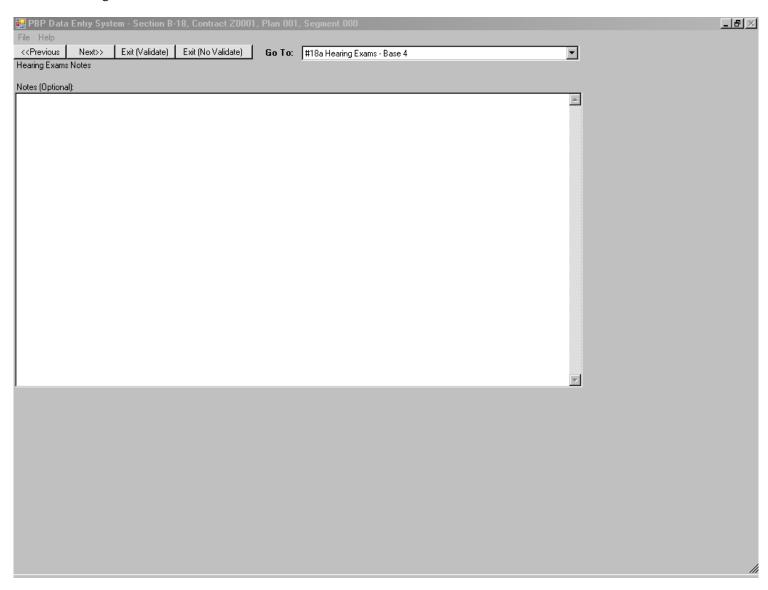
### Section B – 18A– Hearing Exams – Base 2 Screen



#### Section B – 18A– Hearing Exams – Base 3 Screen



Section B – 18A– Hearing Exams – Base 4 Screen



# Section B – 18B– Hearing Aids – Base 1 Screen

🔛 PBP Data Entry System - Section B-18, Co	ontract Z0001, Plan 001, Segment 000		_ & ×
File Help			
< <pre>&lt;<pre>&lt;<pre>c</pre></pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (I</pre></pre>	No Validate) Go To: #18b Hearing Ai		
CLICK FOR DESCRIPTION OF BENEFIT	Select Hearing Aids (all types) periodicity:	Select Hearing Aids - Inner Ear periodicity:	
	C Every three years	C Every three years	
Do you offer any Mandatory or Optional Supplemental Benefits?	C Every two years	© Every two years	
	C Every year C Every six months	© Every year © Every six months	
C Yes	C Every three months	C Every three months	
○ No	O Other	O Other	
Select enhanced benefits:		Select type of benefit for Hearing Aids - Outer Ear:	
Hearing Aids (all types)	Select type of benefit for Hearing Aids - Inner Ear:		
☐ Hearing Aids - Inner Ear ☐ Hearing Aids - Outer Ear		C Mandatory C Optional	
☐ Hearing Aids - Outer Ear ☐ Hearing Aids - Over the Ear	C Mandatory C Optional	Optional	
Treating Alas To vertile Ear	O Optional	Is this benefit unlimited for Hearing Aids - Outer Ear?	
Select type of benefit for Hearing Aids (all types):	Is this benefit unlimited for Hearing Aids -	C Yes	
C Mandatory	Inner Ear?	O No, indicate number	
O Optional	O Yes	1	
	No, indicate number	Indicate quantity for Hearing Aids - Outer Ear:	
Is this benefit unlimited for Hearing Aids (all			
types)?	Indicate quantity for Hearing Aids - Inner Ear:		
C Yes		Select Hearing Aids - Outer Ear periodicity:	
No, indicate number		C Every three years	
Indicate quantity for Hearing Aids (all types):		© Every two years	
maicate quantity for freating Alas (all types).		C Every year C Every six months	
		C Every three months	
		C Other	

# Section B – 18B– Hearing Aids – Base 2 Screen

🔛 PBP Data Entry System - Section B-18, Contract Z	0001, Plan 001, Segment 000	_ B ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	e) Go To: #18b Hearing Aids - Base 2	<u> </u>
Select type of benefit for Hearing Aids - Over the Ear:	Select the Maximum Plan Benefit Coverage type:	
C Mandatory	C Covered under Hearing Exams Category - 18a	
Optional	Plan-specified amount per period	
Is this benefit unlimited for Hearing Aids - Over the Ear?  C 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?	
S (10, Indicate Hamber	C In-network services only	
Indicate quantity for Hearing Aids - Over the Ear:	Both In-network and Out-of-network services	
	Indicate Maximum Plan Benefit Coverage amount:	
Select Hearing Aids - Over the Ear periodicity:		
© Every three years	Indicate Maximum Plan Benefit Coverage periodicity:	
C Every two years C Every year	C Every three years	
C Every six months	C Every two years C Every year	
© Every three months	C Every six months	
C Other	C Every three months	
Is there a service-specific Maximum Plan Benefit Coverage amount?	O Other	
C Yes		
O No		

# Section B – 18B– Hearing Aids – Base 3 Screen

🔛 PBP Data Entry System - Section B-18, Contract ZC	20001, Plan 001, Segment 000	_ & ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?  © Yes	
O Yes	O No	
○ No		
Select the Maximum Enrollee Out-of-Pocket Cost type:	Indicate Coinsurance percentage for Hearing Aids [all types]:	
C Covered under Hearing Exams Category - 18a C Plan-specified amount per period		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Coinsurance percentage for Hearing Aids - Inner Ear:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Coinsurance percentage for Hearing Aids - Outer Ear;	
C Every three years C Every two years	ower La.	
C Every year		
C Every six months	Indicate Coinsurance percentage for Hearing Aids -	
C Every three months	Over the Ear:	
O Other		

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

🔛 PBP Data Entry System - Section B-18, Contract Z0001,	Plan 001, Segment 000	_ 8 ×
File Help		
< <pre>&lt;<pre>&lt;<pre> <pre> </pre> <pre></pre></pre></pre></pre>	Go To: #18b Hearing Aids - Base 4	
Is there an enrollee Copayment?	Indicate Copayment amount per Hearing Aid - Over the Ear:	
O Yes O No		
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?  C Yes C No	
Indicate Copayment amount per Hearing Aid - Inner Ear:	Indicate Deductible Amount:	
Indicate Copayment amount per two Hearing Aids - Inner Ear:		
Indicate Copayment amount per Hearing Aid - Outer Ear:		
Indicate Copayment amount per two Hearing Aids - Outer Ear:		

### Section B – 18B– Hearing Aids – Base 5 Screen



# Section B – 20– Outpatient Drugs – Base 1 Screen

🔡 PBP Data Entry System - Section B-20, Co	ontract Z0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre>&lt;<pre>&lt;<pre>c</pre></pre> Next&gt;&gt; Exit (Validate) Exit (Validate)</pre>	(No Validate) Go To: #20 Outpatient		
CLICK FOR DESCRIPTION OF BENEFIT	Is there a Maximum Plan Benefit Coverage amount for drugs?	Indicate Max Plan Benefit Cov amount annually for drugs:	
Do you offer any Mandatory or Optional Supplemental Benefits?	O Yes O No	Indicate Max Plan Benefit Cov amount semi-annually for drugs:	
O Yes O No	Indicate type of Maximum Plan Benefit Coverage:		
Select type of benefit:	☐ All drug groups covered by plan☐ Combination of drug groups	Indicate Max Plan Benefit Cov amount quarterly for drugs:	
C Mandatory C Optional	☐ Individual drug groups		
Indicate the number of drug groupings that are offered:	Is the Maximum Plan Benefit Coverage net of the enrollee copay?	Indicate Max Plan Benefit Cov amount monthly for drugs:	
C 1 C 2	O Yes O No	Indicate Max Plan Benefit Cov amount for Other for drugs:	
C 3 C 4 C 5	Indicate Maximum Plan Benefit Coverage periodicity for drugs:		
<u> </u>	☐ Annually ☐ Semi-annually		
	Quarterly		
	☐ Monthly ☐ Other, describe		
	_ Gwa, accombo		

# Section B – 20– Outpatient Drugs – Base 2 Screen

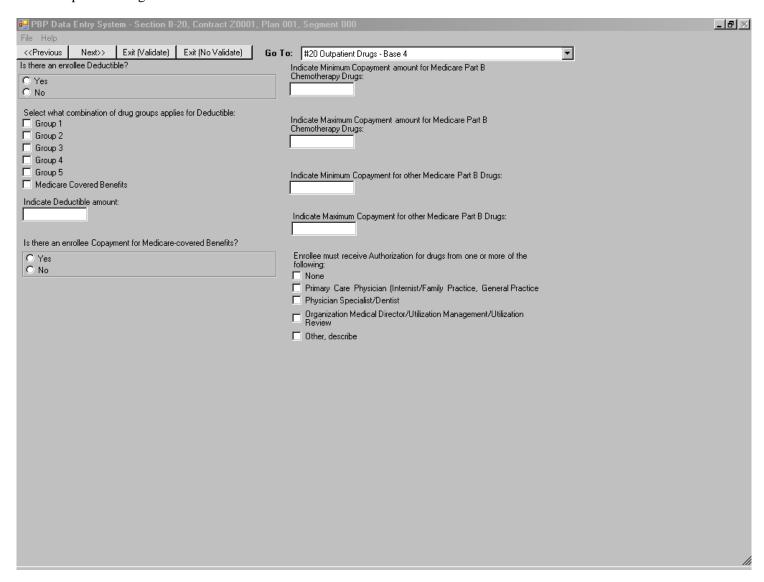
Fu Associates, Ltd.

🔛 PBP Data Entry System - Section B-20, Contract Z0001, Plan 001	, Segment 000	_ & ×
File Help		
< <pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To:</pre>	#20 Outpatient Drugs - Base 2	
Can any unused amounts be carried forward to the next period within the contract period?	Indicate Max Plan Benefit Cov amount annually for combination of drug groups:	
C Yes		
○ No		
Select what combination of drug groups are included in the Maximum Plan Benefit:	Indicate Max Plan Benefit Cov amount semi-annually for combination of drug groups:	
Group 2		
Group 3	Indicate Max Plan Benefit Cov amount quarterly for combination of drug	
Group 4	groups:	
Group 5		
Indicate Maximum Plan Benefit Coverage periodicity for combination of drug groups:  Annually	Indicate Max Plan Benefit Cov amount monthly for combination of drug groups:	
☐ Semi-annually	· · · · · · · · · · · · · · · · · · ·	
Quarterly	Indicate Max Plan Benefit Cov amount for Other for combination of drug	
Monthly	groups:	
Other, describe		

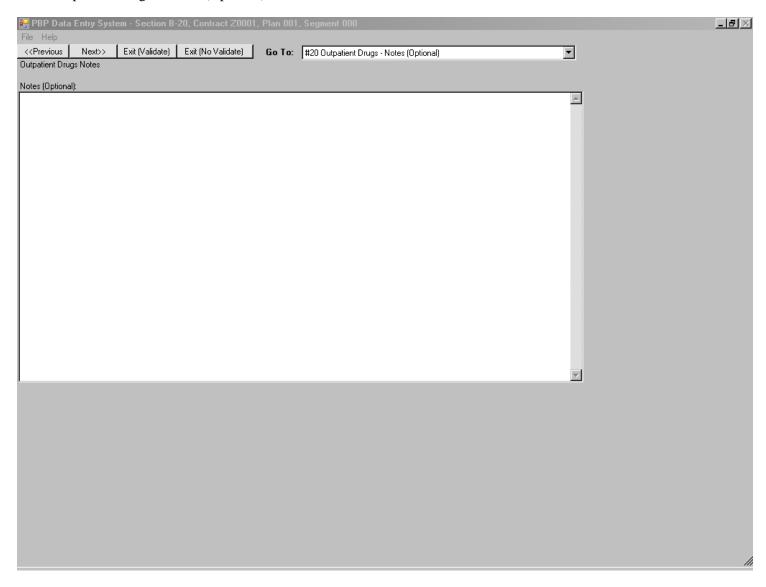
# Section B – 20– Outpatient Drugs – Base 3 Screen

🔛 PBP Data Entry System - Section B-20, Contract Z0001, Plan	001, Segment 000	_ B ×
File Help		
< <pre>&lt;<pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate) Go</pre></pre>	To: #20 Outpatient Drugs - Base 3	₹
Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	_
○ Yes	·	
○ No	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived: Group 1 Group 2	C Every year C Every six months C Every three months	
☐ Group 3		
☐ Group 4		
☐ Group 5	Lathers are consider Colores of the Constant o	
Does the enrollee incur a cost in addition to the Coinsurance or Copay for	Is there an enrollee Coinsurance for Medicare-covered Benefits?	
selecting a higher priced drug when a less expensive drug is available?	C Yes C No	
C Yes	Indicate Minimum Coinsurance percentage for Medicare Part B	
C No	Chemotherapy Drugs:	
Is there a Maximum Enrollee Out-of-Pocket Cost?		
C Yes		
○ No	Indicate Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:	
Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost:		
Group 1		
Group 2	Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	
Group 3		
Group 4		
☐ Group 5 ☐ Medicare Covered Benefits	Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:	
Medicale Covered Derients		

Section B – 20– Outpatient Drugs – Base 4 Screen



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	_ 8 ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	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:	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:	
☐ Generic ☐ Preferred Brand		
☐ Brand		
	Indicate Maximum Plan Benefit Coverage quarterly amount for	
Is there a Maximum Plan Benefit Coverage amount for Group 1?	Group 1:	
C Yes		
C No		
- · · ·	Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:	
Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:		
☐ Annually ☐ Semi-annually		
Quarterly	Indicate Maximum Plan Benefit Coverage amount per	
☐ Monthly	prescription for Group 1:	
Per Prescription		
☐ Other, describe		
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:	
	Group I.	

# Section B – 20– Outpatient Drugs- Group 1 – Base 2 Screen

BP Data Entry System - Section B-20, Contract Z0001,			_BX
File Help			
< <pre>&lt;<pre> </pre> <pre></pre></pre>	Go To: #20 Outpatient Drugs - Group 1 - Bas	e 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?	Is there an enrollee Copayment for Group 1?		
C Yes C No	O Yes O No		
Indicate Coinsurance percentage for Group 1 Designated Retail Pharmacy:	Indicate Copayment amount for Group 1 Designated Retail Pharmacy:	Up to a day supply covered for Group 1 Designated Retail Pharmacy:	
Indicate Coinsurance percentage for Group 1 HMO-Owned Pharmacy:	Indicate Copayment amount for Group 1 HMO- Owned Pharmacy:	Up to aday supply covered for Group 1 HMO-Owned Pharmacy:	
Indicate Coinsurance percentage for Group 1 Mail Order:	Indicate Copayment amount for Group 1 Mail Order:	Up to aday supply covered for Group 1 Mail Order:	
Indicate Coinsurance percentage for Group 1 Other:	Indicate Copayment amount for Group 1 Other:	Up to a day supply covered for Group 1 Other:	

Section B – 20– Outpatient Drugs- Group 2 – Base 1 Screen

🔛 PBP Data Entry System - Section B-20, Contract Z000	11, Plan 001, Segment 000	8 ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> Next&gt;&gt;</pre> Exit (Validate) Exit (No Validate)</pre>	Go To: #20 Outpatient Drugs - Group 2 - Base 1 ▼	
Select a label for Group 2:	Indicate Maximum Plan Benefit Coverage annual amount for Group 2:	
Select the drug type(s) covered for Group 2:  Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:	
Is there a Maximum Plan Benefit Coverage amount for Group 2?  C Yes  No	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:	
Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:  Annually  Semi-annually  Quarterly  Monthly	Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:	
☐ Per Prescription ☐ Other, describe	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:	
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:	
		//

Section B – 20– Outpatient Drugs- Group 2 – Base 2 Screen

🔛 PBP Data Entry System - Section B-20, Con			_ B ×
File Help			
< <pre>&lt;<pre>&lt;<pre>revious</pre></pre></pre>	Validate) Go To: #20 Outpatient Drugs - Grou	μp 2 - Base 2 ▼	
Select from where Group 2 Drugs can be acquired:			
Designated Retail Pharmacy			
HMO-Owned Pharmacy			
☐ Mail Order ☐ Other, describe			
) Other, describe			
Is there an enrollee Coinsurance for Group 2?	Is there an enrollee Copayment for Group 2?		
O Yes	C Yes		
○ No	O No		
Indicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy:	Indicate Copayment amount for Group 2 Designated Retail Pharmacy:	Up to a day supply covered for Group 2 Designated Retail Pharmacy:	
Indicate Coinsurance percentage for Group 2 for	Indicate Copayment amount for Group 2 HMO-	Up to a day supply covered for Group 2	
HMO-Owned Pharmacy:	Owned Pharmacy:	HMO-Owned Pharmacy:	
1.5.4.6.	1.5.0		
Indicate Coinsurance percentage for Group 2 for Mail Order:	Indicate Copayment amount for Group 2 Mail Order:	Up to a day supply covered for Group 2 Mail Order:	
		_ <del></del>	
Indicate Coinsurance percentage for Group 2 for	Indicate Copayment amount for Group 2 Other:	Up to a day supply covered for Group 2	
Other:		Other:	

# Section B – 20– Outpatient Drugs- Group 3 – Base 1 Screen

🔛 PBP Data Entry System - Section B-20, Contract Z00		_ & ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #20 Outpatient Drugs - Group 3 - Base 1	
Select a label for Group 3:	Indicate Maximum Plan Benefit Coverage annual amount for Group 3:	
_	a. 104p 5.	
Select the drug type(s) covered for Group 3:	Indicate Maximum Plan Benefit Coverage semi-annual amount	
☐ Generic ☐ Preferred Brand	for Group 3:	
Freneried Brand  Brand		
J. Diano		
Is there a Maximum Plan Benefit Coverage amount for Group 3?	Indicate Maximum Plan Benefit Coverage quarterly amount for	
C Yes	Group 3:	
O res		
Indicate Maximum Plan Benefit Coverage Group 3 periodicity:	Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:	
☐ Annually ☐ Semi-annually		
Quarterly		
☐ Monthly	Indicate Maximum Plan Benefit Coverage amount per prescription	
Per Prescription	for Group 3:	
Other, describe		
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 3:	

# Section B – 20– Outpatient Drugs- Group 3 – Base 2 Screen

🔛 PBP Data Entry System - Section B-20, Contract Z0			_ <u>- 121 ×</u>
File Help			
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	e) 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			
) Other, describe			
Is there an enrollee Coinsurance for Group 3?	Is there an enrollee Copayment for Group 3?		
C Yes	C Yes		
C No	◯ No		
Indicate Coinsurance percentage for Group 3 Designated Retail Pharmacy:	Indicate Copayment amount for Group 3 Designated Retail Pharmacy:	Up to a day supply covered for Group 3 Designated Retail Pharmacy:	
Indicate Coinsurance percentage for Group 3 HMO-Owned Pharmacy:	Indicate Copayment amount for Group 3 HMO- Owned Pharmacy:	Up to a day supply covered for Group 3 HMO-Owned Pharmacy:	
Indicate Coinsurance percentage for Group 3 Mail Order:	Indicate Copayment amount for Group 3 Mail Order:	Up to a day supply covered for Group 3 Mail Order:	
Indicate Coinsurance percentage for Group 3 Other:	Indicate Copayment amount for Group 3 Other:	Up to a day supply covered for Group 3 Other:	

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

🔛 PBP Data Entry System - Section B-20, Contract Z000	01, Plan 001, Segment 000	_ 8 ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	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?  C Yes  No	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4:	
Indicate Maximum Plan Benefit Coverage Group 4:  Annually Semi-annually Quarterly Monthly	Indicate Maximum Plan Benefit Coverage monthly amount for Group 4:	
☐ Per Prescription ☐ Other, describe	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 Z0			_ <b>.</b>
File Help			
< <pre>&lt;<pre>&lt;<pre>revious</pre> <pre>Next&gt;&gt;</pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Bo To: #20 Outpatient Drugs - Group 4 - B	lase 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?	Is there an enrollee Copayment for Group 4?		
O Yes	O Yes		
○ No	○ No		
Indicate Coinsurance percentage for Group 4 Designated Retail Pharmacy:	Indicate Copayment amount for Group 4 Designated Retail Pharmacy:	Up to aday supply covered for Group 4 Designated Retail Pharmacy:	
Indicate Coinsurance percentage for Group 4 HMO-Owned Pharmacy:	Indicate Copayment amount for Group 4 HMO- Owned Pharmacy:	Up to aday supply covered for Group 4 HMO-Owned Pharmacy:	
Indicate Coinsurance percentage for Group 4 Mail Order:	Indicate Copayment amount for Group 4 Mail Order:	Up to a day supply covered for Group 4 Mail Order:	
Indicate Coinsurance percentage for Group 4 Other:			
	Indicate Copayment amount for Group 4 Other:	Up to a day supply covered for Group 4 Other:	

Section B – 20– Outpatient Drugs- Group 5 – Base 1 Screen

🔛 PBP Data Entry System - Section B-20, Contract Z000	1, Plan 001, Segment 000	_ B ×
File Help		
< <pre>&lt;<pre>&lt;<pre>revious</pre></pre></pre>	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:	
Ţ	andap s.	
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?  O Yes  No	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:	
Indicate Maximum Plan Benefit Coverage for Group 5 periodicity:  Annually  Guarterly  Monthly	Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:	
☐ Per Prescription ☐ Other, describe	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 Z	0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre>&lt;<pre>revious</pre></pre>	e) Go To: #20 Outpatient Drugs - Group 5 -	Base 2	
Select from where Group 5 Drugs can be acquired:  Designated Retail Pharmacy			
Designated Retail Pharmacy     HMO-Owned Pharmacy			
Mail Order			
☐ Other, describe			
Is there an enrollee Coinsurance for Group 5?			
	Is there an enrollee Copayment for Group 5?		
C Yes C No	C Yes C No		
3.10			
Indicate Coinsurance percentage for Group 5 Designated Retail Pharmacy:	Indicate Copayment amount for Group 5 Designated Retail Pharmacy:	Up to a day supply covered for Group 5 Designated Retail Pharmacy:	
netali Fridillacy.	Designated recall Financials.	Croup 3 Designated Fredair Franciscy.	
Indicate Coinsurance percentage for Group 5 HMO-	Indicate Copayment amount for Group 5 HMO-	Up to a day supply covered for	
Owned Pharmacy:	Owned Pharmacy:	Up to a day supply covered for Group 5 HMO-Owned Pharmacy:	
Indicate Coinsurance percentage for Group 5 Mail Order:	Indicate Copayment amount for Group 5 Mail Order:	Up to a day supply covered for Group 5 Mail Order:	
		<u></u>	
Indicate Coinsurance percentage for Group 5 Other:	Indicate Copayment amount for Group 5 Other:	Up to a day supply covered for	
		Group 5 Other:	

### Section B – 20– Part C Home Infusion Bundled Services – Screen

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