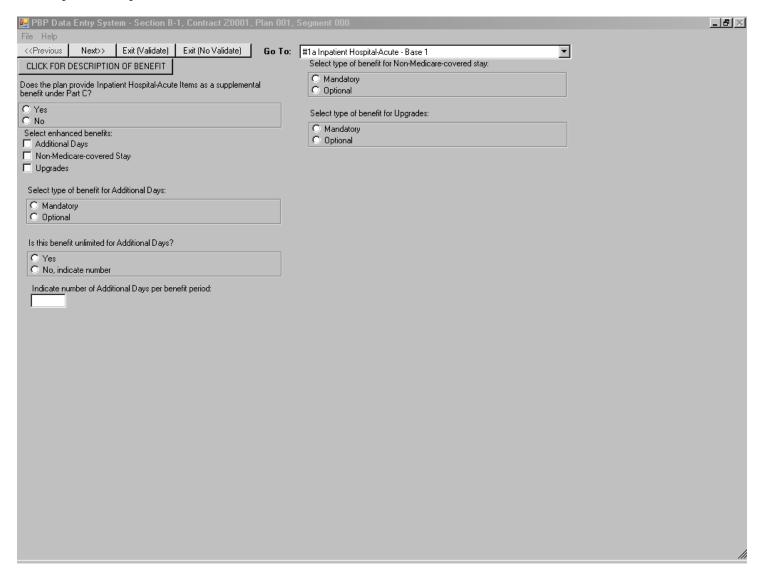
Section B - 1A - Inpatient Hospital-Acute – Base 1 Screen



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

Fu Associates, Ltd.

PBP Data Entry System - Section B-1, Contract Z0001, Plan 001,	Segment 000	_ & ×
File Help		
<pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre> <pre>Go To:</pre></pre></pre>	#1a Inpatient Hospital-Acute - Base 2	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Is there an enrollee Coinsurance?	
	C Yes	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	© No	
O Yes O No	Medicare-covered Coinsurance Cost Sharing for Tier 1:	
Indicate the Maximum Enrollee Out-of-Pocket Cost amount:	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	C Yes C No	
Select the Maximum Enrollee Dut-of-Pocket Lost periodicity: © Every three years © Every year © Every six months © Every Stay © Other, Describe Does this plan's cost sharing vary by hospital(s) in which an enrollee obtains care? © Yes © No How many cost sharing tiers do you offer? What is your lowest cost tier? © Tier 1 © Tier 2 © Tier 3	Indicate Coinsurance percentage for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay: Zero (No Coinsurance per Day) Done 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: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	

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

🚂 PBP Data I	Entry Syster	m - Section B-1, Cont	ract Z0001, Plai	n 001, 9	Segment 000			_ & ×
File Help								
< <pre><<pre>revious</pre></pre>	Next>>	Exit (Validate)	Validate) G	o To:	#1a Inpatient Hospital-Acute - Ba	se 3	▼	
Medicare-covere	d Coinsurance	e Cost Sharing for Tier 2:			Medicare-covered Coinsurance	Cost Sharing for Tier 3:		
Do you charge th charges for all se	ne Medicare-d rivices provide	lefined cost shares? (The ed to the enrollee in the in	se are the total patient facility.)		Do you charge the Medicare-de charges for all services provided	fined cost shares? (The d to the enrollee in the in	se are the total patient facility.)	
O Yes O No					O Yes O No			
Indicate Coi	insurance per	centage for the Medicare-	covered stay:		Indicate Coinsurance perce	ntage for the Medicare-c	overed stay:	
Indicate the	number of da	y intervals for the Medica	re-covered stay:		Indicate the number of day i	intervals for the Medicare	e-covered stay:	
C Zero (N C One C Two C Three	o Coinsuranci	e per Day)			C Zero (No Coinsurance p C One C Two C Three	per Day)		
Indicate the covered sta	coinsurance by (e.g., 1 to 30	percentage and day inter 0; 31 to 90):	val(s) for the Medic	are-	Indicate the coinsurance pe covered stay (e.g., 1 to 30;	ercentage and day interv 31 to 90):	al(s) for the Medicare-	
Coinsurance	e % Interval 1:	Begin Day Interval 1:	End Day Interva	al 1:	Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:	
Coinsurance	e % Interval 2:	Begin Day Interval 2:	End Day Interva	al 2:	Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:	
Coinsurance	e % Interval 3:	Begin Day Interval 3:	End Day Interve	al 3:	Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:	
								/

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

🔛 PBP Data I	Entry Syste	em - Section	B-1, Contract Z0	1001, Plan 001,	Segmer	nt 000						_ 8 ×
File Help												
< <pre>revious</pre>	Next>>	Exit (Validate	e) Exit (No Valida	e) Go To:	#1a Inp	atient Hospita	l-Acute - Base	4		▼		
Medicare-covere	ed Life Time I	Reserve Days	Tier 1	Medicare-covere	d Life Tin	ne Reserve Da	ays Tier 2	Medicare-o	covered Life Time I	Reserve Days	Tier 3	
Indicate the num Medicare-covere	nber of day in ed Lifetime R	tervals for the eserve Days:		Indicate the num Medicare-covere	nber of da ed Lifetim	y intervals for I e Reserve Day	the ys:	Indicate th Medicare-c	e number of day in covered Lifetime R	ntervals for the eserve Days:		
C Zero (No Co C One C Two C Three	insurance pe	er Day)		C Zero (No Co C One C Two C Three	insurance	e per Day)		C Zero (I C One C Two C Three	No Coinsurance pe	er Day)		
Indicate the coin interval(s) for the Reserve Days (i.	nsurance per 60 Medicare e., 1 - 60):	centage and di e-covered Lifeti	ay ime	Indicate the coin interval(s) for the Reserve Days (i.	surance 60 Medi e., 1 - 60	percentage an care-covered l):	id day Lifetime	Indicate th interval(s) f Reserve D	e coinsurance per or the 60 Medicare ays (i.e., 1 - 60):	centage and da e-covered Lifeti	ay me	
		Inter	val Days			Interv	val Days			Interva	l Days	
Coinsu	urance %	Begin Day	End Day	Coinsur	ance %	Begin Day	End Day	Interval 1	Coinsurance %	Begin Day	End Day	
Interval 1:				Interval 1:				Interval 1:				
Interval 2:				Interval 2:				Interval 2:				
Interval 3:				Interval 3:				Interval 3:				
,												

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

🔢 PBP Data Entry System - Section B-1, Contract Z0001, Pla	1 001, Segment 000	
File Help		
< <pre><<pre> </pre> <pre></pre></pre>	o To: #1a Inpatient Hospital-Acute - Base 5	
Indicate the number of day intervals for Additional Days:		
C 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		

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

#It a Impatient Hospital-Acute - Base 6 Is the Consultance structure for the Medicare-covered stay the same as the Consultance structure for the Medicare-covered stay? No	🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000	_ B ×
Indicate Consurance structure for the Nort-Medicare-covered stay the same as the Consurance structure for the Medicare-covered stay. Yes Indicate Consurance percentage for the Nort-Medicare-covered stay. Indicate the number of day intervals for the Nort-Medicare-covered stay. Zero (No Consurance per Day) One Two Three Indicate the consurance percentage and day interval (3 for the Nort-Medicare-covered stay (enter "399" trustment days are offered, e.g., 1 to 999). Consurance % Interval 1: Begin Day Interval 2: End Day Interval 2: Consurance % Interval 2: Begin Day Interval 3: End Day Interval 2. Consurance % Interval 3: Begin Day Interval 3: End Day Interval 3: Indicate Consurance percentage for Upgrades:	File Help	
Indicate Consurance structure for the Nort-Medicare-covered stay the same as the Consurance structure for the Medicare-covered stay. Yes Indicate Consurance percentage for the Nort-Medicare-covered stay. Indicate the number of day intervals for the Nort-Medicare-covered stay. Zero (No Consurance per Day) One Two Three Indicate the consurance percentage and day interval (3 for the Nort-Medicare-covered stay (enter "399" trustment days are offered, e.g., 1 to 999). Consurance % Interval 1: Begin Day Interval 2: End Day Interval 2: Consurance % Interval 2: Begin Day Interval 3: End Day Interval 2. Consurance % Interval 3: Begin Day Interval 3: End Day Interval 3: Indicate Consurance percentage for Upgrades:	< <pre><<pre></pre> Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 6 ▼</pre>	
Indicate the number of day intervals for the Non-Medicare-covered stay: Caro (No Consurance per Day) C one Three Indicate the consurance percentage and day interval(s) for the Non-Medicare-covered stay (enter "399" if unfamilied days are offered, e.g., 1 to 399). Consurance % Interval 1: Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3: Indicate Consurance percentage for Upgrades:	Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay?	
Indicate Coinsurance percentage for the Non-Medicare-covered stay. Indicate the number of day intervals for the Non-Medicare-covered stay. Zato (No Coinsurance per Day) Three Indicate the coinsurance percentage and day interval(a) for the Non-Medicare-covered stay (enter "395" it unlimited days are oldered; e.g.; 1 to 995). Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 3: End Day Interval 3: Indicate Coinsurance percentage for Upgrades:		
Indicate the number of day intervals for the Non-Medicare-covered stay. Zeto (No Coinsurance per Day) One Two Three Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are officered; 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 4: End Day Interval 5: End Day Interval 5: End Day Interval 5: End Day Interval 6: End Day Interval 6: End Day Interval 7: End Day Interval 7: End Day Interval 8: End Day Interval	□ No	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day In	Indicate Coinsurance percentage for the Non-Medicare-covered stay:	
Coinsurance % Interval 1: Begin Day Interval 2: End Day Interval 3: End Day Interval 3	Indicate the number of day intervals for the Non-Medicare-covered stay:	
Indicate the coinsurance percentage and day interval(s) for the Non-Medicate covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 993). Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3: Indicate Coinsurance percentage for Upgrades:		
Indicate the coinsurance percentage and day interval(s) for the Non-Medicate-covered stay (enter "999" if unlimited days are offered: e.g.; 1 to 999); Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3: Indicate Coinsurance percentage for Upgrades:		
Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter "999" it unlimited days are offered; e.g., 1 to 999); Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3: Indicate Coinsurance percentage for Upgrades:		
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3: End Day Interval 3: Indicate Coinsurance percentage for Upgrades:		
Coinsurance % Interval 2: Begin Day Interval 3: End Day Interval 3: Indicate Coinsurance percentage for Upgrades:	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 3: Begin Day Interval 3: End Day Interval 3: Indicate Coinsurance percentage for Upgrades:	Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
Indicate Coinsurance percentage for Upgrades:	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 7 Screen

🔛 PBP Data Entry System - Section B-1, Contract Z0001	1, Plan 001, Segment 000	_ 5 ×
File Help		
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #1a Inpatient Hospital-Acute - Base 7	
If you do not have a service-specific deductible for this benefit but offer a plan-specific, global deductible, then enter the global deductible in Section D.	Medicare-covered Copayment Cost Sharing for Tier 1: Do you charge the Medicare-defined cost shares? (These are the total charges for	
Is there an enrollee Deductible?	all services provided to the enrollee in the inpatient facility.)	
C Yes C No	C Yes C No	
Indicate Deductible Amount for Tier 1:	Indicate Copayment amount for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay:	
Indicate Deductible Amount for Tier 2:	C Zero (No Copayment per Day) C One C Two	
Indicate Deductible Amount for Tier 3:	C Three Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.	
Is there an enrollee Copayment?		
C Yes C No	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 8 Screen

🔛 PBP Data Entry System - Section B-1, Contract Z0001,	, Plan 001, Segment 000	_ & ×
File Help		
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #1a Inpatient Hospital-Acute - Base 8	
Medicare-covered Copayment Cost Sharing for Tier 2:	Medicare-covered Copayment Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the tot charges for all services provided to the enrollee in the inpatient facility	al 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	C Yes	
Indicate Copayment amount for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay:	Indicate Copayment amount for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copayment per Day) C One C Two C Three	
Indicate the copayment amount and day interval(s) for the Medicare- covered stay (e.g., 1 to 30; 31 to 90): For more information on cost sh limitations please view the variable help.	Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.	
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval Begin Day Interval 2: End Day Interval	Pagin Day Interval 2: Find Day Interval 2:	
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interv	val 3: Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
		<i>II</i>

Page 8 of 200

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

File Help > Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 9	
MICHIGAN DESCRIPTION OF THE PROPERTY OF THE PR	
Medicare-covered Life Time Reserve Days Tier 1 Medicare-covered Life Time Reserve Days Tier 2 Medicare-covered Life Time Reserve Days Tier 3	
Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days: Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days: Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	
C Zero (No Copayment per Day) C Zero (No Copayment per Day) C One C One C Two C Two C Three C Three	
Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	
Interval Days Interval Days Interval Days	
Copay Amount Begin Day End Day Copay Amount Begin Day End Day Copay Amount Begin Day End Day	
Interval 1: Interval 1: Interval 1:	
Interval 2: Interval 2: Interval 2:	
Interval 3: Interval 3:	

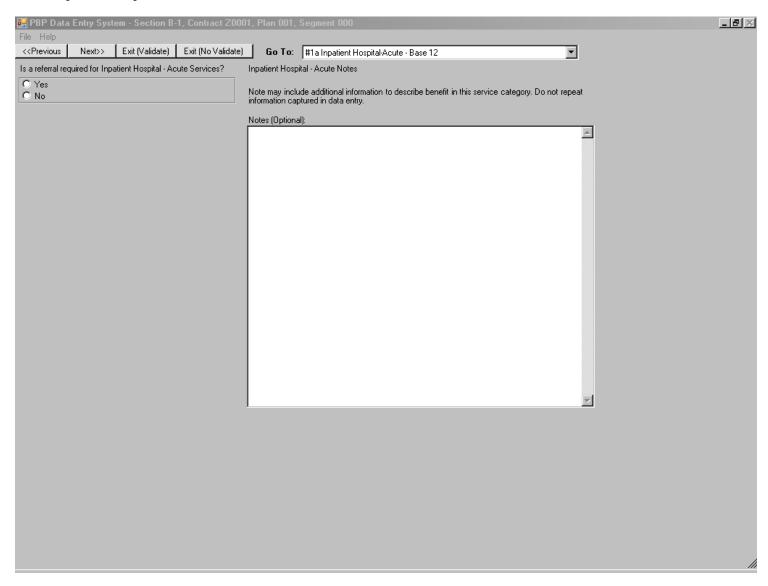
Section B - 1A - Inpatient Hospital-Acute – Base 10 Screen

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 00	0 <u> </u>	\times
File Help		
< <pre><<pre>revious Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatien</pre></pre>	it Hospital-Acute - Base 10	
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:		
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:		
		111

Section B - 1A - Inpatient Hospital-Acute – Base 11 Screen

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001,	Segment 000	_ B ×
File Help		
< <pre><<pre>revious</pre></pre>	#1a Inpatient Hospital-Acute - Base 11	
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:	
C Yes C No	Indicate Consumer and white Hagrades are day.	
	Indicate Copayment amount for Upgrades per day: Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe	

Section B - 1A - Inpatient Hospital-Acute – Base 12 Screen



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

🔛 PBP Data Entry System - Section B-1, Contract Z0001,	, Plan 001, Segment 000	_ B ×
File Help		
< <pre><<pre><<pre>c<pre>vious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre></pre>	Go To: #1a Inpatient Hospital-Acute (B Only) - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount?	
Do you offer Inpatient Hospital - Acute Services as a benefit?	C Yes C No	
C Yes	Indicate Maximum Plan Benefit Coverage amount:	
○ No		
Select type of benefit for Inpatient Hospital - Acute Services:		
O Optional	Select Maximum Plan Benefit Coverage periodicity:	
Does this benefit have unlimited days?	C Every three years C Every two years	
O Yes	C Every year	
O No, indicate number	© Every six months © Every three months	
Indicate number of days per period:	C Every Benefit Period	
	C Every Stay C Other, Describe	
Select the days periodicity:		
C Every three years C Every two years		
C Every year		
C Every six months C Every three months		
C Every Benefit Period		
© Every Stay © Other, Describe		
Uther, Describe		
		//

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

🔛 PBP Data Entry System - Section B-1, Contract Z0001, PL			_ B >
File Help			
< <pre><<pre><<pre>vious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</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:	
O Yes		C Zero (No Coinsurance per Day)	
© No		○ One	
Indicate the Maximum Enrollee Out-of-Pocket Cost amount:		C Two	
The country of the state of the		C 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 three years		Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
© Every two years			
C Every year			
© Every six months		Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
© Every three months			
C Every Benefit Period C Every Stay			
O Other, Describe		Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
Is there an enrollee Coinsurance?			
O Yes			
O No			
Indicate Coinsurance 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><<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 "99 if unlimited days are offered; e.g., 1 to 999):	9"
O 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	
		Espaymontaine Bogint Bay Interval E. Ena Bay Interval	•
Is there an enrollee Copayment?			
O Yes		Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3	t
O No			
Indicate Copayment amount per stay:	Г	ollee must receive Authorization from one or more of the following:	
		oliee mast receive Admonization from one of 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		Organization Medical Director/Utilization Management/Utilization Review Other, describe	
© Two			
○ Three		referral required for Inpatient Hospital - Acute Services?	
		Yes	
	O	No	

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



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

🔛 PBP Data	Entry Syste	em - Section B	-1, Contract Z0001,	Plan 001,		_ B ×
File Help						
< <pre>revious</pre>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric - Base 1	
CLICK FOR D	ESCRIPTION	N OF BENEFIT			Maximum Plan Benefit Coverage is not applicable for this Service Category	
Does the plan p supplemental b	provide Inpation	ent Hospital Psycl Part C?	hiatric Items as a		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
C Yes					O Yes	
C No Select enhance	and banafit				Select the Maximum Enrollee Out-of-Pocket Cost type:	
Additional					C Covered under Inpatient Hospital Services Category 1a	
☐ Non-Medic	care-covered :	Stay			Plan-specified amount per period	
Select type of	of benefit for A	Additional Days:			Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
O Mandato						
O Optional					Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
	t unlimited for.	Additional Days?			C Every three years	
O Yes					C Every two years C Every year	
C No, indic	ate number				C Every six months	
Indicate nu	mber of Additi	onal Days per bei	nefit period:		C Every three months	
					C Every Benefit Period	
					C Every Stay O Other, Describe	
		Ion-Medicare-cov	vered stay:		2 01101, 20001120	
O Mandato O Optional						
Optional						

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

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001,	Segment 000	_ & ×
File Help		
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre> <pre>Go To:</pre></pre></pre>	#1b Inpatient Hospital Psychiatric - Base 2	
Does this plan's cost sharing vary by hospital(s) in which an enrollee obtains	Medicare-covered Coinsurance Cost Sharing for Tier 1:	
C Yes	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 No	C Yes	
How many cost sharing tiers do you offer?	Indicate Coinsurance percentage for the Medicare-covered stay:	
What is your lowest cost tier?		
C Tier 1 C Tier 2	Indicate the number of day intervals for the Medicare-covered stay:	
C Tier 3	C Zero (No Coinsurance per Day) C One	
Is there an enrollee Coinsurance?	C Two	
C Yes	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 Syste	em - Section B	-1, Contrac	ct Z0001, I	Plan 001,	1, Segment 000				_ B ×
File Help										
< <pre>revious</pre>	Next>>	Exit (Validate)	Exit (No V	/alidate)	Go To:	#1b Inpatient Hospital Psychiatric	- Base 3	▼		
Medicare-cove	red Coinsurand	ce Cost Sharing f	or Tier 2:			Medicare-covered Coinsurance (Cost Sharing for Tier 3:			
Do you charge charges for all s	the Medicare- services provid	defined cost shar ded to the enrolle	es? (These e in the inpal	are the total tient facility.)		Do you charge the Medicare-def charges for all services provided	ined cost shares? (Thes to the enrollee in the inp	se are the total patient facility.)		
C Yes						C Yes				
○ No						○ No				
		rcentage for the I				Indicate Coinsurance percer				
Indicate th	ne number of d	lay intervals for th	e Medicare-	covered stay	r:	Indicate the number of day in	ntervals for the Medicare	-covered stay:	_	
C Zero (C One C Two C Three	(No Coinsurand	ce per Day)				C Zero (No Coinsurance p C One C Two C Three	er Day)			
	ne coinsurance tay (e.g., 1 to 3	e percentage and 30; 31 to 90);	day interval	l(s) for the Me	edicare-	Indicate the coinsurance pe covered stay (e.g., 1 to 30;)		al(s) for the Medicare-		
Coinsuran	ce % Interval 1	: Begin Daylı	nterval 1:	End Day Int	erval 1:	Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:		
Coinsuran	ce % Interval 2	2: Begin Day I	nterval 2:	End Day Int	erval 2:	Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:		
Coinsuran	ce % Interval 3	Begin Daylı	nterval 3:	End Day Int	erval 3:	Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:		

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

🔛 PBP Data	a Entry Syst	em - Section	B-1, Contrac	t Z0001, Plan (001, Segmer	nt 000						_ B ×
File Help		,										
< <pre>revious</pre>	Next>>	Exit (Validate	Exit (No V	alidate) Go	To: #16 Inp	oatient Hospita	l Psychiatric -	Base 4		▼		
Medicare-cove	red Life Time	Reserve Days	Tier 1	Medicare-c	overed Life Tir	me Reserve D	ays Tier 2	Medicare-	covered Life Time	Reserve Days	Tier 3	
Indicate the nu Medicare-cove	ımber of day in ered Lifetime F	ntervals for the leserve Days:		Indicate th Medicare-o	e number of da covered Lifetim	ay intervals for e Reserve Da	the ys:	Indicate th Medicare-	ie number of day in covered Lifetime R	ntervals for the leserve Days:		
C Zero (No Coinsurance per Day) C One C Two C Three			C Zero (f C One C Two C Three	No Coinsuranc	e per Day)		C Zero (No Coinsurance per Day) C One C Two C Three					
Indicate the co interval(s) for th Reserve Days (ne 60 Medicar	rcentage and di e-covered Lifeti	ay ime	interval(s) f	e coinsurance or the 60 Medi ays (i.e., 1 - 60	care-covered l	nd day Lifetime	interval(s)	e coinsurance per for the 60 Medican ays (i.e., 1 - 60):	centage and d e-covered Lifet	ay ime	
		Inter	val Days			Interv	val Days			Interva	al Days	
Coin:	surance %	Begin Day	End Day	C	oinsurance %	Begin Day	End Day		Coinsurance %	Begin Day	End Day	
Interval 1:				Interval 1:				Interval 1:				
Interval 2:				Interval 2:				Interval 2:				
Interval 3:				Interval 3:				Interval 3:				

Section B - 1B - Inpatient Hospital Psychiatric - Base 5 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)	
One Two	
© Three	
Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):	
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	

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

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000	
File Help	
< <pre><<pre><</pre> Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 6</pre>	
Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay?	
C) Yes	
O No	
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 Two	
© Three	
Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999);	
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	

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

📴 PBP Data Entry System	r - Section B-1,	Contract Z0001,	Plan 001,	Segment 000				_ B ×
File Help								
< <pre><<pre><< Previous Next>> I</pre></pre>	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psyc	chiatric - Base 7		₹	
If you do not have a service-spi offer a plan-specific, global ded deductible in Section D.	ecific deductible fouctible, then enter	or this benefit but the global	all se		ned cost shares? (These ee in the inpatient facility.)	are the total charges for		
Is there an enrollee Deductible? Yes No Indicate Deductible Amount for Indicate Deductible	or Tier 1: or Tier 2:			Indicate Copayment amount Indicate the number of day in C Zero (No Copayment per C One C Two C Three Indicate the copayment amount stay (e.g., 1 to 30; 31 to 90); please view the variable help	tervals for the Medicare-o Day) unt and day interval(s) for For more information on	the Medicare-covered cost share limitations		
Is there an enrollee Copaymer C Yes C No Medicare-covered Copayment (ier 1:] [Copayment Amt Interval 1: Copayment Amt Interval 2: Copayment Amt Interval 3:	Begin Day Interval 2: Begin Day Interval 3:	End Day Interval 1: End Day Interval 2: End Day Interval 3:		
								//

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

🔛 PBP Data	Entry Syste	em - Sectio	n B-1, Co	ntract Z0001,	Plan 001,	Segment 000			_ B ×
File Help									
< <pre>revious</pre>	Next>>	Exit (Valida	te) Exit	(No Validate)	Go To:	#1b Inpatient Hospital Psych	niatric - Base 8	▼	
Medicare-cover	ed Copaymer	nt Cost Sharin	g for Tier 2	:	М	fedicare-covered Copayment C	Cost Sharing for Tier 3:		
Do you charge t charges for all s	the Medicare ervices provi	-defined cost ded to the en	shares? (T rollee in the	hese are the total e inpatient facility.		o you charge the Medicare-del Il services provided to the enrol	fined cost shares? (These llee in the inpatient facility.)	are the total charges for	
C Yes					(O Yes			
C No						⊃ No			
Indicate Copa						Indicate Copayment amount for			
Indicate the nur			e Medicare-	covered stay:		C Zero (No Copayment per	Day)		
C Zero (No Co	opayment per	· Day)				O One O Two			
C Two						O Three			
C Three						Indicate the copayment amou	unt and day interval(e) for th	e Medicare covered	
Indicate the cop covered stay (e. limitations please	payment amou .g., 1 to 30; 3 e view the va	unt and day ir 11 to 90): For riable help.	nterval(s) fo more inforn	r the Medicare- mation on cost sha	are	stay (e.g., 1 to 30; 31 to 90); please view the variable help.	For more information on co	e Medicale-covered ost share limitations	
Copayment Amt	t Interval 1:	Begin Day I	nterval 1:	End Day Interva	al 1:	Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:	
Copayment Amt	t Interval 2:	Begin Day I	nterval 2:	End Day Interva	al 2:	Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:	
Copayment Amt	t Interval 3:	Begin Day I	nterval 3:	End Day Interva	al 3:	Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:	

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

🔛 PBP Data Entry	System - Section	n B-1, Contract	Z0001, Plan 001, Segm	ent 000					_ B ×
File Help							_		
< <pre><< Previous Nex</pre>	kt>> Exit (Validat	te) Exit (NoVa	lidate) Go To: #15	Inpatient Hospital Psychiatric - E	Base 9		▼		
Medicare-covered Life	e Time Reserve Days	: Tier 1	Medicare-covered Life T	ime Reserve Days Tier 2	Medicare-cov	ered Life Time Res	erve Days Tier	3	
Indicate the number of covered Lifetime Rese	f day intervals for the erve Days:	: Medicare-	Indicate the number of d covered Lifetime Reserv	lay intervals for the Medicare- e Days:	Indicate the n covered Lifeti	iumber of day interv ime Reserve Days:	vals for the Med	licare-	
C Zero (No Copaymo C One C Two C Three	O Two			t per Day)	C Zero (No C One C Two C Three	O Two			
Indicate the copaymer 60 Medicare-covered	nt amount and day in Lifetime Reserve Da	iterval(s) for the ys (i.e., 1 - 60):	Indicate the copayment of 60 Medicare-covered Life	amount and day interval(s) for th etime Reserve Days (i.e., 1 - 60	ne Indicate the c): 60 Medicare-	opayment amount covered Lifetime Ro	and day interva eserve Days (i.e	al(s) for the e., 1 - 60):	
	Inter	val Days		Interval Days			Interval	Days	
Copay Am	ount Begin Day	End Day	Copay Am	ount Begin Day End Day		Copay Amount	Begin Day	End Day	
Interval 1:			Interval 1:		Interval 1:				
Interval 2:			Interval 2:		Interval 2:				
Interval 3:			Interval 3:		Interval 3:				
									//

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

🔛 PBP Data Entr	System - Section	B-1, Contract Z000	1, Plan 001,	, Segment 000		_ B ×
File Help					_	
< <pre><< Previous Ne</pre>	kt>> Exit (Validate) Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric - Base 10	 -	
	of day intervals for Ado	litional Days:				
C Zero (No Copayı	nent per Day)					
O One O Two						
C Three						
Indicate the copaym "999" if unlimited da	ent amount and day in s are offered; e.g., 91	nterval(s) for Additional [to 999):	Days (enter			
Copayment Amt Inte	val 1: Begin Day	Interval 1: End Day	Interval 1:			
Copayment Amt Inte	val 2: Begin Day I	nterval 2: End Day	Interval 2:			
Copayment Amt Inte	val 3: Begin Day I	nterval 3: End Day	Interval 3:			
'						
						//

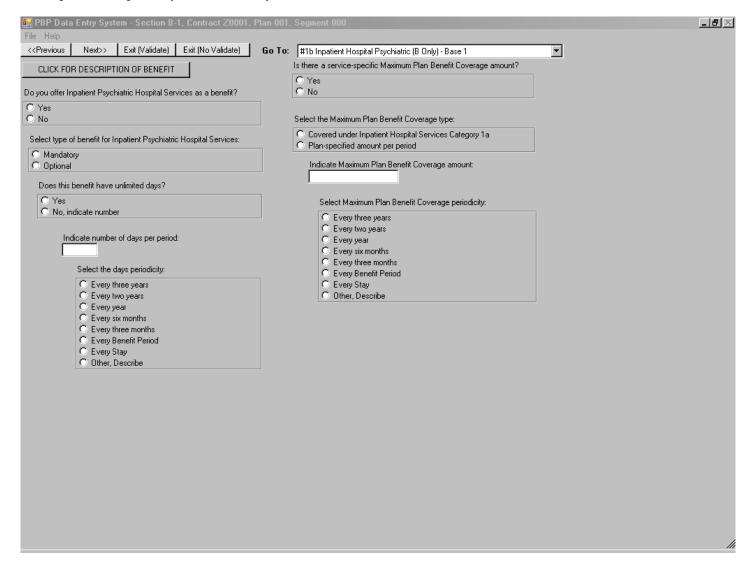
Section B – 1B - Inpatient Hospital Psychiatric – Base 11 Screen

🔛 PBP Data Entry System - Section B-1, Contract Z0001, Plan 001,		_ B ×
File Help		
	#1b Inpatient Hospital Psychiatric - Base 11	
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) Physician Specialist	
Indicate Copayment amount for the Non-Medicare-covered stay:	☐ Organization Medical Director/Utilization Management/Utilization Review ☐ Other, describe	
Indicate the number of day intervals for the Non-Medicare-covered stay:	Is a referral required for Inpatient Psychiatric Hospital Services?	
C Zero (No Copayment per Day) C One C Two C Three	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 12 Screen

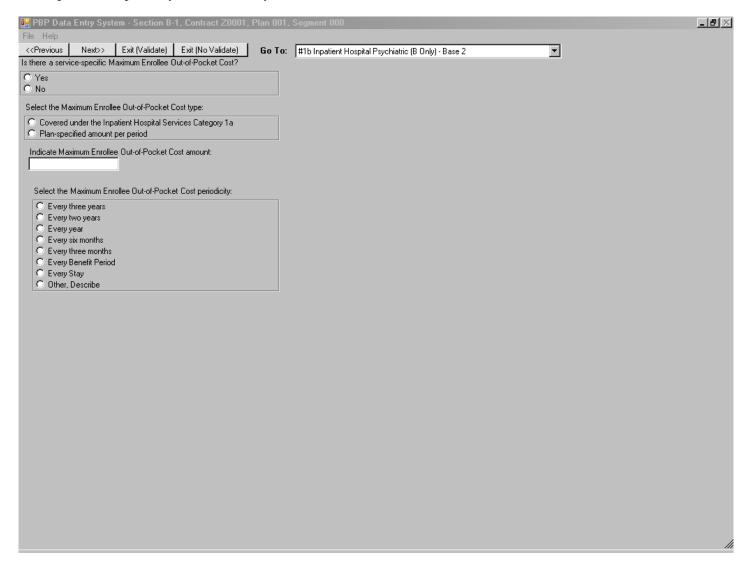


Section B – 1B - Inpatient Hospital Psychiatric (B Only) – Base 1 Screen



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



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

🔛 PBP Data Entry System - Section B-1, Contract Z0001,	Plan 001, Segment 000				_ B ×	
File Help						
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 3					
Is there an enrollee Coinsurance?	Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999);					
O Yes	terrier 333 il urillinited days ale orieled, e.g., 1 to 333).					
○ No	Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:			
Indicate Coinsurance percentage per stay:						
	0: %1, 10	D : D 1. 10	5 ID 11 IO			
	Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:			
Indicate the number of day intervals for the stay:						
C Zero (No Coinsurance per Day)	Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:			
C One C Two						
O Three						

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

🔛 PBP Data Entry System - Section B-1, Contract Z0001,	Plan 001, Segment 000	_ 8 ×
File Help		
< <pre><<pre><<pre>c<pre>vious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre></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):	
C Yes	ii di iiiiikod dayo dio oriolod, o.g., i ko oooj.	
○ 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:	
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	
C One	Other, describe	
○ Two ○ Three	Is a referral required for Inpatient Psychiatric Hospital Services?	
O Three	C Yes	
	O No	

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



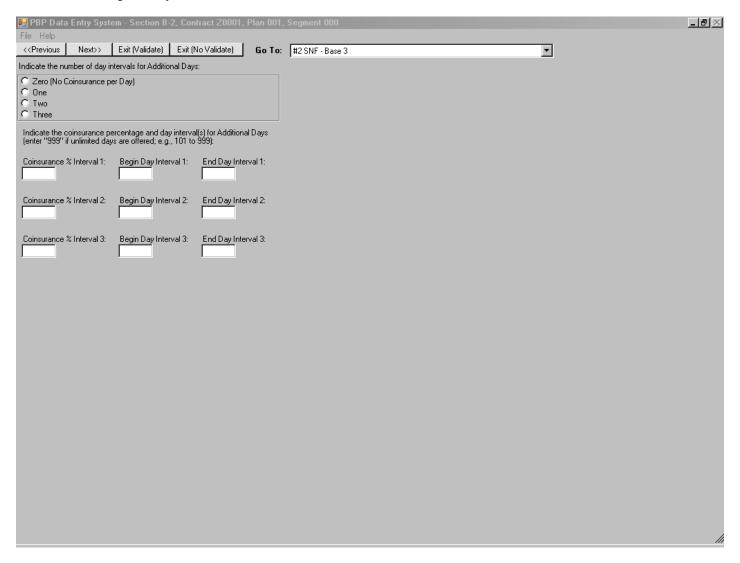
Section B-2 – Skilled Nursing Facility – Base 1 Screen

🔛 PBP Data Entry System - Section B-2, Contract Z0001, Plan 001,		_ 8 ×
File Help		
< <pre><<pre>revious Next>> Exit (Validate) Exit (No Validate) Go To:</pre></pre>	#2 SNF - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Do you allow less than 3 day hospital stay prior to SNF admission?	
Does the plan provide Skilled Nursing Facility Items as a supplemental benefit under Part C?	O Yes O No	
C Yes C No	Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	
Select enhanced benefits: Additional days beyond Medicare-covered Non-Medicare-covered stay	C Zero C One C Two	
To The decide corolled stay		
Select type of benefit for Additional Days beyond Medicare-covered:	Maximum Plan Benefit Coverage is not applicable for this Service Category.	
C Mandatory		
O Optional		
Is this benefit unlimited for Additional Days?		
© Yes	7	
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:		
C Mandatory		
C Optional		

Section B-2 – Skilled Nursing Facility – Base 2 Screen

📴 PBP Data Entry System - Section B-2, Contract Z0001, F	Plan 001, Segment 000				_ & ×
File Help					
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #2 SNF - Base 2			▼	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the number of day i	ntervals for the Medicare-	covered stay:		
O Yes	C Zero (No Coinsurance p	er Day)			
○ No	One O Two				
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	C Three				
	Indicate the coinsurance p covered stay (e.g.; 1 to 20,	ercentage and day interva : 21 to 100);	al(s) for Medicare-		
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:					
© Every three years	Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:		
© Every two years					
C Every year C Every six months	Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:		
© Every three months	Coinsulance % Interval 2.	begin bay interval 2.	End Day Interval 2.		
C Every Stay					
O Other, Describe	Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:		
Is there an enrollee Coinsurance?					
○ Yes					
○ No					
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)					
O Yes					
○ No					
Indicate Coinsurance percentage for the Medicare-covered stay:					

Section B – 2 – Skilled Nursing Facility – Base 3 Screen



Section B-2 – Skilled Nursing Facility – Base 4 Screen

🔛 PBP Data Entry System - Section B-2, Contract Z0001, Plan 0	001, Segment 000	_ B ×
File Help		
< <pre><<pre>revious</pre></pre>	To: #2 SNF - Base 4	
Is the Coinsurance structure for the Non-Medicare-covered stay the same as Coinsurance structure for the Medicare-covered stay?	the Is there an enrollee Deductible? O Yes	
O Yes	O No	
O 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		
C Three		
Indicate the coinsurance percentage and day interval(s) for the Non-Medico covered stay (enter "999" if unlimited days are offered; e.g., 1 to 999):	are-	
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1		
Commander of the Command of the Comm		
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2	<u>.</u>	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3):	

Section B-2 – Skilled Nursing Facility – Base 5 Screen

File Help <pre> <pre> <pre> <pre> <pre></pre></pre></pre></pre></pre>
Is there an enrollee Copayment? Indicate the number of day intervals for Additional Days: C) Yes C) Zero (No Copayment per Day)
C Yes C Zero (No Copayment per Day)
10 163
O No
C Iwo
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)
C Yes Indicate the copayment amount and day interval(s) for Additional Days C No (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: Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2: Copayment Part Interval 2: End Day Interval 2: End Day Interval 2:
© One
C Two Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): For more information on cost share limitations please view the variable help.
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:

Section B-2 – Skilled Nursing Facility – Base 6 Screen

🔛 PBP Data Entry System - Section B-2, Contract Z0001, Plan 001	, Segment 000	_ B ×
File Help		
< <pre><<pre> </pre> <pre></pre></pre>	#2 SNF - Base 6	
Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?	Enrollee must receive Authorization from one or more of the following:	
	Primary Care Physician (Internist/Family Practice, General Practice)	
○ No	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:	O Yes	
C Zero (No Copayment per Day)	○ No	
O One		
C Two		
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):		
Consequent Antilotecolds - Book Bookstonelds - Ford Bookstonelds		
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:		
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:		
0		
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:		
		,

Section B – 2 – Skilled Nursing Facility – Base 7 Screen



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Section B – 2 – Skilled Nursing Facility (B Only) – Base 1 Screen

🔛 PBP Data	Entry Syste	em - Section B-	2, Contract Z0001,	Plan 001,	Segment 000		_ 8 ×
File Help							
< <pre>revious</pre>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#2 SNF (B Only) - Base 1	▼	
CLICK FOR	DESCRIPTIO	N OF BENEFIT		Is a hospital SNF?	al stay required before admission to a		
Do you offer S	NF Care as a l	penefit?		C Yes C No			
C Yes C No				Indicate i	number of days required for hospital stay:		
Select type o	of benefit for St	NF Care:		_			
C Mandato C Optional				Is there a: Coverage	service-specific Maximum Plan Benefit amount?		
	nefit have unlir	nited days?		C Yes			
O Yes O No, indic	ate number			○ No			
Indicate nur	mber of days p	er period:		Indicate	Maximum Plan Benefit Coverage amount:		
C Every C Every C Every C Every	six months three months Stay	y.		Periodic C Ev C Ev C Ev C Ev C Ev C Ev	Maximum Plan Benefit Coverage city: ery three years ery two years ery year ery six months ery three months ery Stay her, Describe		
							li.

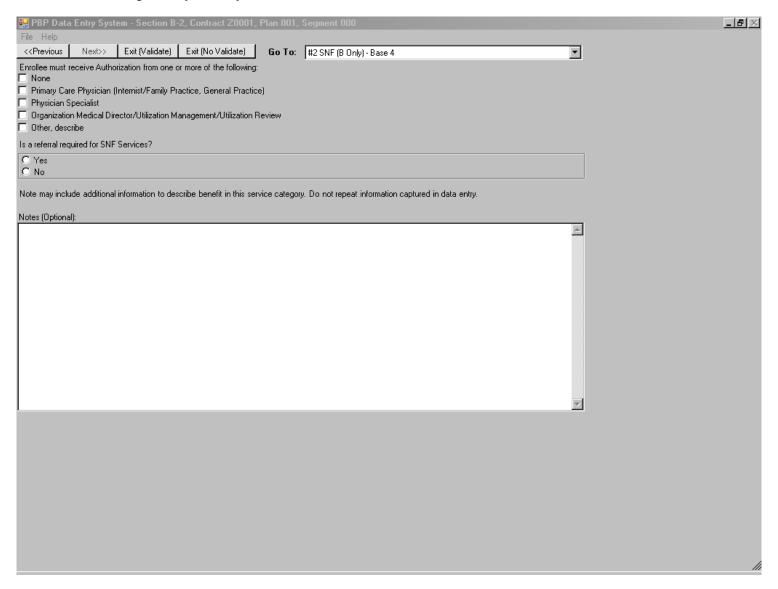
Section B – 2 – Skilled Nursing Facility (B Only) – Base 2 Screen

🔛 PBP Data Entry System - Section B-2, Contract Z0001,	Plan 001, Segment 000				_ B ×
File Help					
< <pre><<pre>c<previous< th=""><th>Go To: #2 SNF (B Only) - Base</th><th>2</th><th></th><th>▼</th><th></th></previous<></pre></pre>	Go To: #2 SNF (B Only) - Base	2		▼	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the number of day int	ervals for the stay:			
O Yes	C Zero (No Coinsurance pe	r Day)			
○ No	One One				
Indicate amount for Maximum Enrollee Out-of-Pocket Cost:	C Two				
	C Three				
	Indicate the coinsurance pe (enter "999" if unlimited days	rcentage and day interv	al(s) for the stay		
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	(eriter 333 il di lillillited days	, ale olicieu, e.g., i to s	100).		
C Every three years	Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:		
C Every two years					
C Every year					
C Every six months C Every three months	Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:		
© Every Stay					
O Other, Describe	6-1	Danie Daniela and O	Fud Davidstand 2		
Is there an enrollee Coinsurance?	Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:		
O Yes					
○ No					
Indicate Coinsurance percentage:					

Section B – 2 – Skilled Nursing Facility (B Only) – Base 3 Screen

🔛 PBP Data Entry System - Section B-2, Contract Z0001, F			<u>_[5]</u>	Х
File Help		-		
< <pre><<pre><<pre></pre></pre></pre>	Go To: #2 SNF (B Only) - Base 3	or the stau (enter "999"		
C Yes	Indicate the copayment amount and day interval(s) for if unlimited days are offered; e.g., 1 to 999):	or the day (ortor loop		
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:		
	Copayman America var 2.	End Day Interval 2.		
Is there an enrollee Copayment?	1			
C No	Copayment Amt Interval 3: Begin Day Interval 3:	End Day Interval 3:		
Indicate Copayment amount per Stay:	· -			
Indicate the number of day intervals for the stay:				
C Zero (No Copayment per Day) C One				
C Two				
○ Three				
				//

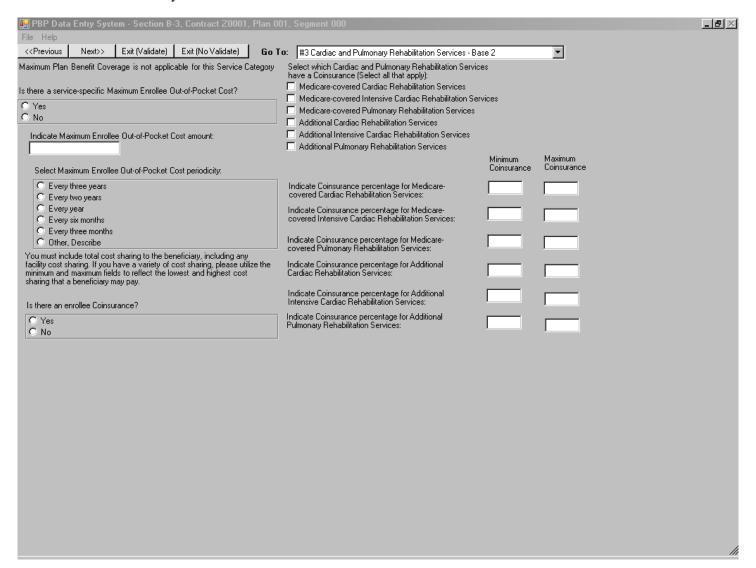
Section B – 2 – Skilled Nursing Facility (B Only) – Base 4 Screen



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

🔛 PBP Data Entry System - Section B-3, Contract Z0001, Plan 001,	Segment 000	_ B ×
File Help > Exit (Validate) Exit (No Validate) Go To:	#3 Cardiac and Pulmonary Rehabilitation Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Cardiac and Pulmonary Rehabilitation Services Items as a supplemental benefit under Part C?	Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services?	
C Yes C No Select enhanced benefit:	No, indicate number Indicate number of visits for Additional Intensive Cardiac Rehabilitation Services:	
Additional Cardiac Rehabilitation Services Additional Intensive Cardiac Rehabilitation Services Additional Pulmonary Rehabilitation Services Select type of benefit for Additional Cardiac Rehabilitation Services:	Select the Additional Intensive Cardiac Rehabilitation Services periodicity: © Every three years	
C Mandatory C Optional Is this benefit unlimited for Additional Cardiac Rehabilitation Services? C Yes C No, indicate number	C Every two years C Every year C Every six months C Every three months O Other, Describe	
Indicate number of visits for Additional Cardiac Rehabilitation Services: Select the Additional Cardiac Rehabilitation Services periodicity:	Select type of benefit for Additional Pulmonary Rehabilitation Services: Mandatory Optional Is this benefit unlimited for Additional Pulmonary Rehabilitation Services?	
Every three years Every two years Every year Every six months Every three months Other, Describe Select type of benefit for Additional Intensive Cardiac Rehabilitation Services:	C Yes No, indicate number Indicate number of visits for Additional Pulmonary Rehabilitation Services: Select the Additional Pulmonary Rehabilitation Services periodicity:	
C Mandatory C Optional	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	
		//

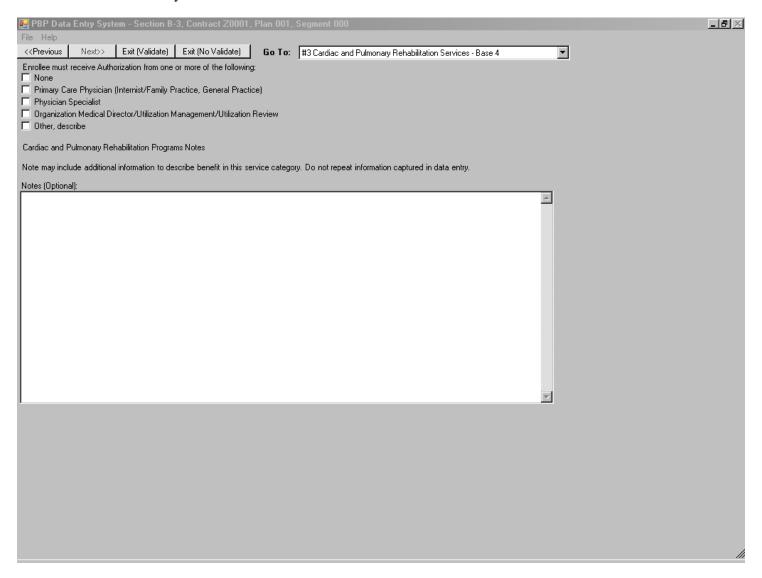
Section B – 3 – Cardiac and Pulmonary Rehabilitation Services – Base 2 Screen



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

🔛 PBP Data Entry System - Section B-3, Contract Z0001, I	Plan 001, Segment 000			_ & ×
File Help				
< <pre><<pre>revious</pre></pre>	Go To: #3 Cardiac and Pulmonary Rehabilitation Serv	vices - Base 3	▼	
Is there an enrollee Deductible?		Minimum Copayment	Maximum Copayment	
C Yes		Сораушетк	Сораушетк	
C No	Indicate Copayment amount for Medicare-covered Cardiac Rehabilitation Services:			
Indicate Deductible Amount:				
	Indicate Copayment amount for Medicare-covered Intensive Cardiac Rehabilitation Services:			
Is there an enrollee Copayment?	Indicate Copayment amount for Medicare-covered			
C Yes	Pulmonary Rehabilitation Services:			
© No	Indicate Copayment amount for Additional Cardiac			
Select which Cardiac and Pulmonary Rehabilitation Services have a	Rehabilitation Services:			
Copayment (Select all that apply):	Indicate Copayment amount for Additional Intensive			
Medicare-covered Cardiac Rehabilitation Services Medicare-covered Intensive Cardiac Rehabilitation Services	Cardiac Reĥabilitation Services:			
Medicare-covered Pulmonary Rehabilitation Services	Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:			
Additional Cardiac Rehabilitation Services	ruimonaly henabilitation services.			
☐ Additional Intensive Cardiac Rehabilitation Services ☐ Additional Pulmonary Rehabilitation Services				
Additional Fulliforally menabilitation services				
				li.

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



$Section \ B-4A-Emergency \ Care-Base \ 1 \ Screen$

🔛 PBP Data Entry System - Section B-4, Contract 2	20001, Plan 001, Segment 000		_ - 5 ×
File Help		_	
< <pre>revious Next>> Exit (Validate) Exit (No Validate)</pre>	date) Go To: #4a Emergency Care - Base 1	▼	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a Maximum Plan Benefit Coverage amount for Worldwide Coverage?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Does the plan provide Emergency Care Items as a supplemental benefit under Part C?	C Yes C No	C Yes C No	
C Yes C No	Indicate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select enhanced benefit: Worldwide Coverage			
This supplemental benefit includes Worldwide coverage of urgent/emergent and post-stabilization care.	Select the Maximum Plan Benefit Coverage periodicity: © Every three years	Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years	
Select type of benefit for Worldwide Coverage:	C Every two years C Every year	C Every two years C Every year	
	C Every six months	C Every six months	
Mandatory Optional	C Every three months C Other, Describe	C Every three months C Other, Describe	

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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	_ 6 ×
File Help		
< <pre><<pre><<pre>c</pre></pre> Next>> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre>	Go To: #4a Emergency Care - Base 2	
Is there an enrollee Coinsurance?	Indicate Coinsurance percentage for Worldwide Coverage:	
○ 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 C Hours		
Enter number of Days or Hours:		

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

🔛 PBP Data Entry System - Section B-4, Con	ntract Z0001, Plan 001, Segment 000	_ B ×
File Help		
< <pre><<pre><<pre>c</pre></pre></pre>	(No Validate) Go To: #4a Emergency Care - Base 3	
Is there an enrollee Copayment? C Yes C No	Indicate Copayment amount for Worldwide Coverage:	
Indicate Minimum Copayment amount for Medicare -covered Benefits:	Is this Copayment for Worldwide Coverage waived if admitted to hospital? C Yes No	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	Does ER cost sharing count towards any plan-level deductibles?	
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	C No	
O Yes O No	Indicate the plan-level deductibles where ER cost sharing counts:	
Select either Days or Hours within which admission must occur for waiver:	Ut-of-Network only Combined (In-Network and Out-of-Network)	
O Days O Hours		
Enter number of Days or Hours:		
		//

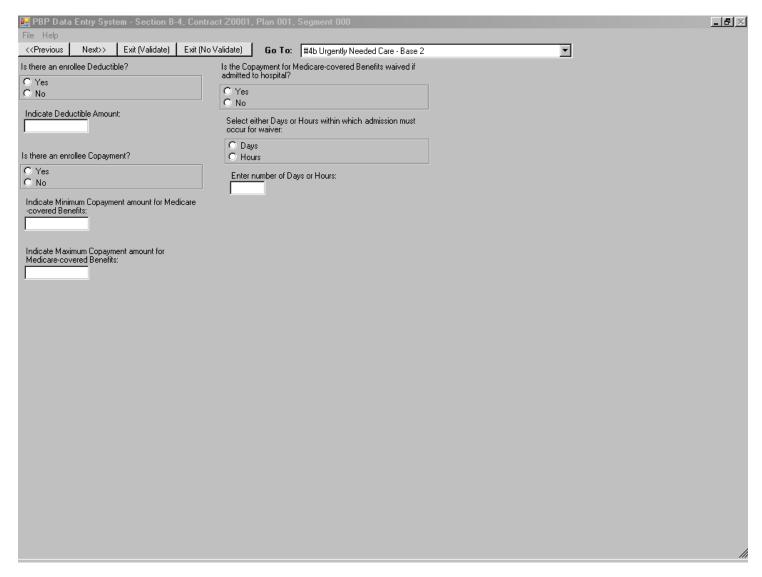
Section B – 4A – Emergency Care – Base 4 Screen



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

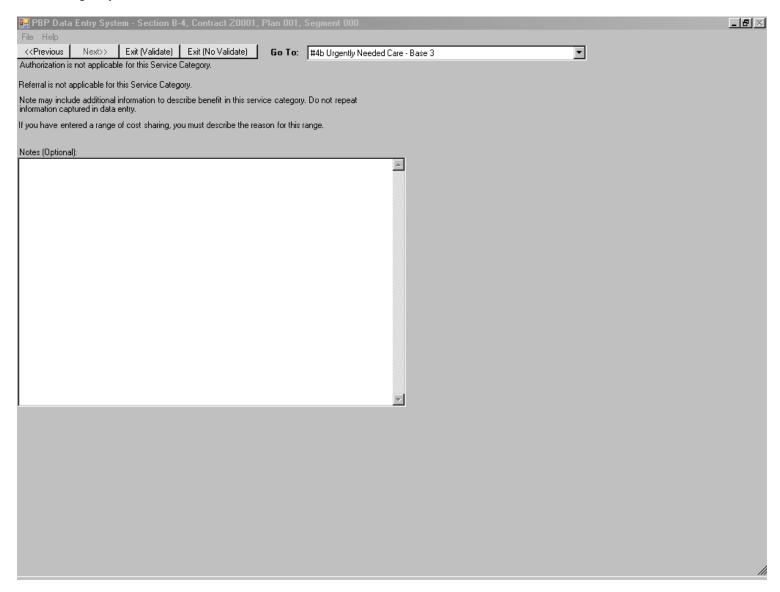
🔛 PBP Data Entry System - Section B-4, Contr	ract Z0001, Plan 001, Segment 000	_ & ×
File Help		
< <pre><<pre><<pre>exit (No</pre></pre></pre>	o Validate) Go To: #4b Urgently Needed Care - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Enrollee Out-of-Pocket Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?	
Urgently needed services means covered services that a emergency services provided when an enrollee is tempo absent from the MA plan's service (or, if applicable, continued area (or, under unusual and extraordinary circumstances provided when the enrollee is in the service or continuation the organization's provider network is temporarily under inaccessible) when the services are medically necessimmediately required as a result of an unforeseen illness or condition; and it was not reasonable given the circums obtain the services through the organization offering the (CFR 422.113(b)(1)(iii)). Maximum Plan Benefit Coverage is not applicable for this Category. Is there a service-specific Maximum Enrollee Out-of-Po Yes No Select the Maximum Enrollee Out-of-Pocket Cost type: Covered under Emergency Care Service Category Plan-specified amount per period	are not orarily tinuation) s. Select Maximum Enrollee Out-of-Pocket Cost periodicity: Select either Days or Hours within which admission must occur for waiver: C Every three years C Every two years Statence to Every six months C Every three months C Every three months C Other, Describe Is there an enrollee Coinsurance? C Yes C No Indicate Maximum Coinsurance percentage for Medicare-covered Benefits Indicate Maximum Coinsurance percentage for Medicare-covered Benefits	
		11.

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

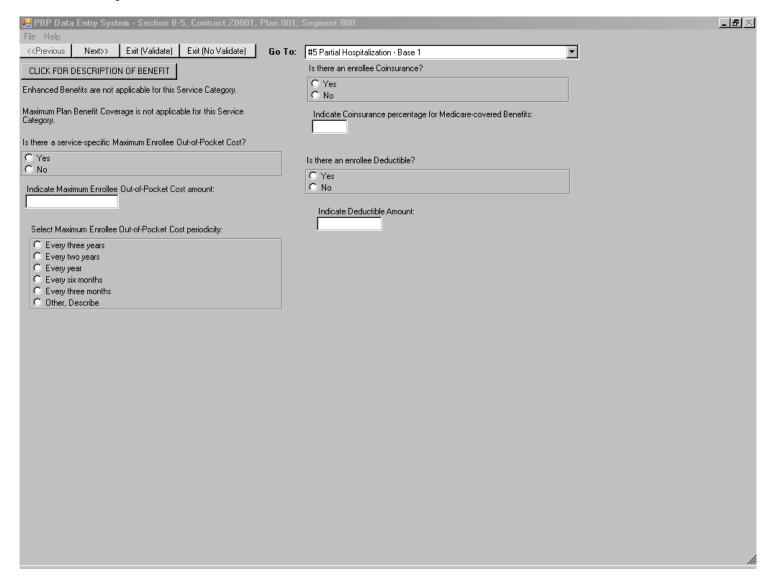


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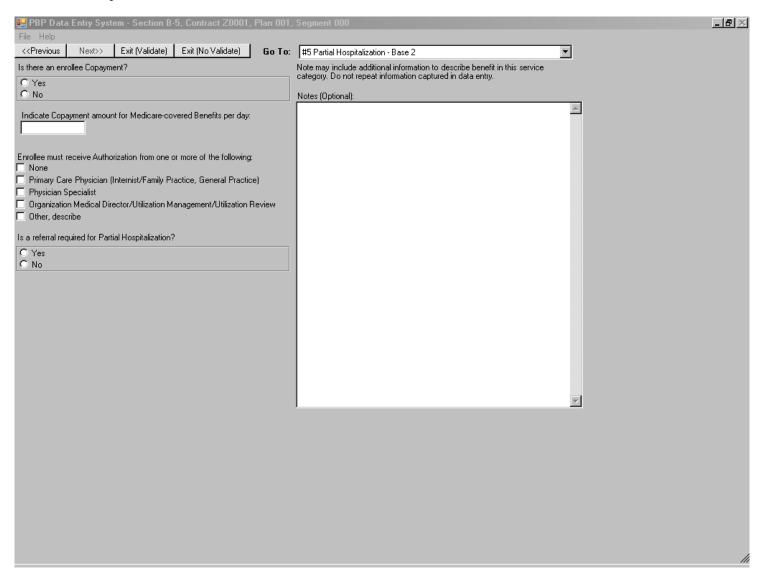
Section B – 4B – Urgently Needed Care – Base 3 Screen



Section B – 5 – Partial Hospitalization – Base 1 Screen

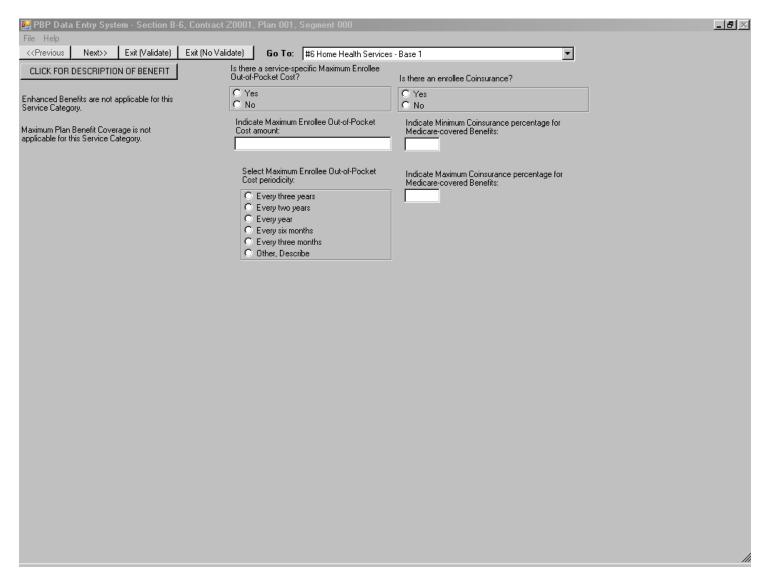


Section B – 5 – Partial Hospitalization – Base 2 Screen

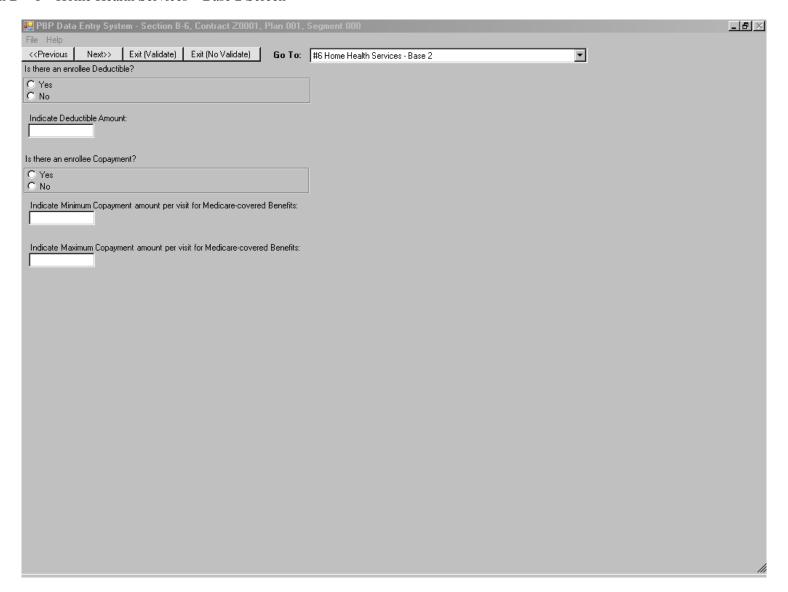


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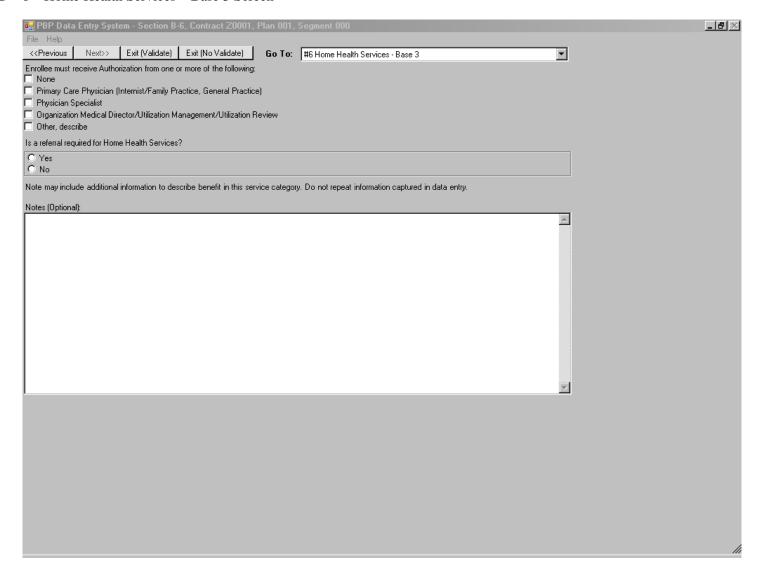
Section B – 6 – Home Health Services – Base 1 Screen



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



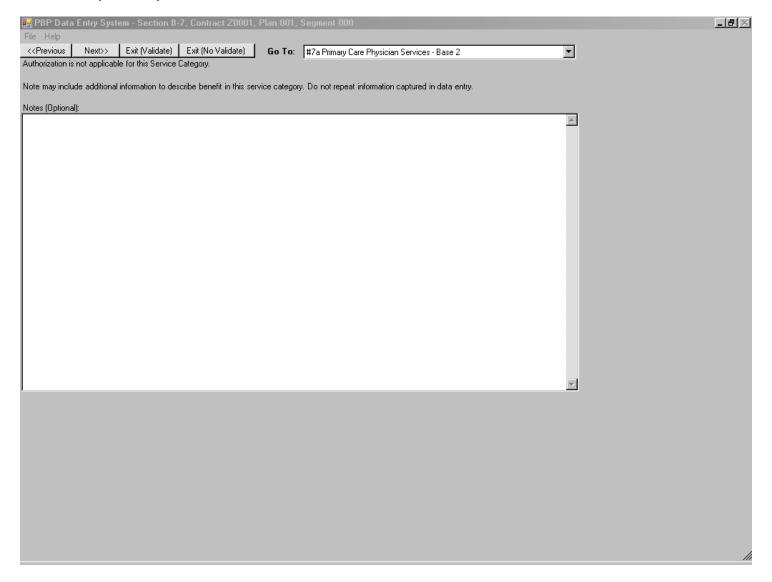
Section B – 6 – Home Health Services – Base 3 Screen



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><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #7a Primary Care Physician Services - Base 1	<u> </u>
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
	C Yes	
If cost sharing for this benefit is not the same as primary care,	○ No	
reflect the cost sharing in the range.	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	The state of the s	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
© Yes	<u>'</u>	
○ No	Is there an enrollee Deductible?	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	O Yes O No	
<u>'</u>	Indicate Deductible Amount:	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	This date because I mount.	
C Every three years	<u> </u>	
C Every two years	Is there an enrollee Copayment?	
C Every year	O Yes	
© Every six months	O No	
C Every three months C Other, Describe	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
2 Grid, Eddelle		
	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	

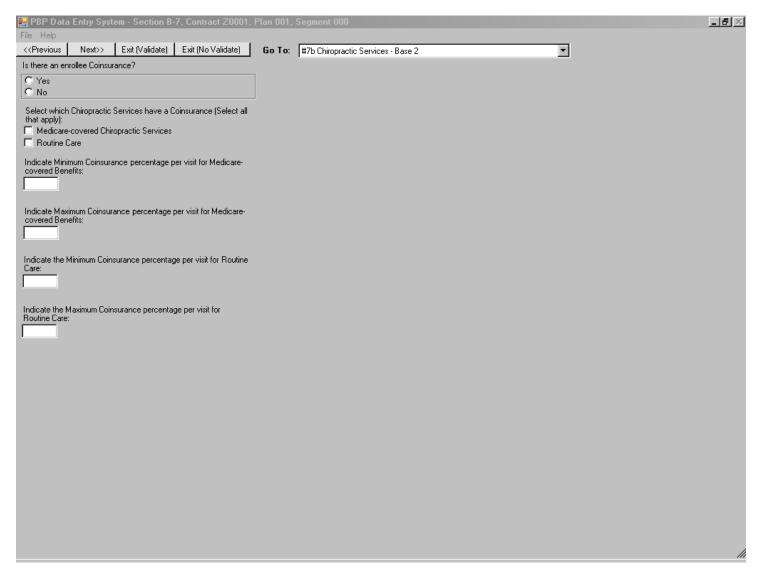
Section B – 7A – Primary Care Physician Services – Base 2 Screen



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><<pre><< Previous</pre></pre>	Exit (No Validate) Go To: #7b Chiropractic Ser	vices - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select Routine Care periodicity:	Is there a service-specific Maximum Enrollee Out-of- Pocket Cost?	
Does the plan provide Chiropractic Services Items as a supplemental benefit under Part C?	C Every two years C Every year C Every six months	O Yes O No	
C Yes C No	© Every three months © Other, Describe	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select enhanced benefit: Routine Care	Is there a service-specific Maximum Plan Benefit Coverage amount?		
Select type of benefit for Routine Care:	C Yes C No	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years	
Mandatory Optional	Indicate Maximum Plan Benefit Coverage amount:	C Every two years C Every year	
Is this benefit unlimited for Routine Care?		© Every six months © Every three months	
O No, indicate number	Select Maximum Plan Benefit Coverage periodicity: © Every three years	Other, Describe	
Indicate number of visits for Routine Care:	C Every two years C Every year C Every six months C Every three months		
	C Other, Describe		

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



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

	Entry Syst	em - Section B	-7, Contract Z0001,	Plan 001,	Segment 000	_ & ×
File Help						
< <pre>revious</pre>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#7b Chiropractic Services - Base 3	•
Is there an enro	ollee Deductil	ole?			Indicate Minimum Copayment amount per visit for Routine Care:	
C Yes						
C No						
Indicate Dedu	ictible Amour	ıt:			Indicate Maximum Copayment amount per visit for Routine Care:	
				E	nrollee must receive Authorization from one or more of the following:	
Is there an enro	ollee Copaym	ent?			None	
C Yes					Primary Care Physician (Internist/Family Practice, General Practice)	
					Physician Specialist Organization Medical Director/Utilization Management/Utilization Review	
Select which apply):	Chiropractic (Services have a C	Copayment (Select all tha		Other, describe	
☐ Medicare-		opractic Services				
☐ Routine C	are				a referral required for Chiropractic Services?	
Indicate Mini	imum Copavn	ent amount for M	ledicare-covered Benefil	ts:	Yes No	
				L	, no	—
Indicate Max	kimum Copayı	ment amount for M	Medicare-covered Benef	its:		

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

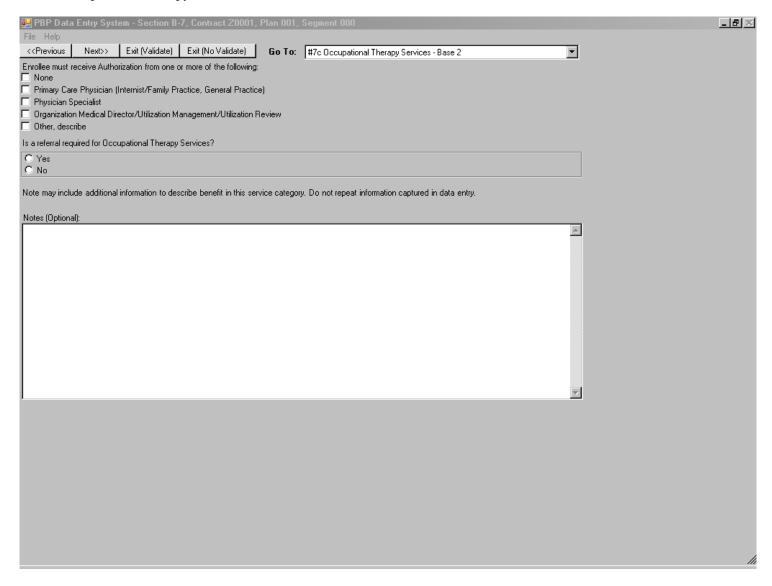


Section B – 7C – Occupational Therapy Services – Base 1 Screen

🔛 PBP Data Entry System - Section B-7,	, Contract Z0001, Plan 001, Segment 000		_ & ×
File Help			
< <pre><<pre><< Previous</pre></pre>	Exit (No Validate) Go To: #7c Occupational The	erapy Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	
	Select the Maximum Enrollee Out-of-Pocket Cost		
			//

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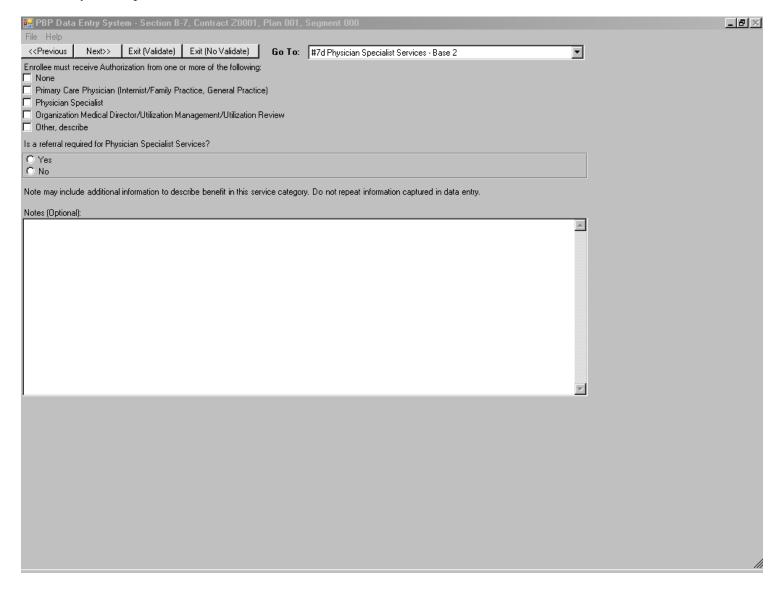
Section B – 7C – Occupational Therapy Services – Base 2 Screen



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

PBP Data Entry System - Section B-7	, Contract Z0001, Plan 001, Segment 000		_
	Exit (No Validate) Go To: #7d Physician Special	ist Services - Base 1 ▼	
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	
Enhanced Benefits are not applicable for this Service Category.	C Every three years C Every two years	C Yes C No	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	C Every year C Every six months	Indicate Deductible Amount:	
	C Every three months C Other, Describe	Is there an enrollee Copayment?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes	Is there an enrollee Coinsurance?	C Yes	
C No	○ No	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	ror medicare-covered Benefits:	
	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	

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



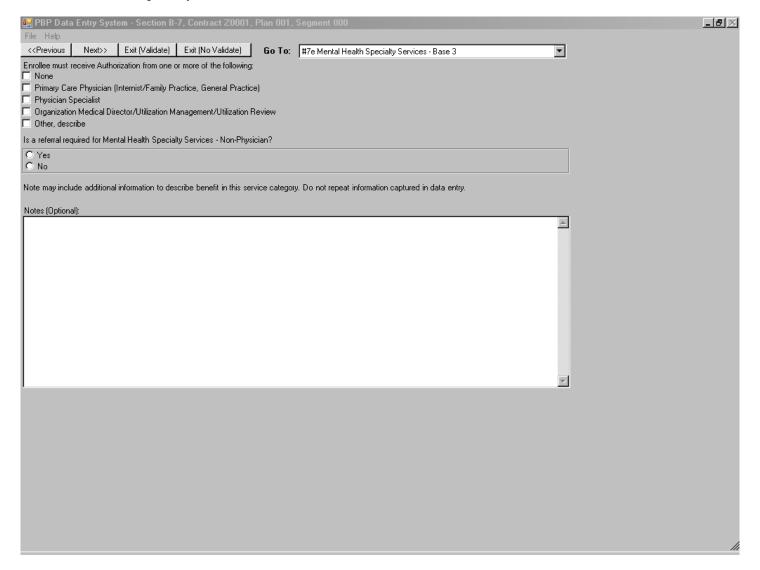
Section B - 7E - Mental Health Specialty Services - Base 1 Screen

🔛 PBP Data Entry System - Section B-7, Contract Z0001, Plan 00	1, Segment 000	_ B ×
File Help		
< <pre><<pre>revious Next>> Exit (Validate) Exit (No Validate) Go To</pre></pre>	p: #7e Mental Health Specialty Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT		
Enhanced Benefits are not applicable for this Service Category.		
Maximum Plan Benefit Coverage is not applicable for this Service Category.		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
C Yes C No		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
Select Maximum Enrollee Out-of-Pocket Cost periodicity:		
© Every three years		
© Every two years		
C Every year C Every six months		
© Every three months		
C Other, Describe		

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

🔛 PBP Data Entry System - Section B-7, Contract Z0001, I	Plan 001, Segment 000	_ & ×
File Help		
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #7e Mental Health Specialty Services - Base 2	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes	C Yes	
C No	© No	

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



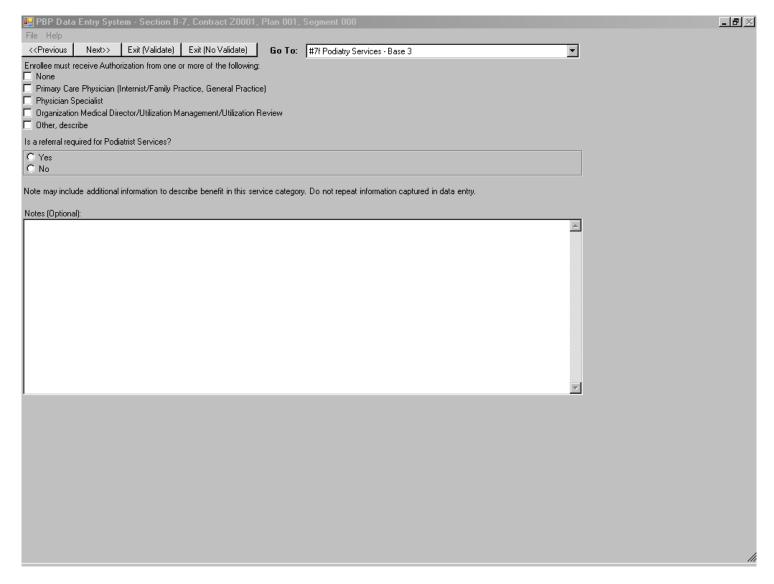
Section B – 7F – Podiatry Services – Base 1 Screen

🔛 PBP Data Entry System - Section B-7, Con	tract Z0001, Plan 001, Segment 000		_ & ×
File Help			
< <pre><<pre><<pre>c</pre></pre><pre>Next>></pre></pre>	No Validate) Go To: #7f Podiatry Services - Base	1	
File Help	,	Is there a service-specific Maximum Enrollee Out- of-Pocket Cost? C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every year C Every six months C Other, Describe	
			,

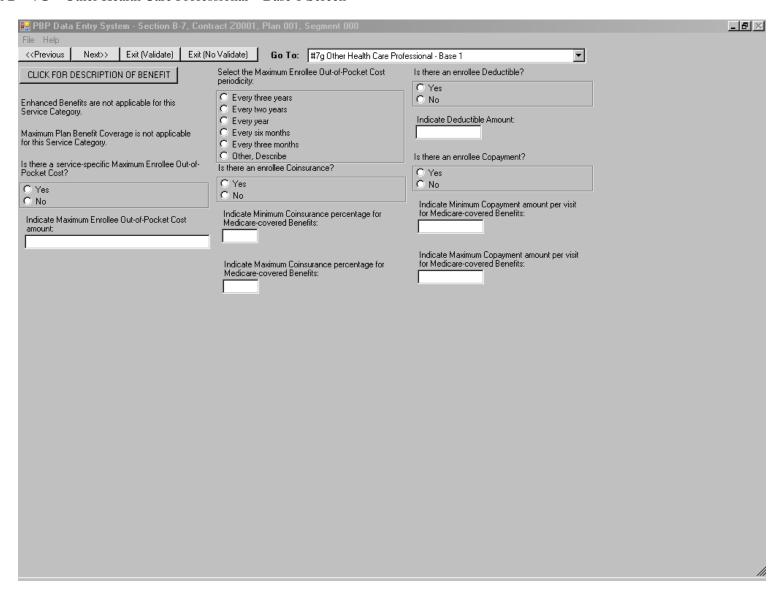
$Section \ B-7F-Podiatry \ Services-Base \ 2 \ Screen$

🔛 PBP Data Entry System - Section B-7, Contract Z0001, Plan 001	, Segment 000	_B×
File Help		
< <pre></pre> Next>> Exit (Validate) Exit (No Validate) Go To:	#7f Podiatry Services - Base 2	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes C No	C Yes C No	
Select which Podiatry Services have a Coinsurance (Select all that apply): Medicare-covered Podiatry Services Routine Footcare	Select which Podiatry Services have a Copayment (Select all that apply): Medicare-covered Podiatry Services Routine Footcare	
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Minimum Coinsurance percentage for Routine Footcare:	Indicate Minimum Copayment amount per visit for Routine Footcare:	
Indicate Maximum Coinsurance percentage for Routine Footcare:	Indicate Maximum Copayment amount per visit for Routine Footcare:	
Is there an enrollee Deductible?		
O Yes		
No Indicate Deductible Amount:		

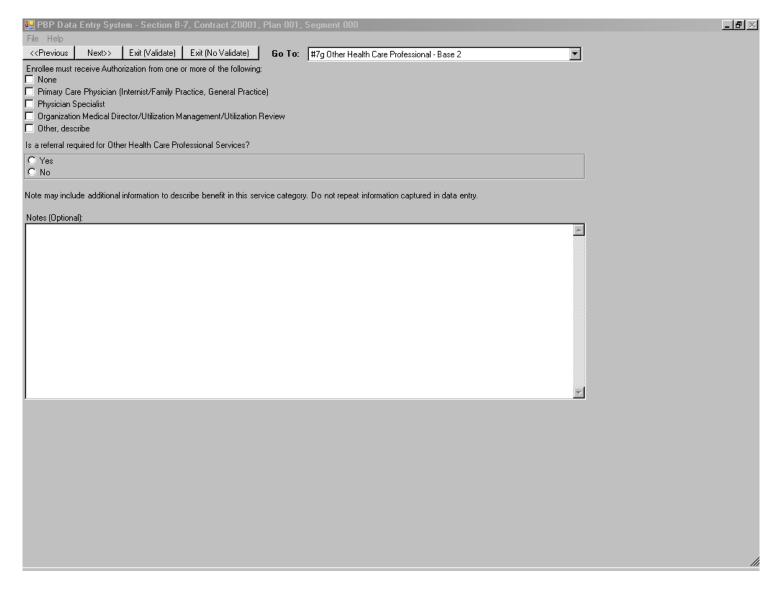
Section B – 7F – Podiatry Services – Base 3 Screen



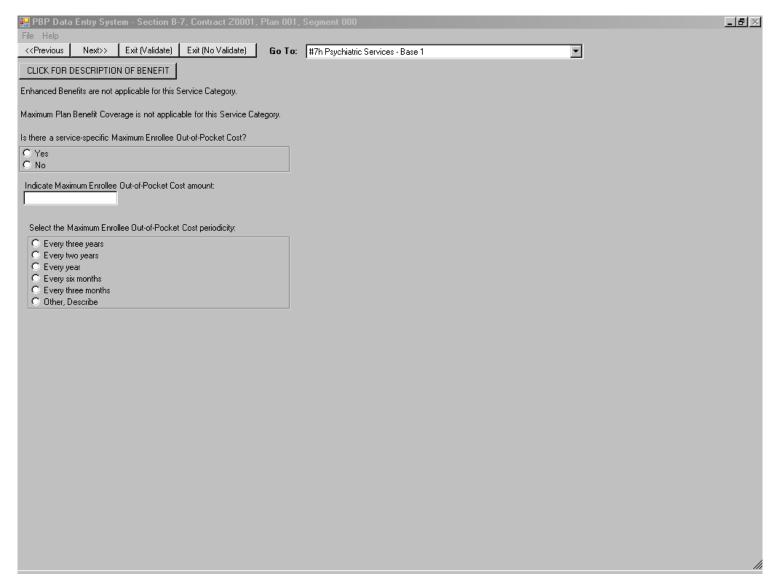
Section B – 7G – Other Health Care Professional – Base 1 Screen



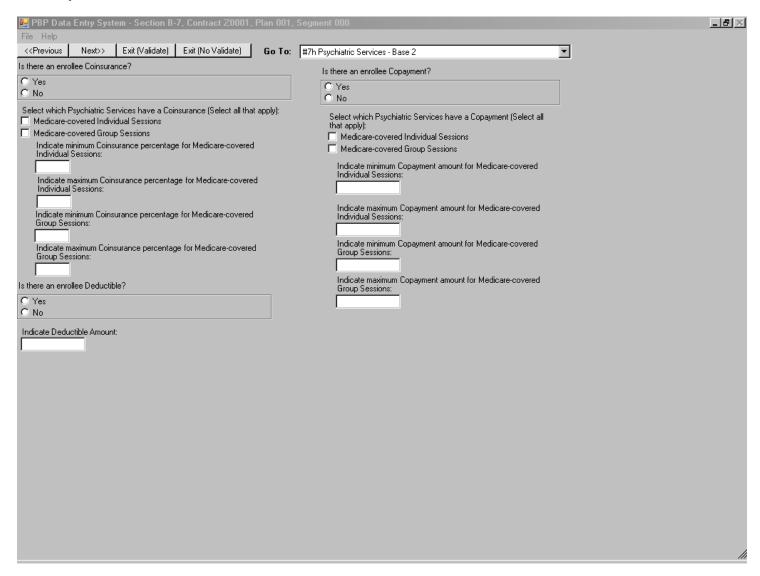
Section B – 7G – Other Health Care Professional – Base 2 Screen



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

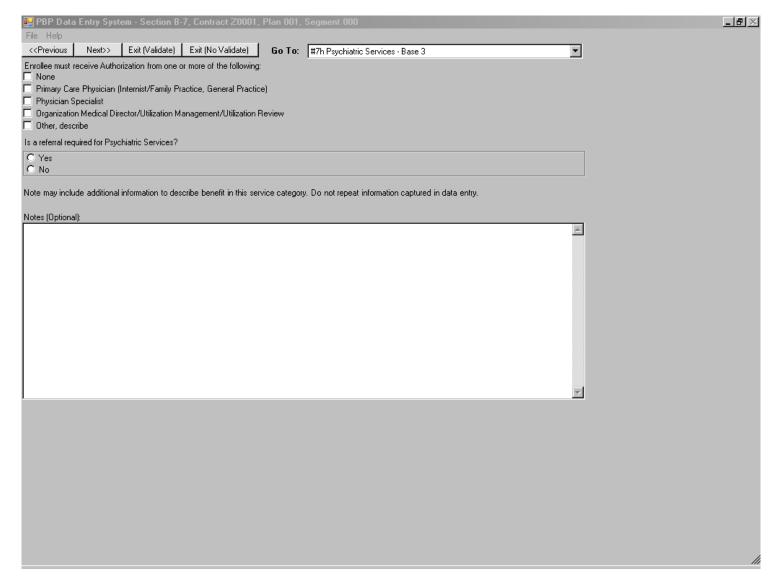


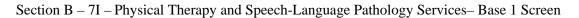
Section B – 7H – Psychiatric Services – Base 2 Screen



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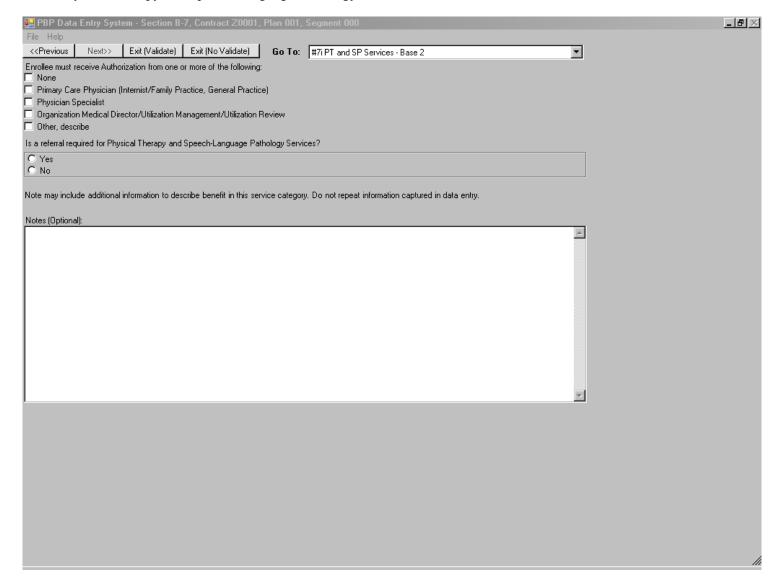
Section B – 7H – Psychiatric Services – Base 3 Screen





🔛 PBP Data Entry System - Section B-7, I	Contract Z0001, Plan 001, Segment 000		<u>_ & </u>
File Help			
<pre><<pre><<pre>c</pre></pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>E</pre></pre>	xit (No Validate) Go To: #7i PT and SP Service:	s - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	
Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not	C Every three years C Every two years C Every year C Every six months	C No Indicate Deductible Amount:	
Maximum Plan Benefit Coverage is not applicable for this Service Category. Do you apply the Medicare coverage limit?	C Every three months C Other, Describe	Is there an enrollee Copayment?	
C Yes C No	You must include total cost sharing to the beneficiary, including any facility cost sharing.	C Yes	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance? C Yes C No	Indicate Copayment amount per visit for Medicare- covered Benefits:	
C Yes C No	Indicate Coinsurance percentage per visit for Medicare-covered Benefits:		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:			

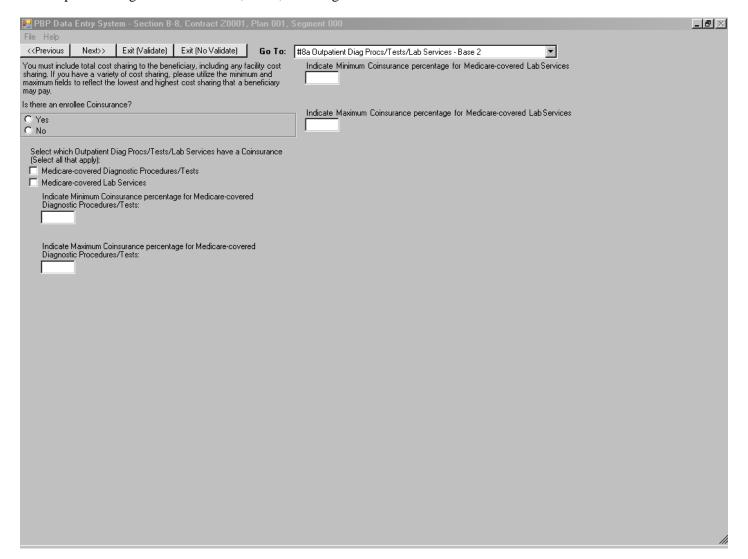
Section B – 7I – Physical Therapy and Speech-Language Pathology Services – Base 2 Screen



Section B – 8A – Outpatient Diagnostic Procedures, Tests, and Diagnostic Lab Services – Base 1 Screen

🔛 PBP Data Entry System - Section B-8, Contract Z0001, Plan 001, Segment 000	_ B ×
File Help	
< <pre></pre> Next>> Exit (Validate)	
CLICK FOR DESCRIPTION OF BENEFIT	
Enhanced Benefits are not applicable for this Service Category.	
Entranced behalits are not applicable for this service edicagory.	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
C Yes	
O No	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
© Every three years	
C Every two years C Every year	
© Every six months	
© Every three months	
○ Other, Describe	
	/

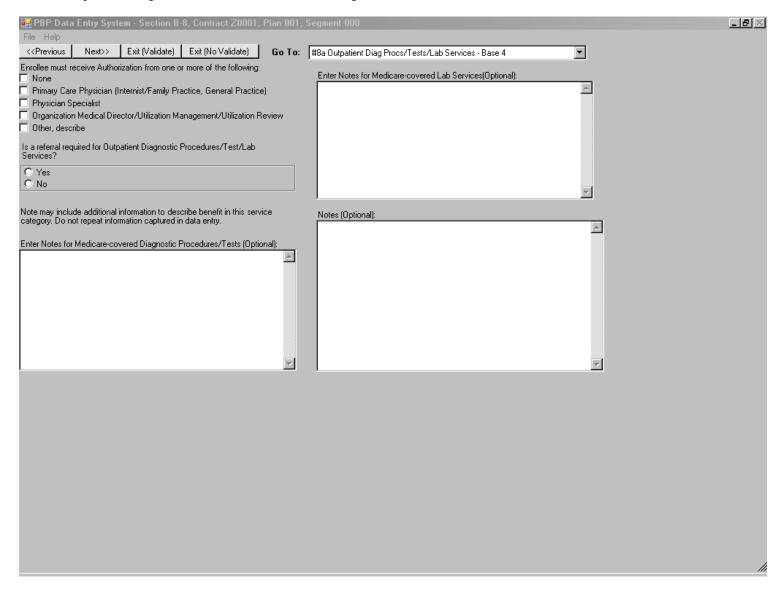
Section B – 8A – Outpatient Diagnostic Procedures, Tests, and Diagnostic Lab Services – Base 2 Screen



Section B – 8A – Outpatient Diagnostic Procedures, Tests, and Diagnostic Lab Services – Base 3 Screen

🔛 PBP Data Entry System - Section B-8, Contract Z0001, P	lan 001,	. Segment 000	_ & ×
File Help			
< <pre><<pre><<pre> </pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To:	#8a Outpatient Diag Procs/Tests/Lab Services - Base 3	
Is there an enrollee Deductible?		Indicate whether a separate physician/professional service cost share applies:	
© Yes		O Sometimes, describe	
O No		● No	
Indicate Deductible Amount:			
		Is there an enrollee Coinsurance for a separate physician/professional service?	
Initiation on another Community		C Yes	
Is there an enrollee Copayment?	_	C No	
C Yes C No		Indicate Minimum Coinsurance percentage for a separate physician/professional service:	
		physician/professional service.	
Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):		Indicate Maximum Coinsurance percentage for a separate	
☐ Medicare-covered Diagnostic Procedures/Tests		physician/professional service:	
Medicare-covered Lab Services			
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	;	Is there an enrollee Copayment for a separate physician/professional service?	
		O Yes	
		C No Indicate Minimum Copayment amount for a separate physician/professional	
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	С	service:	
Indicate Minimum Copayment amount for Medicare-covered Lab		Indicate Maximum Copayment amount for a separate physician/professional	
Services:		service:	
Indicate Maximum Copayment amount for Medicare-covered Lab Services:			
Jervices.			
			,

Section B – 8A – Outpatient Diagnostic Procedures, Tests, and Diagnostic Lab Services – Base 4 Screen



Section B – 8B– Outpatient Diagnostic and Therapeutic Radiological Services – Base 1 Screen

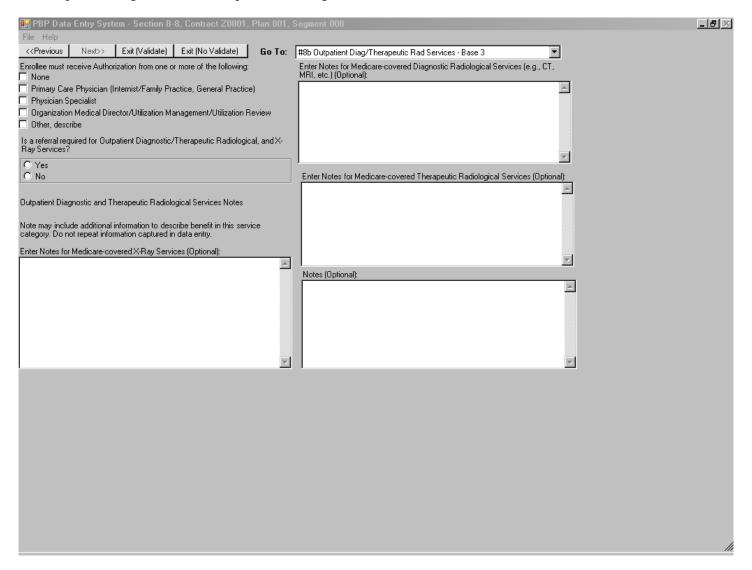
🔛 PBP Data Entry System - Section B-8, Contract Z0001, Plan 0	01, Segment 000	_ 8 ×
File Help		
< <pre><<pre>revious</pre></pre>	To:	
CLICK FOR DESCRIPTION OF BENEFIT	Select which Outpatient Diag/Therapeutic Rad Services have a Coinsurance (Select all that apply):	
Enhanced Benefits are not applicable for this Service Category.	☐ Medicare-covered X-Ray Services	
	Medicare-covered Diagnostic Radiological Services	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Medicare-covered Therapeutic Radiological Services	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Minimum Coinsurance percentage for Medicare-covered X-Ray Services:	
C Yes		
O No		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered X-Ray Services:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	
C Every three years	Radiological Services (e.g., CT, MRI, etc):	
© Every two years		
C Every year C Every six months	Indicate Maximum Coinsurance percentage for Medicare-covered	
C Every three months	Diagnostic Radiological Services (e.g., CT, MRI, etc):	
O Other, Describe		
You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.	Indicate Minimum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services:	
Is there an enrollee Coinsurance?		
© Yes	Indicate Maximum Coinsurance percentage for other Medicare-covered	
C No	Therapeutic Radiological Services:	

Section B – 8B– Outpatient Diagnostic and Therapeutic Radiological Services – Base 2 Screen

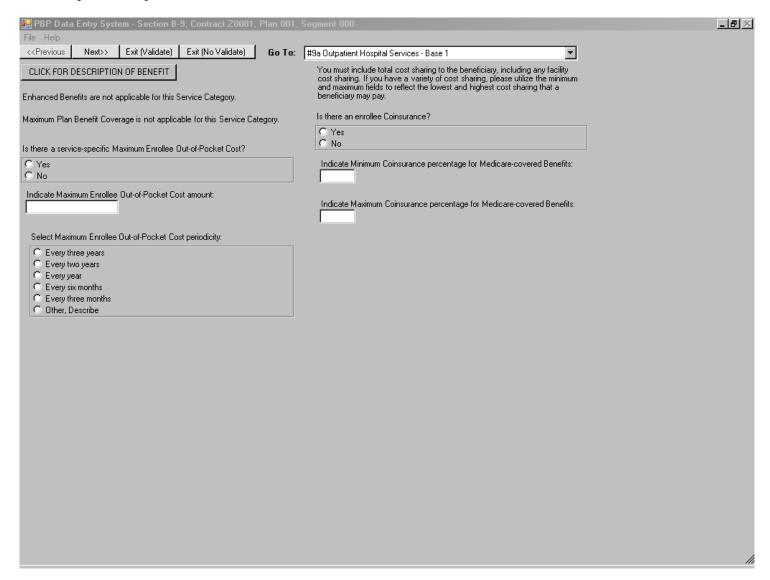
PBP Data Entry System - Section B-8, Contract Z0001, Plan 001,	Segment 000	_ B ×
File Help		
<pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre> <pre>Go To:</pre></pre></pre>	#8b Outpatient Diag/Therapeutic Rad Services - Base 2	
Is there an enrollee Deductible?	Indicate whether a separate physician/professional service cost share applies:	
C No	C Sometimes, describe	
Indicate Deductible Amount: Is there an enrollee Copayment?	Is there an enrollee Coinsurance for a separate physician/professional service?	
O Yes	O Yes	
C No	C No	
Select which Outpatient Diag/Theapeutic Rad Services have a Copayment (Select all that apply):	Indicate Minimum Coinsurance percentage for a separate physician/professional service:	
	Indicate Maximum Coinsurance percentage for a separate physician/professional service:	
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:		
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	Is there an enrollee Copayment for a separate physician/professional service? © Yes	
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	No Indicate Minimum Copayment amount for a separate physician/professional service:	
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	Indicate Maximum Copayment amount for a separate	
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	physician/professional service:	
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:		
		<i>II</i> .

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Section B – 8B– Outpatient Diagnostic and Therapeutic Radiological Services – Base 3 Screen



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

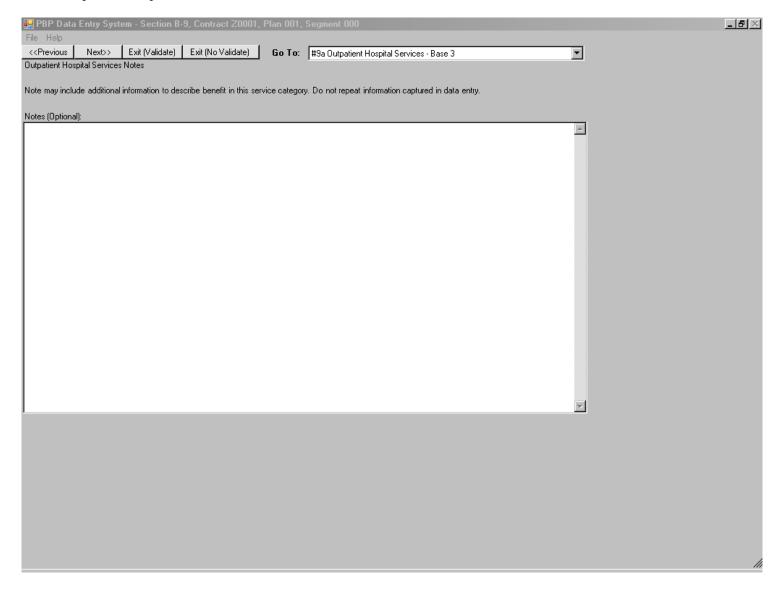


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Section B – 9A – Outpatient Hospital Services – Base 2 Screen

🔛 PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Se	gment 000	_ B ×
File Help		
File Help	9a Outpatient Hospital Services - Base 2 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 Services? Yes No	

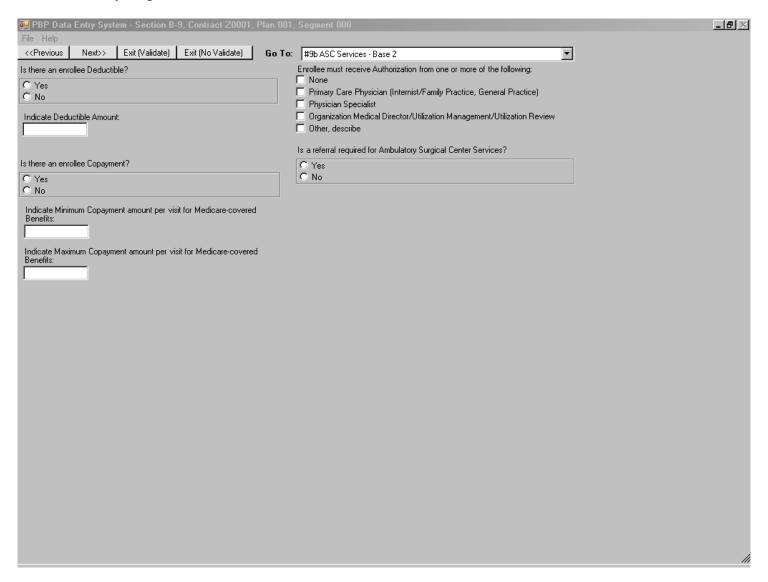
Section B – 9A– Outpatient Hospital Services – Base 3 Screen



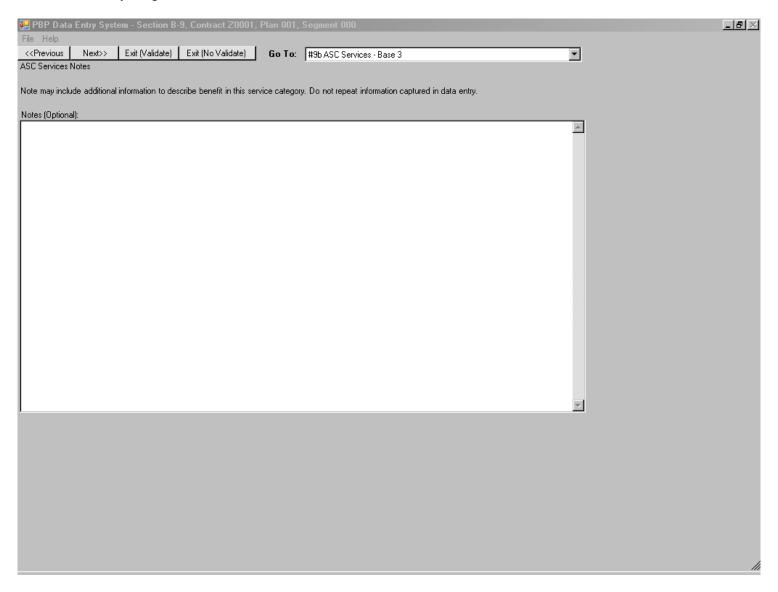
Section B – 9B– Ambulatory Surgical Center Services– Base 1 Screen

🔛 PBP Data Entry System - Section B-9, Contract Z0001, Plan 001,	Segment 000	_B×
File Help		
	#9b ASC Services - Base 1	▼
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are 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.	
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?	O Yes	
O Yes	C No	
O No	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
Select the Maximum Enrollee Out-of-Pocket Cost type:	Delicits.	
Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:		
C Every three years C Every two years		
C Every year		
C Every six months C Every three months		
O Other, Describe		

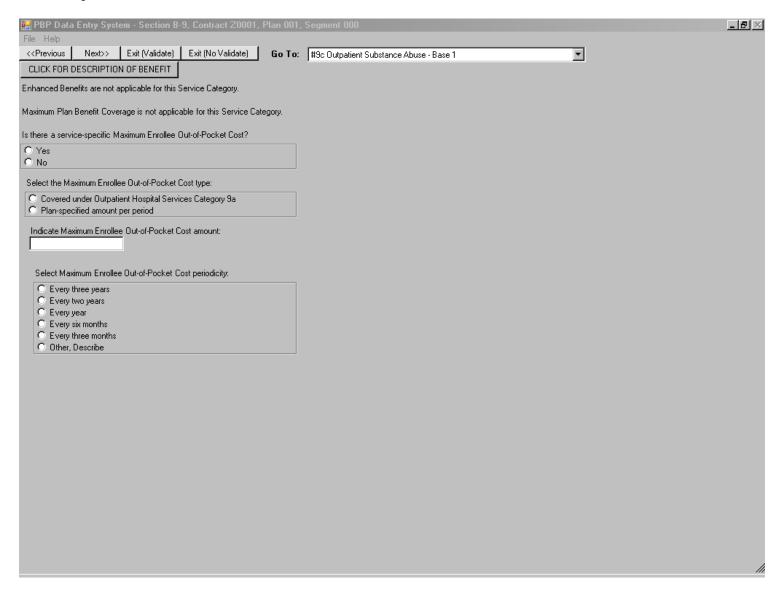
Section B – 9B– Ambulatory Surgical Center Services– Base 2 Screen



Section B – 9B– Ambulatory Surgical Center Services– Base 3 Screen



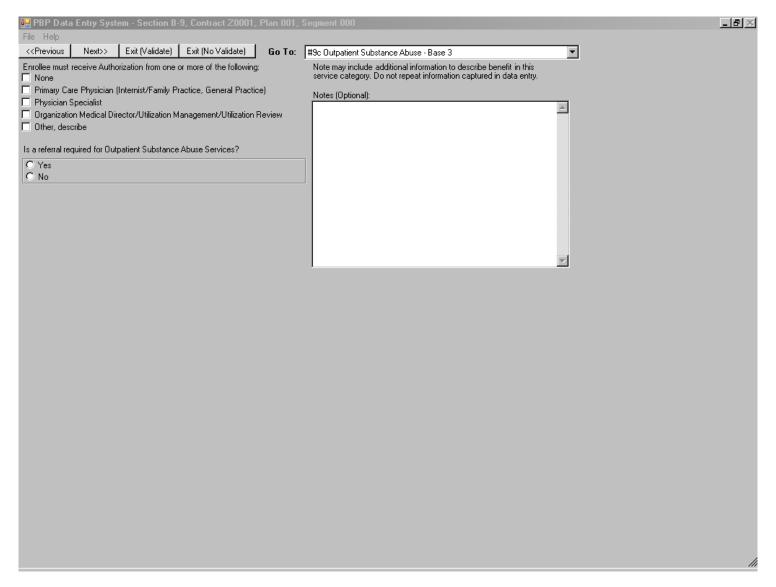
Section B – 9C– Outpatient Substance Abuse– Base 1 Screen



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

🔛 PBP Data	Entry Syst					_ B ×
File Help						
< <pre>revious</pre>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#9c Outpatient Substance Abuse - Base 2	
You must include total cost sharing to the beneficiary, including any facility cost sharing, If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.		Is there an enrollee Deductible? O Yes O No				
Is there an enr	ollee Coinsur	ance?			Indicate Deductible Amount:	
C Yes C No Select which (Select all the Medicare Indicate min Individual Se Indicate man Individual Se Indicate min Group Session	Outpatient S at apply); -covered Indi -covered Gro imum Coinsur essions; imum Coinsu essions; mum Coinsur ons;	ubstance Abuse S vidual Sessions up Sessions ance percentage rance percentage	Services have a Coinsulation Medicare-covered for Medicare-covered for Medicare-covered for Medicare-covered	rance	Is there an enrollee Copayment? Yes No Select which Dutpatient Substance Abuse Services have a Copayment (Select all that apply): Medicare-covered Individual Sessions Medicare-covered Group Sessions Individual Sessions Individual Sessions: Indicate maximum Copayment amount for Medicare-covered Individual Sessions: Indicate minimum Copayment amount for Medicare-covered Group Sessions: Indicate maximum Copayment amount for Medicare-covered Group Sessions:	

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

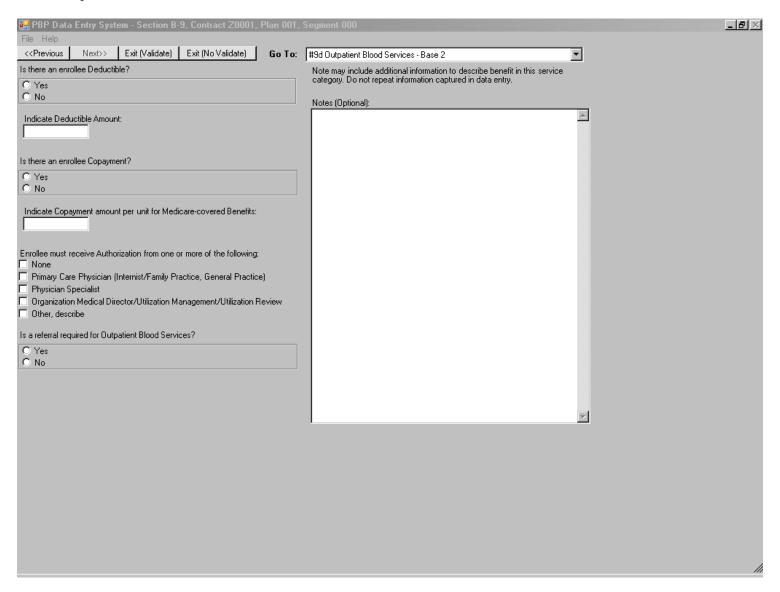


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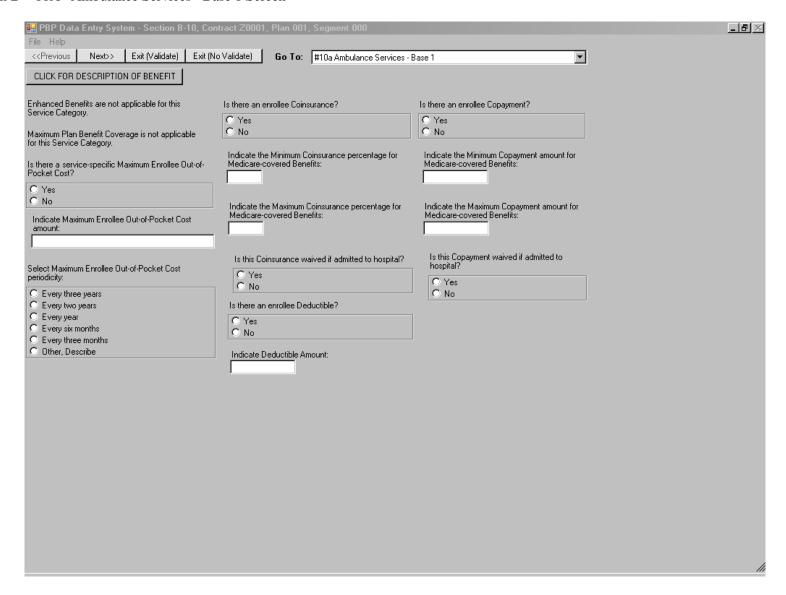
Section B – 9D– Outpatient Blood Services– Base 1 Screen

🔛 PBP Data Entry System - Section B-9, Contract Z0001, Plan 001,		_ B ×
File Help		
	#9d Outpatient Blood Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
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. Does the plan provide Outpatient Blood Services Items as a supplemental benefit under Part C? C Yes C No	C Every three years C Every two years C Every year C Every six months C Every three months Other, Describe Is there an enrollee Coinsurance?	
Select enhanced benefit:	© Yes	
Three (3) pint deductible waived	○ No	
Select type of benefit for Three (3) Pint Deductible Waived: C Mandatory C Optional	Indicate Coinsurance percentage per unit 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?		
C Yes		
C No		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:		

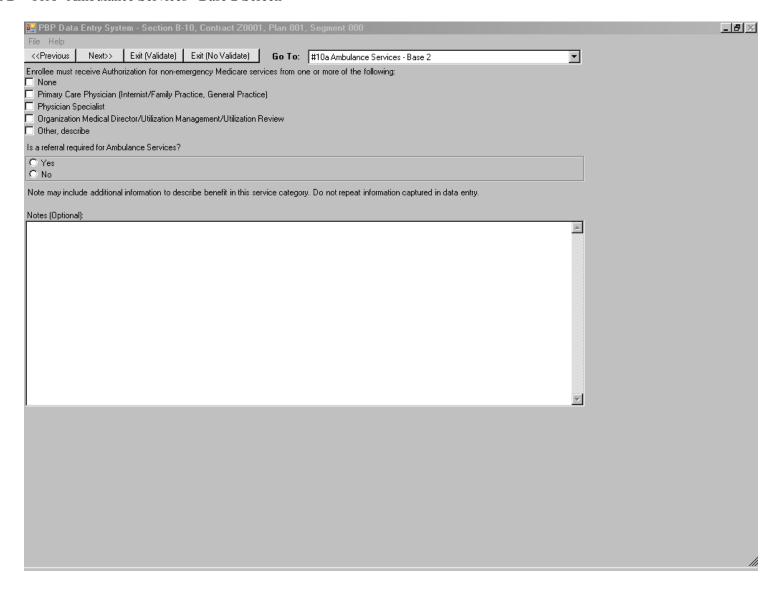
Section B – 9D– Outpatient Blood Services– Base 2 Screen



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



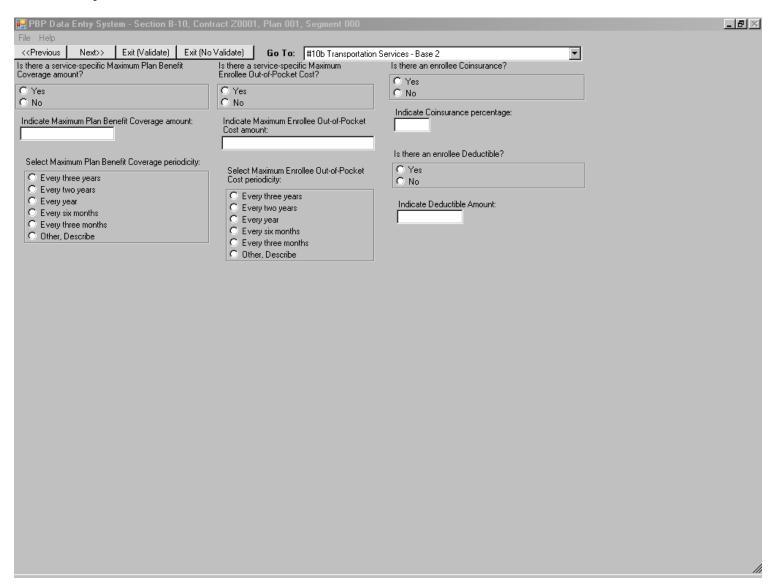
Section B – 10A– Ambulance Services– Base 2 Screen



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

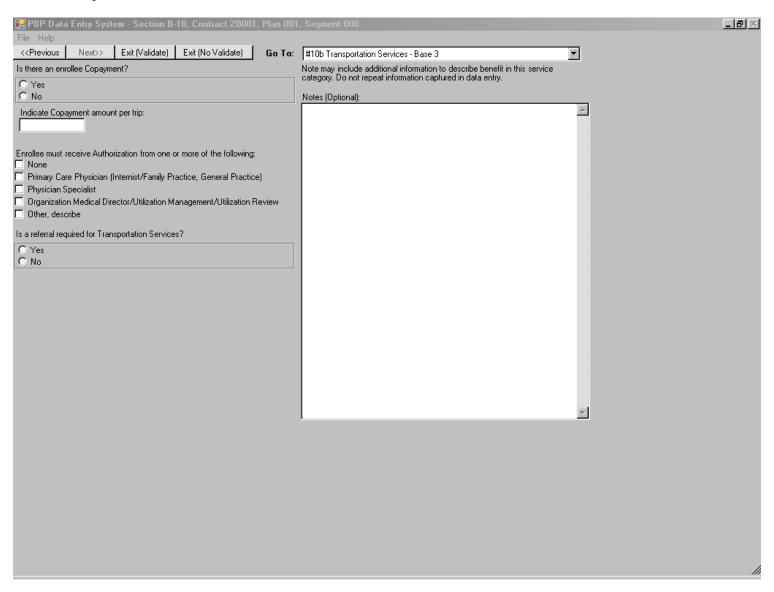
🔛 PBP Data Entry System - Section B-10, Cor	ntract Z0001, Plan 001, Segment 000		_ 5 ×
File Help			
< <pre><<pre><<pre>c</pre></pre><pre>Next>></pre><pre>Exit (Validate)</pre><pre>Exit (N</pre></pre>	o Validate) Go To: #10b Transportation Servi	ices - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select Type of Transportation for Plan-approved Location:	Indicate number of trips for Any Location:	
Does the plan provide Transportation Services Items as a supplemental benefit under Part C?	One-way Round Trip Days	Select Any Location Trips periodicity:	
○ Yes ○ No	C Other, describe	C Every three years	
Select enhanced benefit:	Indicate number of days for Plan-approved Location:	C Every two years C Every year	
Plan-approved Location Any Location	Location:	C Every six months C Every three months C Other, Describe	
Select type of benefit for Plan-approved Location:	Select Mode of Transportation for Plan-approved Location:	Select Type of Transportation for Any Location:	
Mandatory Optional	☐ Taxi ☐ Bus/Subway	C One-way C Round Trip C Days	
Is this benefit unlimited for number of trips for Plan- approved Location?	☐ Van ☐ Other, describe	Other, describe	
O Yes O No	Select type of benefit for Any Location:	Indicate number of days for Any Location:	
Indicate number of trips for Plan-approved Location:	O Optional	Select Mode of Transportation for Any Location:	
	Is this benefit unlimited for number of trips for Any Location?	Taxi Bus/Subway	
Select Plan-approved Location Trips periodicity:	O Yes	☐ Van	
C Every three years C Every two years	○ No	Other, describe	
C Every year			
C Every six months			
C Every three months O Other, Describe			
S Ottler, Describe			

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



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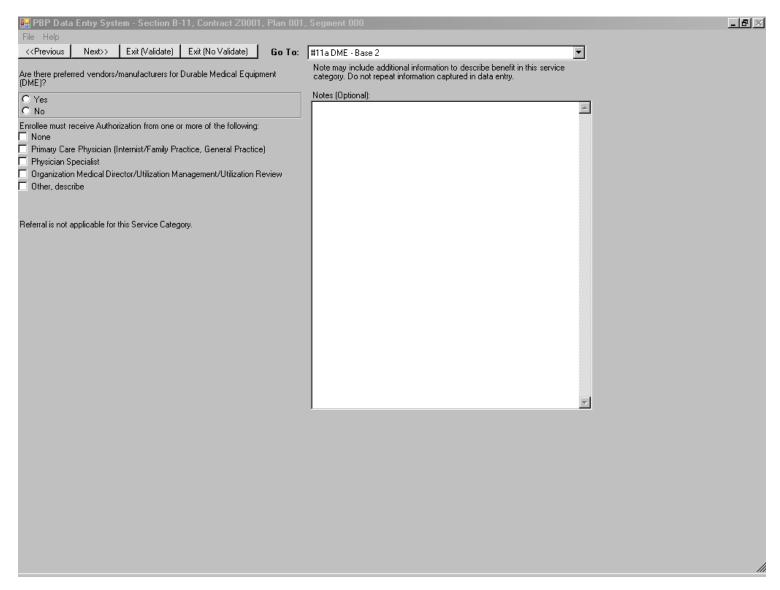
Section B – 10B–Transportation Services– Base 3 Screen



Section B – 11A–Durable Medical Equipment– Base 1 Screen

🔛 PBP Data Entry System - Section B-11, Co	ontract Z0001, Plan 001, Segment 000		_ 8 >
File Help			
< <pre><<pre><<pre>c<<pre><<pre></pre></pre></pre></pre></pre>	No Validate) Go To: #11a DME - Base 1	✓	
CLICK FOR DESCRIPTION OF BENEFIT			
Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select Maximum Enrollee Out-of-Pocket Cost periodicity: © Every three years © Every year © Every six months © Every three months © Other, Describe Is there an enrollee Coinsurance? © Yes © No Indicate Minimum Coinsurance percentage for Medicare -covered Benefits: Indicate Maximum Coinsurance percentage for Medicare -covered Benefits:	Is there an enrollee Deductible? Yes No Indicate Deductible Amount: Is there an enrollee Copayment? Yes No Indicate Minimum Copayment amount per item for Medicare-covered Benefits: Indicate Maximum Copayment amount per item for Medicare-covered Benefits:	

Section B – 11A–Durable Medical Equipment– Base 2 Screen



Section B - 11B-Prosthetics and Medical Supplies- Base 1 Screen

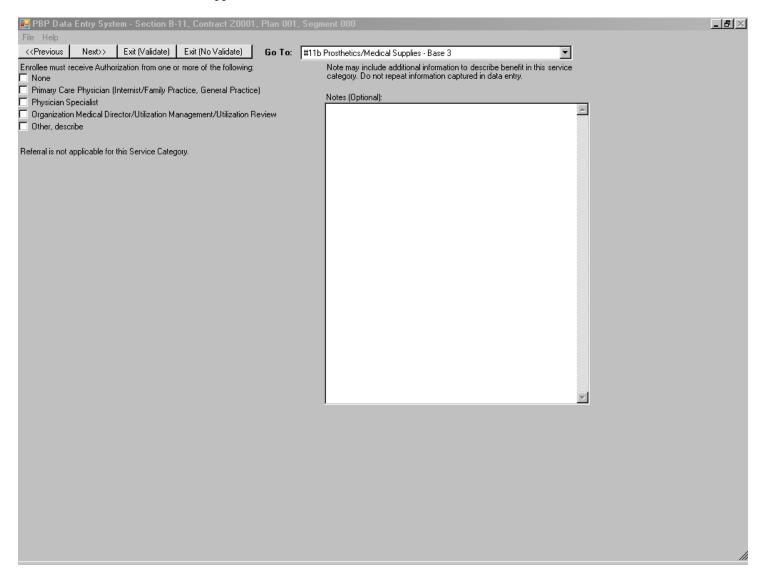
🔛 PBP Data	Entry Syst	tem - Section B	3-11, Contract Z000	11, Plan 001	, Segment 000	_ B ×
File Help						
<< Previous	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#11b Prosthetics/Medical Supplies - Base 1	
CLICK FOR D	ESCRIPTIC	N OF BENEFIT			Is there an enrollee Coinsurance?	
Enhanced Ben	efits are not	applicable for this	Service Category.		O Yes O No	
Enhanced Ben Maximum Plan Is there a servi C Yes No Select Maxim C Covered t Plan-spec Indicate Max C Every t C Every t C Every t C Every t	efits are not of the control of the	applicable for this erage is not applic flaximum Enrollee Out-of-Pocket Cos Category 11a per period ee Out-of-Pocket (cable for this Service C Out-of-Pocket Cost? st type:	-	Is there an enrollee Coinsurance?	

Section B – 11B–Prosthetics and Medical Supplies– Base 2 Screen



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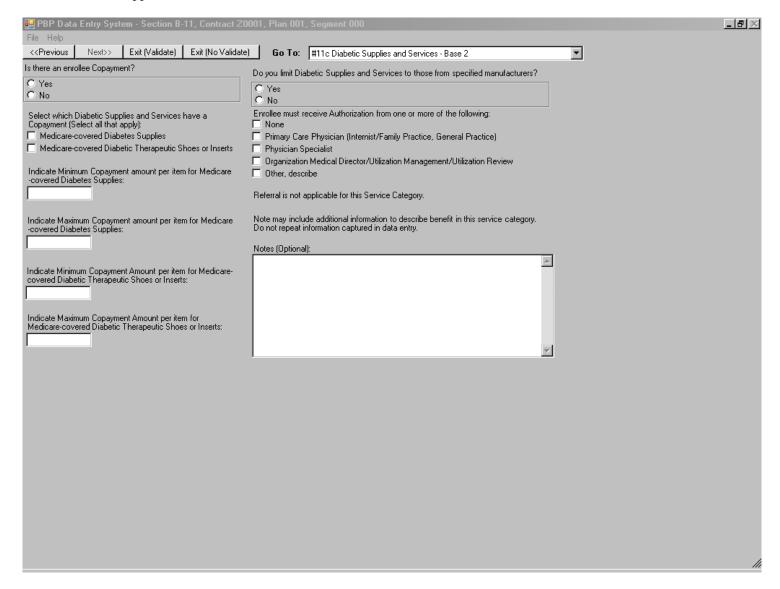
Section B – 11B–Prosthetics and Medical Supplies– Base 3 Screen



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

🔛 PBP Data	Entry Syst	em - Section B	-11, Contract Z0001	, Plan 001	, Segment 000	<u>_ & </u>
File Help						
< <pre>revious</pre>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#11c Diabetic Supplies and Services - Base 1	
		N OF BENEFIT			Select which Diabetic Supplies and Services have a Coinsurance (Select all that apply):	
Enhanced Ben	efits are not a	applicable for this	Service Category.		Medicare-covered Diabetic Supplies	
Maximum Plan	Benefit Cove	rage is not applic	able for this Service Ca	tegory.	Medicare-covered Diabetic Therapeutic Shoes or Inserts	
Is there a servi	ce-specific M	aximum Enrollee	Out-of-Pocket Cost?		Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Supplies:	
C Yes						
O No						
		ut-of-Pocket Cos	t type:		Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Supplies:	
C Covered of C Plan-spec						
Indicate Max	kimum Enrolle	e Out-of-Pocket (Cost amount:		Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	
Select Max	imum Enrollee	e Out-of-Pocket 0	Cost periodicity:		Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	
C Every t						
C Every t					Is there an enrollee Deductible?	
C Every y					C Yes	
	six months				O No	
	hree months					
O Other,					Indicate Deductible Amount:	
Is there an enro	ollee Coinsura	ince?				
C Yes						
C No						

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

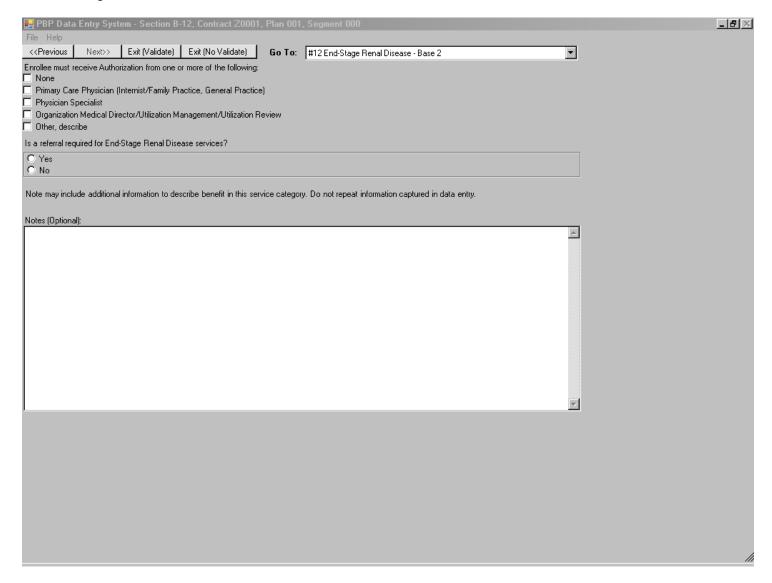


Section B – 12–End-Stage Renal Disease– Base 1 Screen

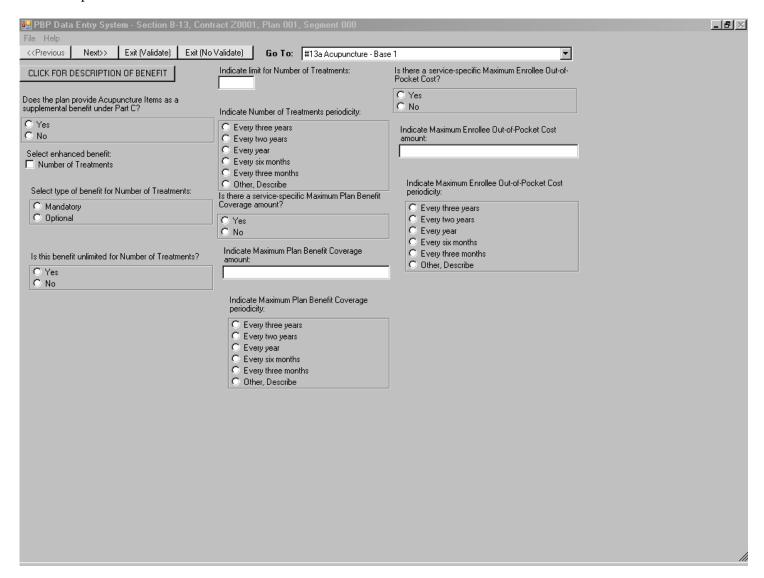
Fu Associates, Ltd.

🔛 PBP Data Entry System - Section B-12,	Contract Z0001, Plan 001, Segment 000		_ & ×
File Help			
< <pre><<pre><<pre>revious</pre> Next>> Exit (Validate) Ex</pre></pre>	xit (No Validate) Go To: #12 End-Stage Renal D	Disease - Base 1 ▼	
CLICK FOR DESCRIPTION OF BENEFIT	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	
Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category.	C Every three years C Every two years C Every year C Every six months C Every three months O Other, Describe	C Yes C No Indicate Deductible Amount:	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C: Yes C: No	You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a heneficiary may pay	Is there an enrollee Copayment? C Yes C No	
	and highest cost sharing that a beneficiary may pay. Is there an enrollee Coinsurance? C Yes C No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Copayment amount per session for Medicare-covered Benefits: Indicate Maximum Copayment amount per session for Medicare-covered Benefits:	

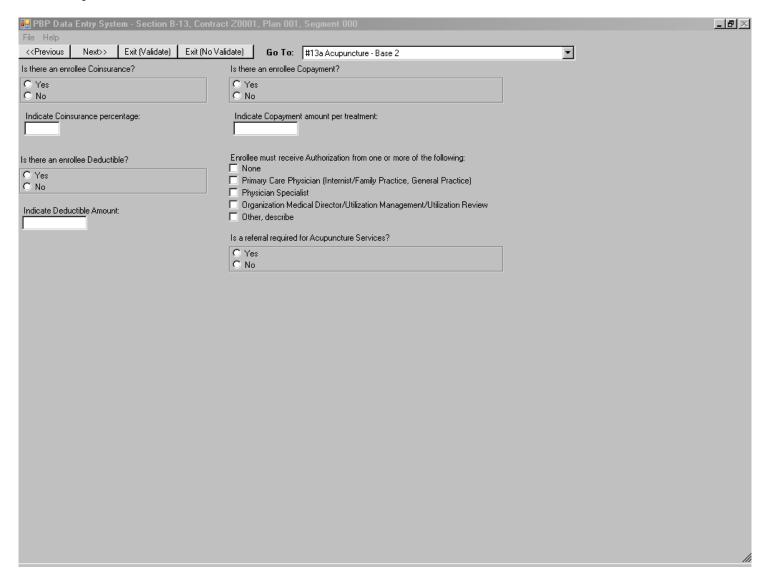
Section B – 12–End-Stage Renal Disease– Base 2 Screen



Section B – 13A–Acupuncture– Base 1 Screen



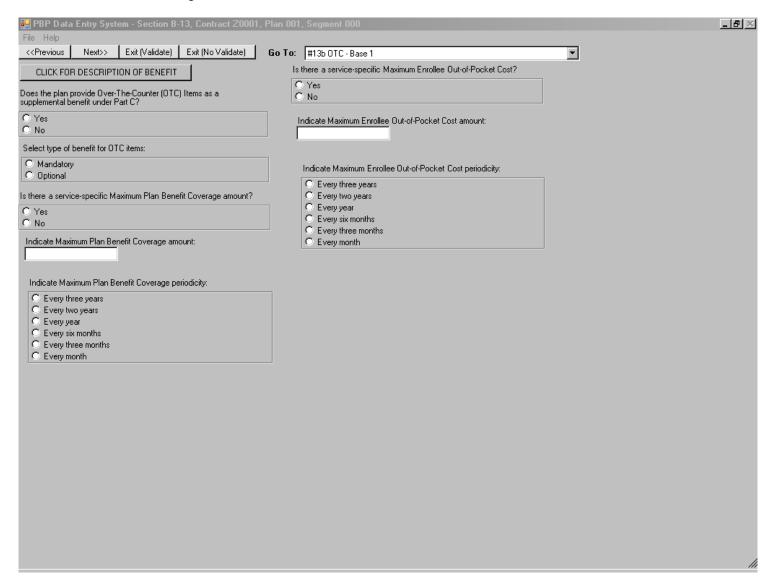
Section B – 13A–Acupuncture– Base 2 Screen



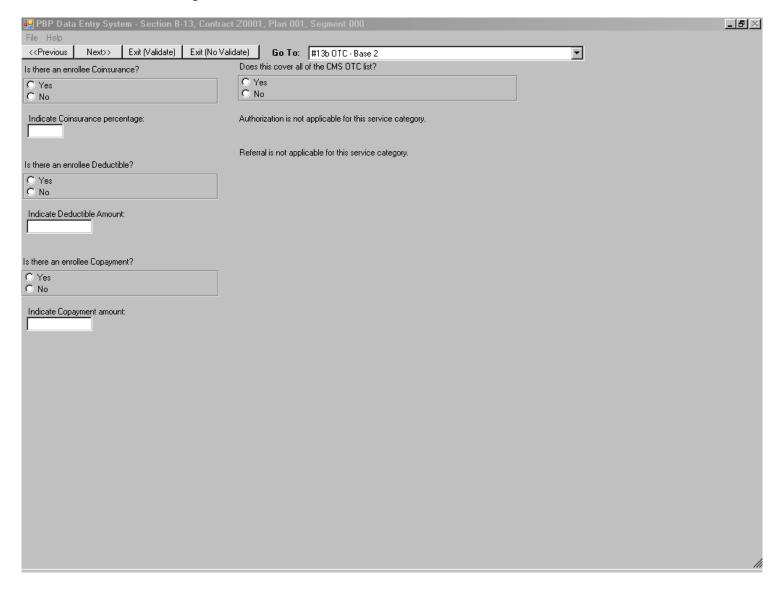
Section B – 13A–Acupuncture– Base 3 Screen



Section B – 13B–Over the Counter Drugs–Base 1 Screen



Section B – 13B–Over the Counter Drugs– Base 2 Screen



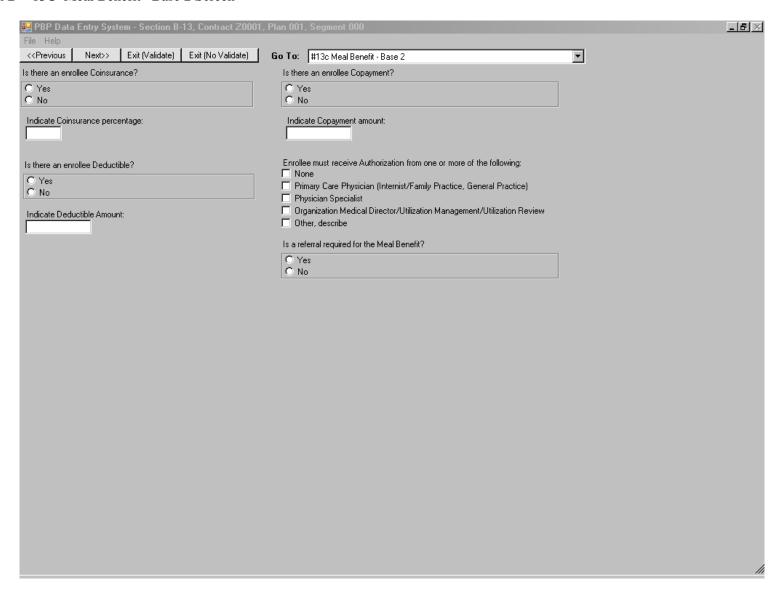
Section B – 13B–Over the Counter Drugs– Base 3 Screen



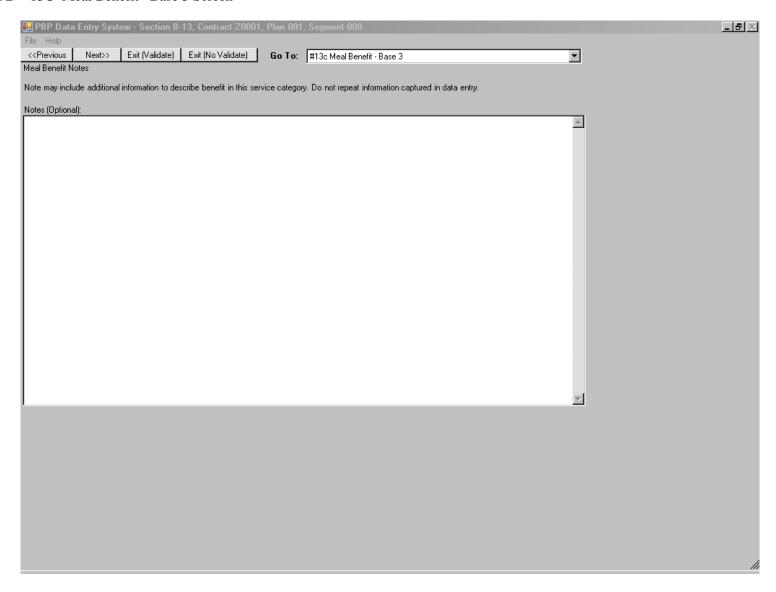
Section B – 13C–Meal Benefit–Base 1 Screen

🔛 PBP Data Entry System - Section B-13, Contract Z000	1, Plan 001, Segment 000	_B×
File Help		
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #13c Meal Benefit - Base 1	<u> </u>
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Does the plan provide a Meal Benefit as a supplemental benefit under Part C?	C Yes C No	
C Yes C No	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select type of benefit:		
○ Mandatory	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:	
O Optional	C Every three years C Every two years	
Is there a service-specific Maximum Plan Benefit Coverage amount	le e i i i	
	C Every six months	
C Yes	C Every three months C Other, Describe	
Indicate Maximum Plan Benefit Coverage amount: Indicate Maximum Plan Benefit Coverage periodicity: © Every three years © Every two years © Every six months © Every three months © Other, Describe		
		li de la companya de
		""

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



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



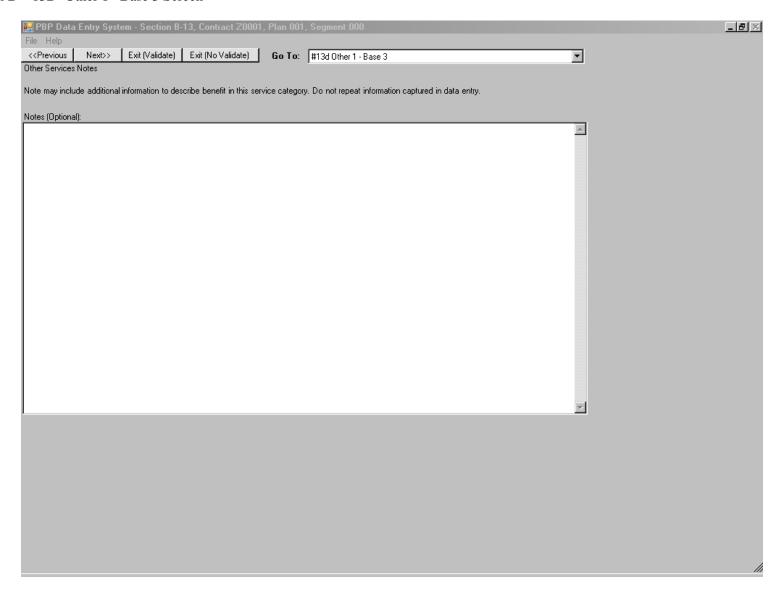
Section B – 13D–Other 1– Base 1 Screen

🔛 PBP Data Entry System - Section B-13, Contract Z0001,	, Plan 001, Segment 000	_ B ×
File Help		
< <pre><<pre><<pre></pre></pre></pre>	Go To: #13d Other 1 - Base 1	T
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Plan Benefit Coverage amount:	
Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional): 'field you will lose all previously entered data. You may edit the name of the service text partially without losing all previously entered data. Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, transportation, medical devices etc). Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13C. If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.	Indicate Maximum Plan Benefit Coverage periodicity: C Every three years C Every two years C Every year C Every six months C Every three months Other, Describe Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No	
,	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select type of benefit: Mandatory Optional Is there a service-specific Maximum Plan Benefit Coverage amount? Yes No	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every year C Every six months C Every three months C Other, Describe	

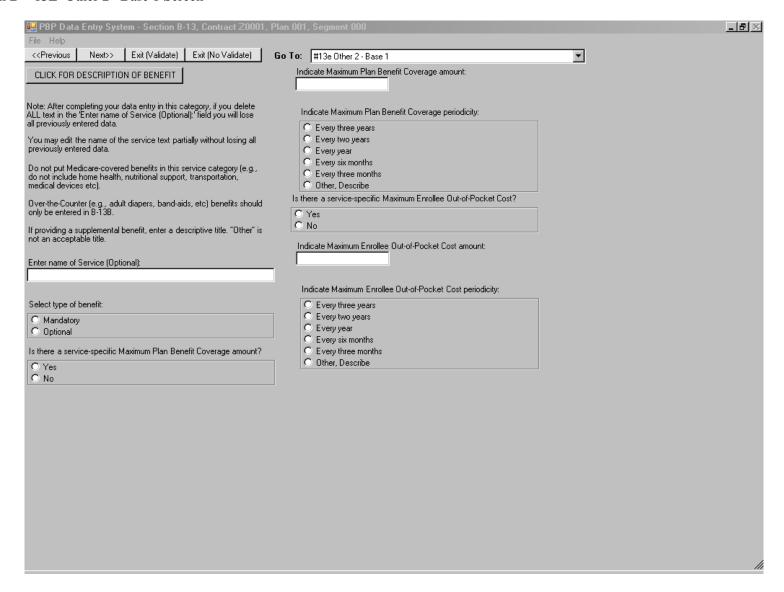
Section B – 13D–Other 1– Base 2 Screen

🔛 PBP Data Entry System - Section B-13, Contract Z	0001, Plan 001, Segment 000	<u>_ & </u>	X
File Help			
< <pre><<pre>revious Next>> Exit (Validate) Exit (No Validate)</pre></pre>	e) Go To: #13d Other 1 - Base 2	▼	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	_	
O Yes	O Yes		
○ No	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		
O Yes O 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		
	C No		
			-/-

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 2	Z0001, Plan 001, Segment 000	_	ĐΧ
File Help			
< <pre><<pre>revious Next>> Exit (Validate) Exit (No Validate)</pre></pre>	ate) Go To: #13e Other 2 - Base 2	▼	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?		
C Yes	○ Yes		
C No	○ No		
Indicate Coinsurance percentage:	Indicate Copayment amount:		
Is there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:		
C Yes	☐ Primary Care Physician (Internist/Family Practice, General Practice)		
C No	Physician Specialist		
Indicate Deductible Amount:	☐ Organization Medical Director/Utilization Management/Utilization Review ☐ Other, describe		
	Uther, describe		
	Is a referral required for Other Services?	_	
	O Yes		
	○ No		
			//

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



CY 2013 PBP - Section B

Section B – 13F–Other 3– Base 1 Screen

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

🔛 PBP Data Entry System - Section B-13, Contract Z0	0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre><<pre><<pre>revious Next>></pre></pre></pre>	e) Go To: #13f Other 3 - Base 2	<u> </u>	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?		
O Yes	O Yes		
○ No	○ No	<u> </u>	
Indicate Coinsurance percentage:	Indicate Copayment amount:		
Is there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:		
C Yes	Primary Care Physician (Internist/Family Practice, General Practice)		
C No	Physician Specialist		
Indicate Deductible Amount:	Organization Medical Director/Utilization Management/Utilization Review Other, describe		
	Other, describe		
	Is a referral required for Other Services?		
	C Yes C No		
	♥ No	」	
			11.

Section B – 13F–Other 3– Base 3 Screen



Section B – 13G–High Quality Special Needs Plan– Base 1 Screen

File Help < <pre> <<pre> </pre> Next>> Exit (Validate) Exit (No Validate) Go To: #13g High Quality SNP - Base 1 </pre>	
CLICK FOR DESCRIPTION OF BENEFIT Indicate Maximum Plan Benefit Coverage amount:	
Plans only fill out this section if they have received written notification from CMS that they qualify for the new supplemental benefit flexibility for certain high-quality SNPs. High Quality SNP Benefit Attestation The plan attests that it has received written notification from CMS that it qualifies for the new supplemental benefit flexibility for certain high-quality SNPs. Note: After completing your data entry in this category, if you delete ALL text in the "Enter name of Service (Optional):" field you will lose all previously entered data. You may edit the name of the service text partially without losing all previously entered data. If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title. Indicate Maximum Plan Benefit Coverage periodicity: © Every three years © Every two years © Every year © Every wonths © Every three months © Other, Describe Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Ves © No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
not an acceptable title. Indicate Maximum Enrollee Out-of-Pocket Cost amount: Enter name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:	
Select type of benefit: C Mandatory C Optional Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes C No	

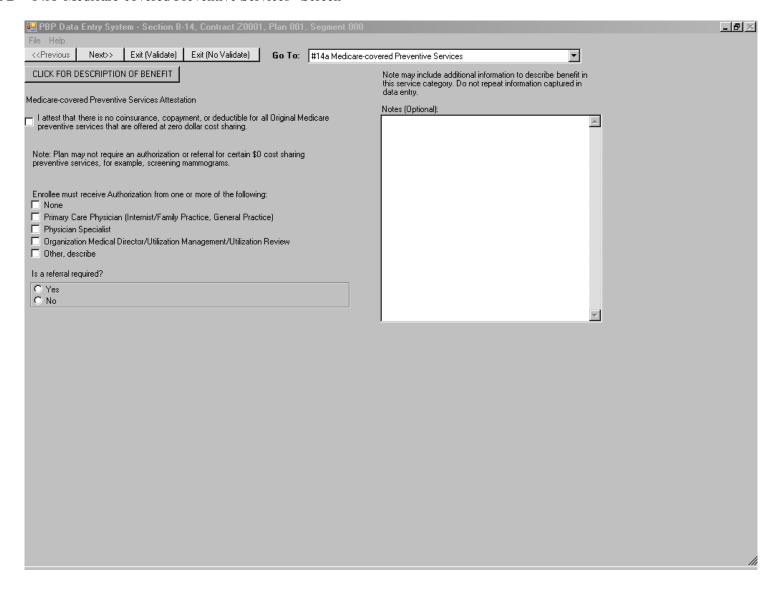
Section B – 13G–High Quality Special Needs Plan– Base 2 Screen

🔛 PBP Data Entry System - Section B-13, Contract Z	0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre><<pre>revious Next>> Exit (Validate) Exit (No Validate)</pre></pre>	e) Go To: #13g High Quality SNP - Base 2	■	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?		
C Yes	O Yes		
● No	● No	_	
Indicate Minimum Coinsurance percentage:	Indicate Minimum Copayment amount: Indicate Maximum Copayment amount:		
Indicate Maximum Coinsurance percentage:			
Is there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:		
O Yes O No	Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist		
Indicate Deductible Amount:	☐ Organization Medical Director/Utilization Management/Utilization Review ☐ Other, describe		
	Is a referral required for Other Services?		
	C Yes		
	O No		

Section B – 13G–High Quality Special Needs Plan– Base 3 Screen



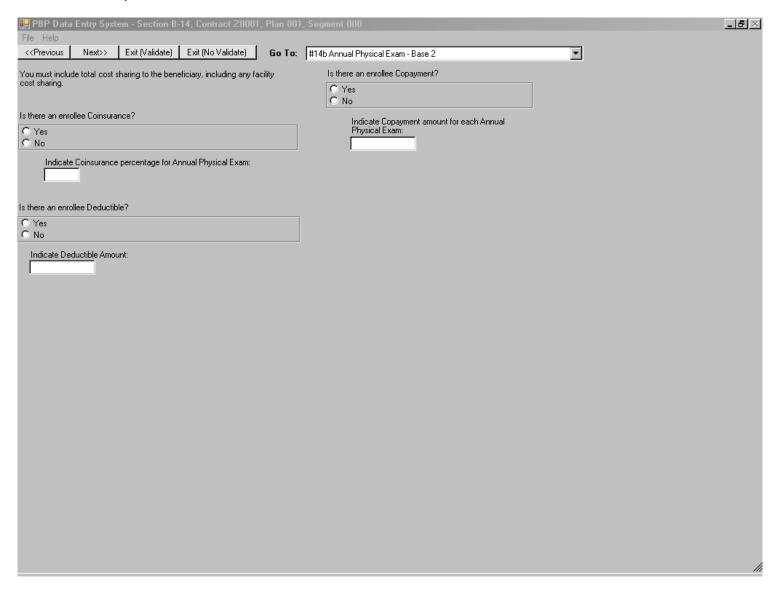
Section B – 14A–Medicare-covered Preventive Services– Screen



Section B – 14B–Annual Physical Exam– Base 1 Screen

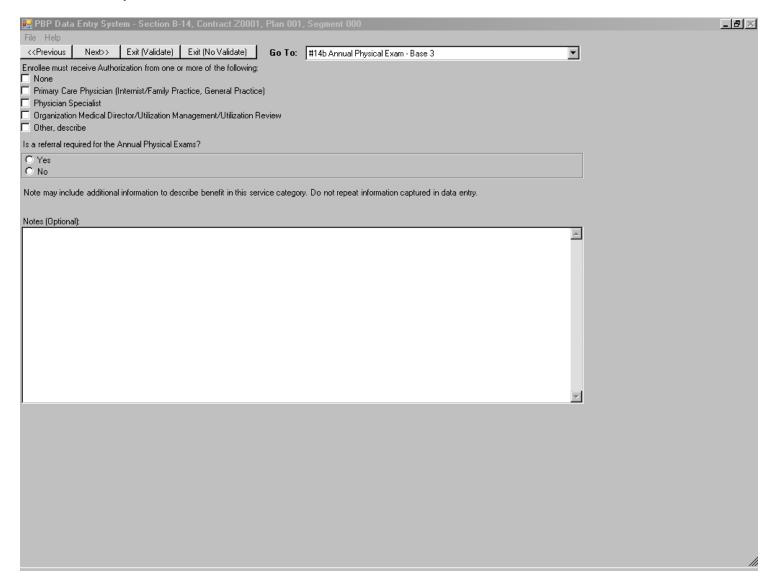
🔛 PBP Data Entry System - Section B-14, Contract Z0001, Plan 001	, Segment 000	_ & ×
File Help		
< <pre><<pre>revious Next>> Exit (Validate) Exit (No Validate) Go To:</pre></pre>	#14b Annual Physical Exam - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount?	
Enter Medicare-covered preventive services at \$0 cost sharing in PBP service category 14a.	○ Yes ○ No	
You should only use these supplemental benefits for Annual Physical Exams not covered by Original Medicare. You may charge copays for these Annual Physical Exams. NOTE: Medicare-covered preventive services are always plan covered when medically necessary, and consequently they are not appropriate as a supplemental benefit. Does the plan provide Annual Physical Exams as a supplemental benefit under Part C?	Indicate Maximum Plan Benefit Coverage amount: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
	C Yes	
© Yes	C No	
C No Select type of benefit for Annual Physical Exam:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
C Mandatory C Optional		

Section B – 14B–Annual Physical Exam– Base 2 Screen



Page 139 of 200

Section B – 14B–Annual Physical Exam– Base 3 Screen



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

🔛 PBP Data Entry System - Section B-14, Contract	t Z0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre><<pre><<pre>c<pre></pre></pre><pre>Next>></pre><pre>Exit (Validate)</pre><pre>Exit (No Validate)</pre></pre></pre>	date) Go To: #14c Supplemental Education	n/Wellness Programs - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Written Health Education Materials:	Select type of benefit for Membership in Health Club/Fitness Classes:	
Does the plan provide Supplemental Education/Wellness Programs Items as a supplemental benefit under Part C?	C Mandatory C Optional	Mandatory Optional	
O Yes O No	Select type of benefit for Nutritional Benefit:	Select type of benefit for Nursing Hotline:	1
Select enhanced benefit (Select all that apply): Written Health Education Materials Nutritional Benefit Additional Smoking and Tobacco Use Cessation Membership in Health Club/Fitness Classes Nursing Hotline	C Mandatory C Optional	C Mandatory C Optional	
	Select type of benefit for Additional Smoking and Tobacco Use Cessation:	Uptional	
	C Mandatory C Optional		

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

🔛 PBP Data Entry System - Section B-14, Cont	ntract Z0001, Plan 001, Segment 000	_ & ×
File Help		
< <pre><<pre><<pre>revious</pre></pre></pre>	o 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?	
C Yes C No	C Yes C No	
Indicate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select the Maximum Plan Benefit Coverage	Select the Maximum Enrollee Dut-of-Pocket	
periodicity: © Every three years	Cost periodicity:	
C Every two years C Every year	C Every two years C Every year	
© Every six months	© Every six months	
C Every three months C Other, Describe	C Every three months C Other, Describe	
	2 Cutot, December	

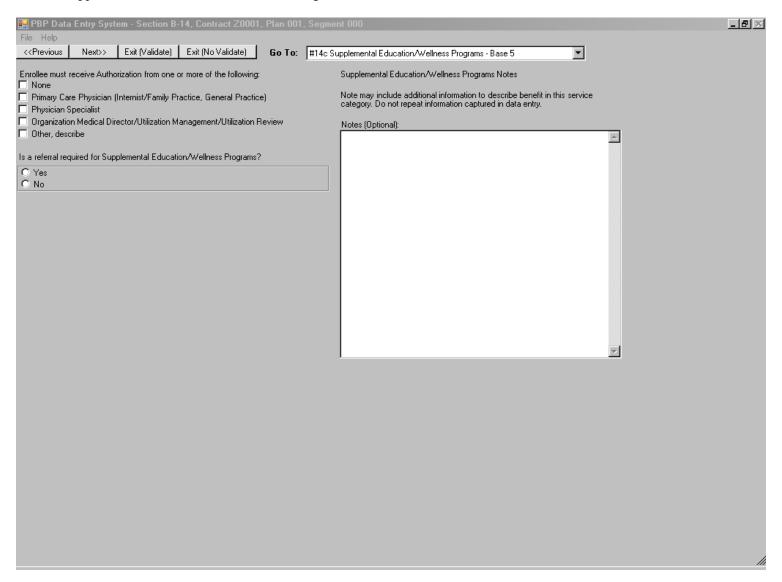
Section B – 14C–Supplemental Education and Wellness Programs– Base 3 Screen

🔛 PBP Data Entry System - Section B-14, Contract		_ B ×
File Help		
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Valid</pre></pre></pre>	idate) Go To: #14c Supplemental Education/Wellness Programs - Base 3 ▼	
You must include total cost sharing to the beneficiary, includin 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 and Tobacco Use Cessation:	
C Yes		
○ No		
Select which Supplemental Education/Wellness Progran have a Coinsurance (Select all that apply): Written Health Education Materials Nutritional Benefit Additional Smoking and Tobacco Use Cessation Membership in Health Club/Fitness classes	Indicate Minimum Coinsurance percentage for Membership in Health Club/Fitness Classes: Indicate Maximum Coinsurance percentage for Membership in Health Club/Fitness Classes:	
☐ Nursing Hotline		
Indicate Minimum Coinsurance percentage for Written Health Education Materials: Indicate Maximum Coinsurance percentage for Written Health Education Materials:	Indicate Coinsurance percentage for Nursing Hotline:	

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

🔛 PBP Data Entry System - Section B-14, Contract Z0001,	Plan 001, Segment 000	_ & ×
File Help		
< <pre><<pre><<pre>revious</pre></pre></pre>	Go To: #14c Supplemental Education/Wellness Programs - Base 4 ▼	
Is there an enrollee Deductible?	Indicate Copayment amount for Written Health Education Materials:	
C Yes	malcate copayment amount for whiten meaning ducation materials.	
○ No		
Indicate Deductible Amount:	Indicate Copayment amount for Nutritional Benefit:	
	Tracace copaymon transcar for transcora porton.	
In these on annulus Community	Indicate Copayment amount for Additional Smoking and Tobacco Use	
Is there an enrollee Copayment? © Yes	Cessation:	
O No		
	Indicate Minimum Copayment amount for Membership in Health Club/Fitness Classes:	
Select which Supplemental Education/Wellness Programs have a Copayment (Select all that apply):	Citasous.	
☐ Written Health Education Materials		
☐ Nutritional Benefit ☐ Additional Smoking and Tobacco Use Cessation	Indicate Maximum Copayment amount for Membership in Health Club/Fitness Classes:	
Membership in Health Club/Fitness classes	Ciasses.	
☐ Nursing Hotline		
	Indicate Copayment amount for Nursing Hotline:	

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



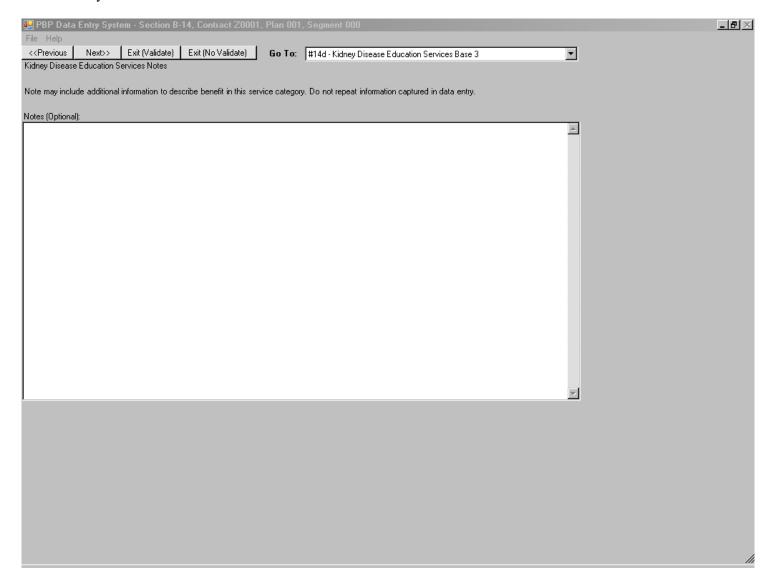
Section B – 14D–Kidney Disease Education Services– Base 1 Screen

🔛 PBP Data Entry System - Section B-14, Contract Z0001, Plan 00'	1, Segment 000	_ <i>6</i> ×
File Help		
< <pre>revious Next>> Exit (Validate) Exit (No Validate) Go To:</pre>	#14d - Kidney Disease Education Services Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are 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.	
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?	O No	
C Yes C No	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:		
C Every three years C Every two years C Every year C Every six months C Every three months Other. Describe		
		<i>II</i>

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

🔛 PBP Data Entry System - Section B-14, Contract Z0001, F	Plan 001, Segment 000	_ & ×
File Help		
< <pre><<pre>c<pre>revious</pre></pre></pre>	Go To: #14d - Kidney Disease Education Services Base 2	
Is there an enrollee Deductible? 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 Deductible Amount:	☐ 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:		

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



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

🔛 PBP Data Entry System - Section B-14, Contract Z0001, Plan 001,	Segment 000	_ - - - ×
File Help		
< <pre><<pre>revious Next>> Exit (Validate) Exit (No Validate) Go To:</pre></pre>	#14e Diabetes Self-Management Training - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
Enhanced Benefits are not applicable for this Service Category.	© Yes © No	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
O Yes O No	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Is there an enrollee Deductible?	
	C Yes	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	O No	
C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	Indicate Deductible Amount:	
		<i></i>

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

Fu Associates, Ltd.

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

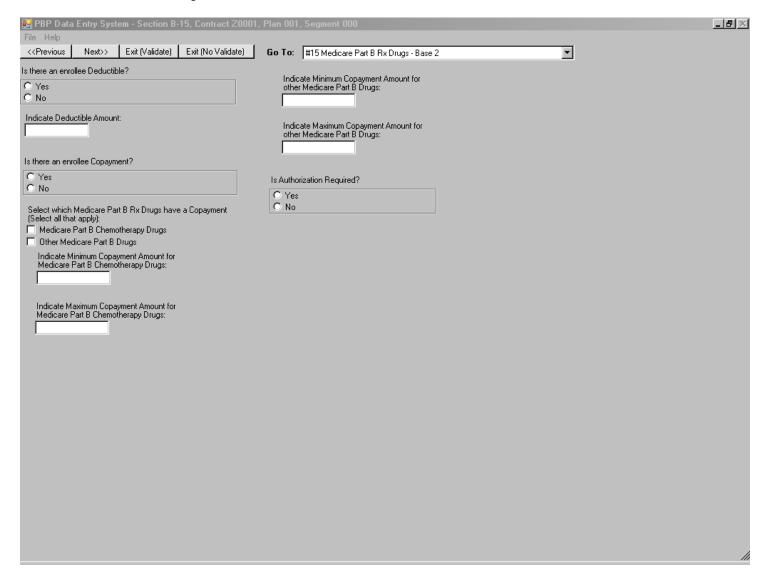
Section B – 14E–Diabetes Self-Management Training– Base 3 Screen



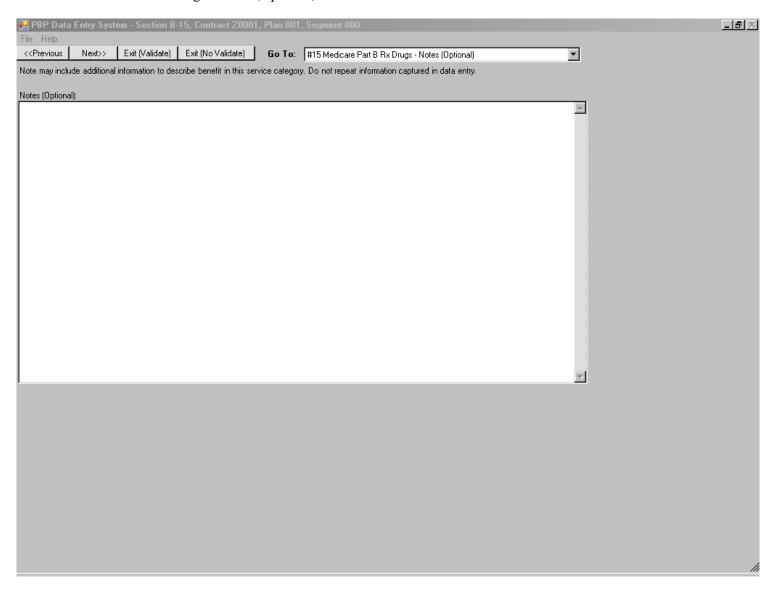
Section B – 15–Medicare Part B Rx Drugs– Base 1 Screen

🔛 PBP Data Entry System - Section B-15, Contract Z0001,	Plan 001, Segment 000	_ 6 ×
File Help		
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #15 Medicare Part B Rx Drugs - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
	C Yes	
Is there a Maximum Enrollee Out-of-Pocket Cost?	○ No	
	Calcate Maide Madages Bart B. Bur Donner have a	
C Yes	Select which Medicare Part B Rx Drugs have a Coinsurance (Select all that apply):	
<i>3</i> 110	Medicare Part B Chemotherapy Drugs	
	☐ Other Medicare Part B Drugs	
Indicate Maximum Enrollee Out-of-Pocket Cost Amount:	Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:	
	To mode at a Communicacy prage.	
	Indicate the Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	To medicale raik b chemorierapy bridgs.	
C Every three years C Every two years		
C Every year	Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	
C Every six months		
C Every three months C Every month	Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:	
C Other, Describe	other Medicare Part B Drugs:	

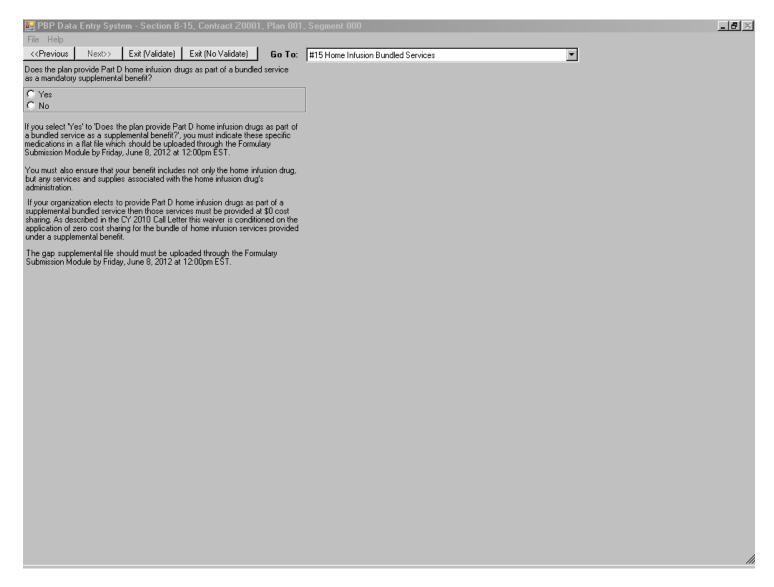
Section B – 15–Medicare Part B Rx Drugs– Base 2 Screen



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



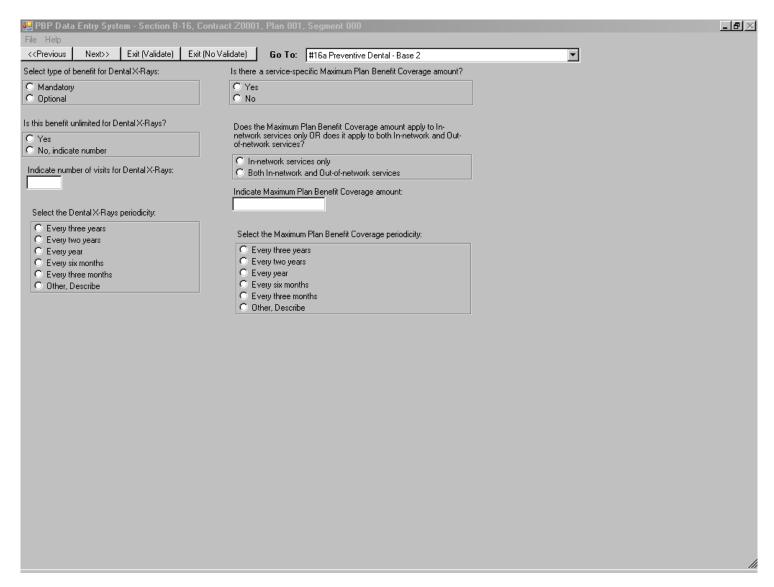
Section B – 15–Home Infusion Bundled Services– Screen



Section B – 16A–Preventive Dental–Base 1 Screen

🔛 PBP Data Entry System - Section B-16, Co	ntract Z0001, Plan 001, Segment 000		_ & ×
File Help			
< <pre><<pre><<pre>c</pre></pre> <pre>Next>> Exit (Validate)</pre></pre>	No Validate) Go To: #16a Preventive Dental - E	Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select the Oral Exams periodicity:	Select type of benefit for Fluoride Treatment:	
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	C Every three years C Every two years C Every year	C Mandatory C Optional	
O Yes O No	C Every six months C Every three months C Other, Describe	Is this benefit unlimited for Fluoride Treatment? C Yes C No, indicate number	
Select enhanced benefits: Oral Exams	Select type of benefit for Prophylaxis (Cleaning):	Indicate number of visits for Fluoride Treatment:	
☐ Prophylaxis (Cleaning) ☐ Fluoride Treatment ☐ Dental X-Rays	C Mandatory C Optional	Indicate number of visits for ridorde freatment.	
Select type of benefit for Oral Exams:	Is this benefit unlimited for Prophylaxis (Cleaning)?	Select the Fluoride Treatment periodicity:	
C Mandatory C Optional	C Yes C No, indicate number	C Every three years C Every two years C Every year	
Is this benefit unlimited for Oral Exams?	Indicate number of visits for Prophylaxis (Cleaning):	C Every six months C Every three months C Other. Describe	
O Yes O No, indicate number	Select the Prophylaxis (Cleaning) periodicity:	S Gard, possibe	
Indicate number of visits for Oral Exams:	C Every three years C Every two years C Every year Every six months Every three months Other, Describe		
			li.

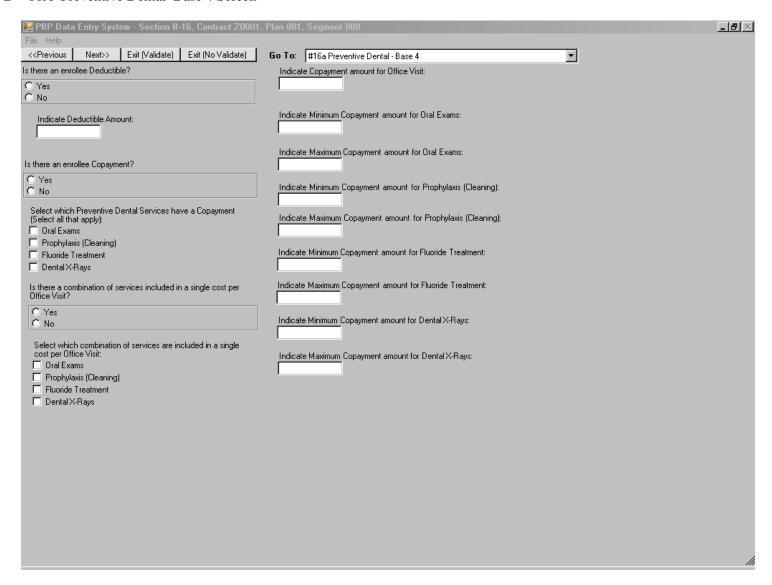
Section B – 16A–Preventive Dental–Base 2 Screen



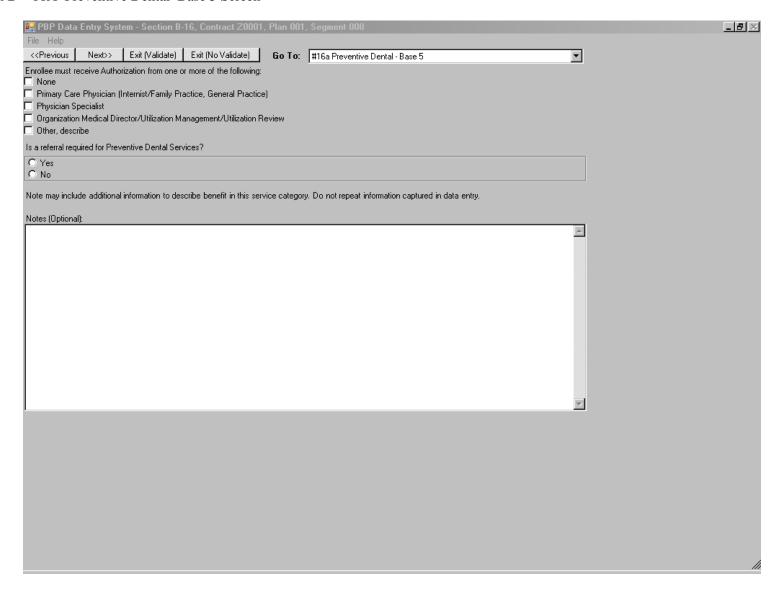
Section B – 16A–Preventive Dental–Base 3 Screen

🔛 PBP Data Entry System - Section B-16, Contract Z0001	l, Plan 001, Segment 000		_ B ×
File Help			
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre></pre></pre>	Go To: #16a Preventive Dental - Base 3	▼	
< <pre><</pre> Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every year C Every year C Every year months	Go To: #16a Preventive Dental - Base 3 Is there a combination of services included in a single cost per Office Visit? O 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 Minimum Coinsurance percentage for Prophylaxis (Cleaning): Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning): Indicate Minimum Coinsurance percentage for Fluoride Treatment:	
C Every six morrors C Every three months C Other, Describe	Indicate Coinsurance percentage for Office Visit:	Indicate Maximum Coinsurance percentage for Fluoride Treatment:	
Is there an enrollee Coinsurance? C Yes No Select which Preventive Dental Services have a Coinsurance (Select all that apply): Oral Exams Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays	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:	

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



Section B – 16A–Preventive Dental–Base 5 Screen



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

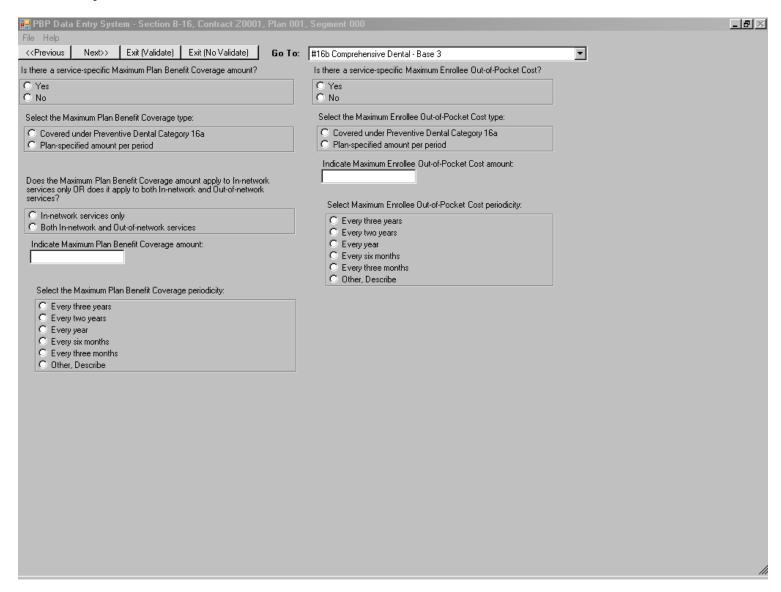
🔛 PBP Data Entry System - Section B-16, Contract Z0001,	Plan 001, Segment 000		_6)
File Help			
< <pre><<pre> </pre> <pre></pre></pre>	Go To: #16b Comprehensive Dental - Base	e 1 💌	
CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Non-routine Services:	Select type of benefit for Diagnostic Services:	
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	Mandatory Optional	Mandatory Optional	
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Is this benefit unlimited for Non-routine Services?	Is this benefit unlimited for Diagnostic Services?	
C Yes C No	C Yes C No, indicate number	C Yes C 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 three years C Every two years	
	C Every year	© Every year	
	C Every six months C Every three months	C Every six months C Every three months	
	O Other, Describe	O Other, Describe	

Page 161 of 200

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

🚂 PBP Data Entry System - Section B-16, (Contract Z0001, Plan 001, Segment 000		_ 6 ×
File Help			
< <pre><<pre><< Previous</pre></pre>	t (No Validate) Go To: #16b Comprehensive D	Pental - Base 2	
Select type of benefit for Restorative Services: C Mandatory	Select type of benefit for Endodontics/Periodontics/Extractions:	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
C Optional	O Mandatory	○ Mandatory	
	O Optional	O Optional	
Is this benefit unlimited for Restorative Services?	Is this benefit unlimited for	Is this benefit unlimited for Prosthodontics, Other	
C Yes	Endodontics/Periodontics/Extractions?	Oral/Maxillofacial Surgery, Other Services?	
No, indicate number	C Yes	C Yes	
Indicate number of visits for Restorative	O No, indicate number	O No, indicate number	
Services:	Indicate number of visits for Endodontics/Peridontics/Extractions:	Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Select the Restorative Services periodicity:			
C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	Select the Endodontics/Periodontics/Extractions periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity: C Every three years C Every years C Every year C Every six months C Every three months Other, Describe	
			//

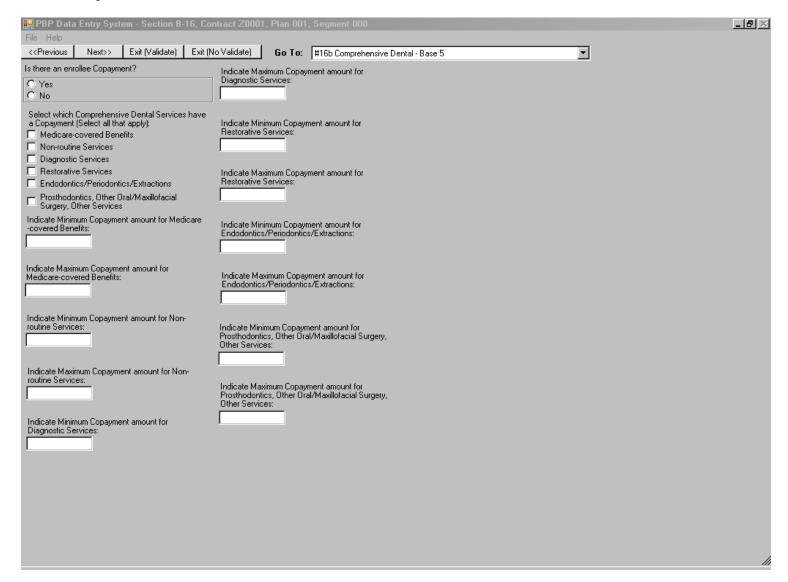
Section B – 16B–Comprehensive Dental–Base 3 Screen



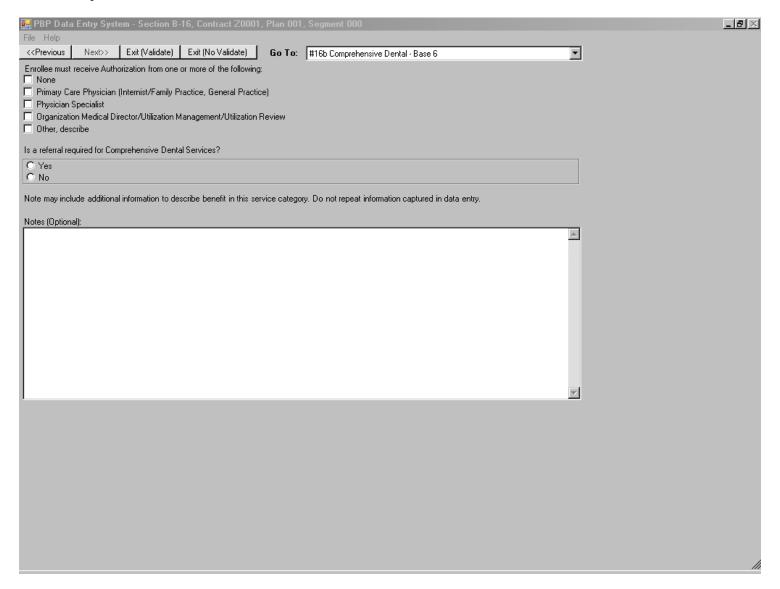
Section B – 16B–Comprehensive Dental–Base 4 Screen

🔛 PBP Data Entry System - Section B-16, Contract Z0001, Plan 001,	, Segment 000	_ B ×
File Help		
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre> <pre>Go To:</pre></pre></pre>	#16b Comprehensive Dental - Base 4	▼
Is there an enrollee Coinsurance?	Indicate Minimum Coinsurance percentage for Restorative Services:	
O Yes		
O No		
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply): Medicare-covered Benefits	Indicate Maximum Coinsurance percentage for Restorative Service	
Non-routine Services	Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions:	
☐ Diagnostic Services	Endodontics/Periodontics/Extractions:	
Restorative Services		
☐ Endodontics/Periodontics/Extractions		
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:	
Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	Endodontics/Periodontics/Extractions:	
Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	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 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Maximum Coinsurance percentage for Non-routine Services:		
	Is there an enrollee Deductible?	
Indicate Minimum Coinsurance percentage for Diagnostic Services:	C Yes C No	
	Indicate Deductible Amount:	
Indicate Maximum Coinsurance percentage for Diagnostic Services:		
		<i>,,</i>

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



Section B – 16B–Comprehensive Dental–Base 6 Screen



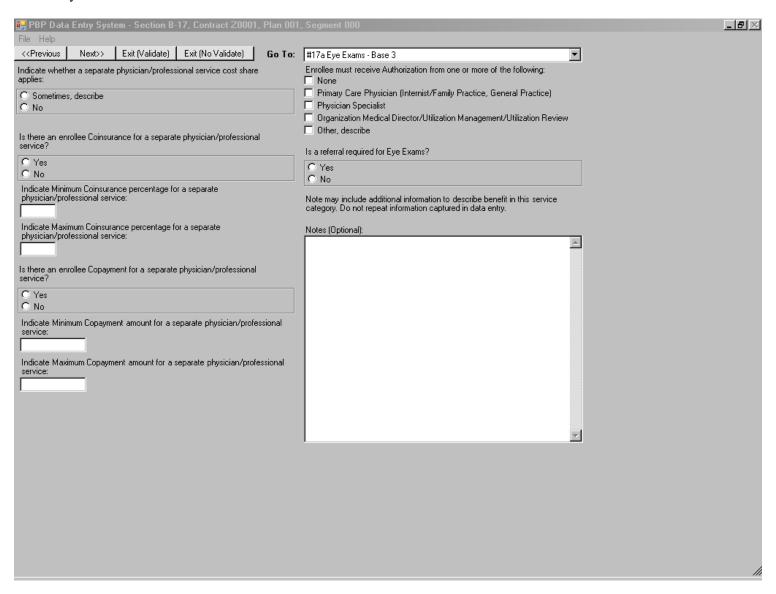
Section B – 17A–Eye Exams–Base 1 Screen

🔛 PBP Data Entry System - Section B-17, Contr	act Z0001, Plan 001, Segment 000		_ 6 ×
File Help			
<pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No \)</pre></pre></pre>	/alidate) Go To: #17a Eye Exams - Base 1	▼	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of- Pocket Cost?	
Does the plan provide Eye Exams Items as a supplemental benefit under Part C?	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 Select type of benefit for Routine Eye Exams: Mandatory	C In-network services only C Both In-network and Out-of-network services Indicate Maximum Plan Benefit Coverage amount:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: © Every three years	
C Optional Is this benefit unlimited for Routine Eye Exams? C Yes C No. indicate number	Select the Maximum Plan Benefit Coverage periodicity:	C Every two years C Every year C Every six months C Every three months C Other, Describe	
Indicate number of exams for Routine Eye Exams:	C Every three years C Every two years C Every year C Every six months C Every three months	S dura, pescribe	
Select the Routine Eye Exams periodicity: C Every three years C Every two years C Every year C Every six months C Every three months Other, Describe	C Other, Describe	J	

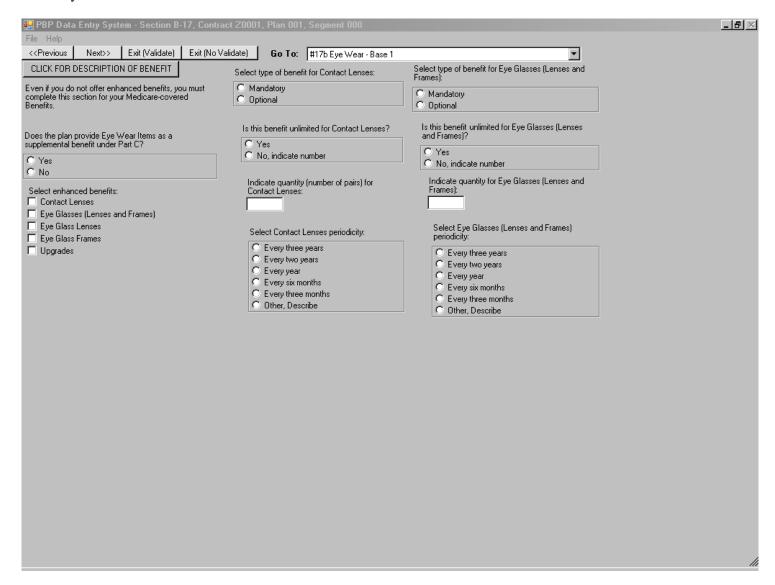
Section B – 17A–Eye Exams–Base 2 Screen

₽ PBP Data Entry System - Section B-17, Contract Z0001	, Plan 001, Segment 000	_ B ×
File Help		
< <pre><<pre><<pre>revious</pre></pre></pre>	Go To: #17a Eye Exams - Base 2	V
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes	C Yes	
○ No	○ No	
Select which Eye Exams have a Coinsurance (Select all that apply)	Select which Eye Exams have a Copayment (Select all that apply):	
☐ Medicare-covered Benefits ☐ Routine Eye Exams	☐ Medicare-covered Benefits ☐ Routine Eye Exams	
- House Eye Evante	1 Housing Eye English	
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 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?		
O Yes		
○ No		
Indicate Deductible Amount:		

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 2	20001, Plan 001, Segment 000	_ B ×
File Help		
< <pre><<pre>revious</pre></pre>	ite) Go To: #17b Eye Wear - Base 2	-
Select type of benefit for Eye Glass Lenses:	Select type of benefit for Eye Glass Frames:	
O Mandatory	○ Mandatory	
O Optional	C Optional	
Is this benefit unlimited for Eye Glass Lenses?	Is this benefit unlimited for Eye Glass Frames?	
© Yes	C Yes	
C No, indicate number	C 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	
C Every two years C Every year	C Every two years C Every year	
C Every year	C Every six months	
C Every three months	© Every three months	
C Other, Describe	C Other, Describe Select type of benefit for Upgrades:	
	© Mandatory	
	O Optional	

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

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

Core Covered under Eye Exams Calegory 17a Indicate Coinsurance percentage for Medicare-covered Benefits: Select Maximum Enrollee Out-of-Pocket Cost type: Indicate Coinsurance percentage for Contact Lenses: Indicate Coinsurance percentage for Contact Lenses: Indicate Coinsurance percentage for Contact Lenses: Indicate Coinsurance percentage for Eye Glasses (Lenses and Frames)
Indicate Coinsurance percentage for Medicare-covered Benefits: Yes
Select the Maximum Enrollee Out-of-Pocket Cost type: Covered under Eye Exams Calegory 17a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost amount: Indicate Coinsurance percentage for Eye Glasses (Lenses and Frames): Select Maximum Enrollee Out-of-Pocket Cost amount: Indicate Coinsurance percentage for Eye Glass Lenses: Every three years Every two years Every two years Every two every year Every three months Other, Describe Is there an enrollee Coinsurance? Yes No Indicate Coinsurance percentage for Eye Glass Frames: Indicate Coinsurance percentage for Eye Glass Frames: Indicate Coinsurance percentage for Eye Glass Frames: Indicate Coinsurance percentage for Upgrades: Indicate Coinsurance percentage for Upgrades:
Select the Maximum Enrollee Out-of-Pocket Cost type: Covered under Eye Exams Category 17a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost amount: Indicate Coinsurance percentage for Eye Glasses (Lenses and Frames): Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every two years Every two years Every two pears Every three months Other, Describe Is there an enrollee Coinsurance? Yes Indicate Coinsurance percentage for Eye Glass Lenses: Indicate Coinsurance percentage for Eye Glass Frames:
Select the Maximum Enrollee Out-of-Pocket Cost type: Covered under Eye Exams Category 17a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every three years Every lives months Other, Describe Is there an enrollee Coinsurance? Yes Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact Lenses Eye Glass Farmes Indicate Coinsurance percentage for Eye Glass Farmes: Indicate Coinsurance percentage for Eye Glass Frames: Indicate Coinsurance percentage for Eye Glass Frames: Indicate Coinsurance percentage for Eye Glass Frames:
Covered under Eye Exams Category 17a Plan-specified amount per period Indicate Maximum Enrollee Dut-of-Pocket Cost amount: Select Maximum Enrollee Dut-of-Pocket Cost periodicity: Every three years Every three years Every three wisk months Other, Describe Indicate Coinsurance percentage for Eye Glass Lenses: Indicate Coinsurance percentage for Eye Glass Lenses: Indicate Coinsurance percentage for Eye Glass Lenses: Indicate Coinsurance percentage for Eye Glass Frames: Indicate Coinsurance percentage for Upgrades: Indicate Coinsurance percentage for Upgrades: Indicate Coinsurance percentage for Upgrades: Indicate Coinsurance percentage for Upgrades:
Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every two years Every three months Other, Describe Is there an enrollee Coinsurance? Yes No Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact Lenses Eye Glass (Lenses and Frames) Indicate Coinsurance percentage for Eye Glass Frames: Indicate Coinsurance percentage for Eye Glass Frames: Indicate Coinsurance percentage for Upgrades:
Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every two years Every year Every two pears Outhor, Describe Is there an enrollee Coinsurance? Yes No Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact Lenses Eye Glass Elenses Eye Glass Elenses Eye Glass Elenses Eye Glass Enroses
Select Maximum Enrollee Dut-of-Pocket Cost periodicity: C Every three years C Every two years C Every six months C Every three months Dither, Describe Is there an enrollee Coinsurance? Yes No Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits C Contact Lenses Eye Glass Lenses (Lenses and Frames) Eye Glass Frames
Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every was years C Every six months C Every six months C Other, Describe Is there an enrollee Coinsurance? Yes No Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits C Contact Lenses Eye Glass Frames) Eye Glass Frames Eye Glass Lenses Eye Glass Lenses Eye Glass Lenses Eye Glass Frames) Eye Glass Frames
Every three years Every two years Every six months Uther, Describe Is there an enrollee Coinsurance? Yes No Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact Lenses Eye Glasss Frames) Eye Glass Frames Indicate Coinsurance percentage for Eye Glass Frames: Indicate Coinsurance percentage for Upgrades:
Every three years Every two years Every six months Uther, Describe Is there an enrollee Coinsurance? Yes No Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact Lenses Eye Glass Frames) Eye Glass Frames Indicate Coinsurance percentage for Eye Glass Frames: Indicate Coinsurance percentage for Upgrades:
C Every two years C Every year C Every six months C Every three months C Other, Describe Is there an enrollee Coinsurance? Yes No Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits C Contact Lenses Eye Glasses (Lenses and Frames) Eye Glasses (Lenses and Frames) Eye Glasses Frames Eye Glasses Frames
C Every year C Every six months C Every three months C Other, Describe Is there an enrollee Coinsurance? Yes No Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits C Contact Lenses Eye Glasses (Lenses and Frames) Eye Glasses Frames Eye Glasses Frames Eye Glass Frames
C Every six months C Every three months Dither, Describe Is there an enrollee Coinsurance? Yes No Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits C Contact Lenses Eye Glasses (Lenses and Frames) Eye Glasses (Lenses and Frames) Eye Glass Frames Eye Glass Frames
Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact Lenses Eye Glasses (Lenses and Frames) Eye Glass Frames
Is there an enrollee Coinsurance? C Yes No Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact Lenses Eye Glasses (Lenses and Frames) Eye Glass Lenses Eye Glass Frames
Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact Lenses Eye Glasses (Lenses and Frames) Eye Glass Lenses Eye Glass Frames
Select which Eye Wear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact Lenses Eye Glasses (Lenses and Frames) Eye Glass Lenses Eye Glass Frames
apply): Medicare-covered Benefits Contact Lenses Eye Glasses (Lenses and Frames) Eye Glass Lenses Eye Glass Frames
☐ Eye Glasses (Lenses and Frames) ☐ Eye Glass Lenses ☐ Eye Glass Frames
☐ Eye Glass Lenses ☐ Eye Glass Frames
☐ Eye Glass Frames
□ Upgrades

Section B – 17B–Eye Wear–Base 5 Screen

File Help
<previous next="">> Exit (Validate) Exit (No Validate) Go To: #17b Eye Wear - Base 5</previous>
Is there an enrollee Deductible? Indicate Copayment amount for Eye Glasses (Lenses and Frames):
O Yes O No
Indicate Deductible Amount: Indicate Copayment amount for Eye Glass Lenses:
Is there an enrollee Copayment? Indicate Copayment amount for Eye Glass Frames:
© Yes
O No
Select which Eye Wear Benefits have a Copayment (Select all that apply): Indicate Copayment amount for Upgrades:
Medicare-covered Benefits
Contact Lenses Enrollee must receive Authorization from one or more of the following:
Lye Glasses (Lenses and Frames) None
☐ Eye Glass Lenses ☐ Primary Care Physician (Internist/Family Practice, General Practice) ☐ Eye Glass Frames ☐ Physician Specialist
Upgrades Organization Medical Director/Utilization Management/Utilization Review
□ Other describe
Indicate Copayment amount for Medicare-covered Benefits: Is a referral required for Eye Wear?
© Yes
Indicate Copayment amount for Contact Lenses:

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



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

🔛 PBP Data Entry System - Section B-18, Contract Z00	01, Plan 001, Segment 000	_ B ×
File Help		
< <pre><<pre>revious Next>> Exit (Validate) Exit (No Validate)</pre></pre>	Go To: #18a Hearing Exams - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select Routine Hearing Exams 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 Every year Every year	
December and the december of the second seconds.	C Every three months C Other, Describe	
Does the plan provide Hearing Exams Items as a supplemental benefit under Part C?	Select type of benefit for Fitting/Evaluation for Hearing Aid:	
C Yes C No	C Mandatory C Optional	
Select enhanced benefits: ☐ Routine Hearing Exams ☐ Fitting/Evaluation for Hearing Aid	Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	
Select type of benefit for Routine Hearing Exams:	 ○ Yes ○ No, indicate number 	
C Mandatory C Optional	Indicate number for Fitting/Evaluation for Hearing Aid:	
Is this benefit unlimited for Routine Hearing Exams? C Yes	Select Fitting/Evaluation for Hearing Aid periodicity:	
C No, indicate number	C Every three years	
Indicate number for Routine Hearing Exams:	C Every two years	
Trialcate number for Froduite Freating Exams.	© Every year	
	C Every six months C Every three months	
	O Other, Describe	

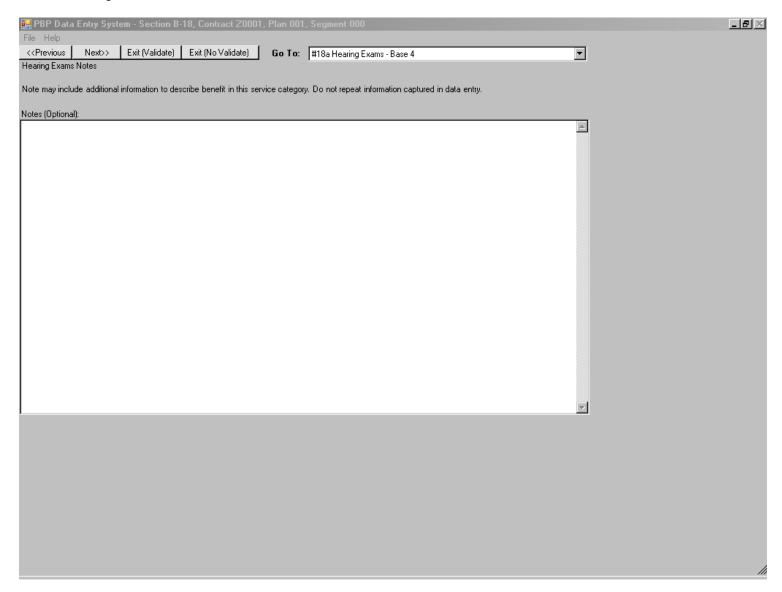
Section B – 18A–Hearing Exams–Base 2 Screen

🔛 PBP Data Entry System - Section B-18, Cor	ntract Z0001, Plan 001, Segment 000		_ & ×
File Help			
< <pre><<pre><<pre>c<pre>vious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (N</pre></pre></pre></pre>	lo Validate) Go To: #18a Hearing Exams	- Base 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	
O Yes	O Yes		
○ No	○ 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:	Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	
C In-network services only			
C Both In-network and Out-of-network services	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Minimum Coinsurance percentage for	
Indicate Maximum Plan Benefit Coverage amount:	© Every three years	Routine Hearing Exams:	
	C Every two years		
	C Every year		
Select the Maximum Plan Benefit Coverage	© Every six months	Indicate Maximum Coinsurance percentage for Routine Hearing Exams:	
periodicity:	C Every three months O Other, Describe	noutrie Healing Exams.	
C Every three years	Is there an enrollee Coinsurance?		
C Every two years		Indicate Minimum Coinsurance percentage for	
© Every year © Every six months	O Yes O No	Fitting/Evaluation for Hearing Aid:	
C Every three months	-		
O Other, Describe	Select which Hearing Exam Benefits have a Coinsurance (Select all that apply):		
	Medicare-covered Benefits	Indicate Maximum Coinsurance percentage for	
Is there an enrollee Deductible?	Routine Hearing Exams	Fitting/Evaluation for Hearing Aid:	
© Yes	Fitting/Evaluation for Hearing Aid		
○ No			
Indicate Deductible Amount:			
			//

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

🚂 PBP Data Entry System - Section B-18, Contract Z0001,	, Plan 001, Segment 000	_ B ×
File Help		
< <pre><<pre><<pre>evious Next>> Exit (Validate) Exit (No Validate)</pre></pre></pre>	Go To: #18a Hearing Exams - Base 3	▼
Is there an enrollee Copayment?	Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	
C Yes		
○ No		
Select which Hearing Exam Benefits have a Copayment(Select all	Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	
that apply): Medicare-covered Benefits		
Routine Hearing Exams		
Fitting/Evaluation for Hearing Aid		
Indicate Minimum Copayment amount for Medicare-covered	Enrollee must receive Authorization from one or more of the following:	
Benefits:	Primary Care Physician (Internist/Family Practice, General Practice)	
	Physician Specialist	
	Organization Medical Director/Utilization Management/Utilization Review	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	Other, describe	
DOTION.	Is a referral required for Hearing Exams?	
	C Yes	
Indicate Minimum Copayment amount for Routine Hearing Exams:	○ No	
ridicate Minimum Copayment amount for Houtine Healing Exams.		
Indicate Maximum Copayment amount for Routine Hearing Exams		
The state of the s		

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



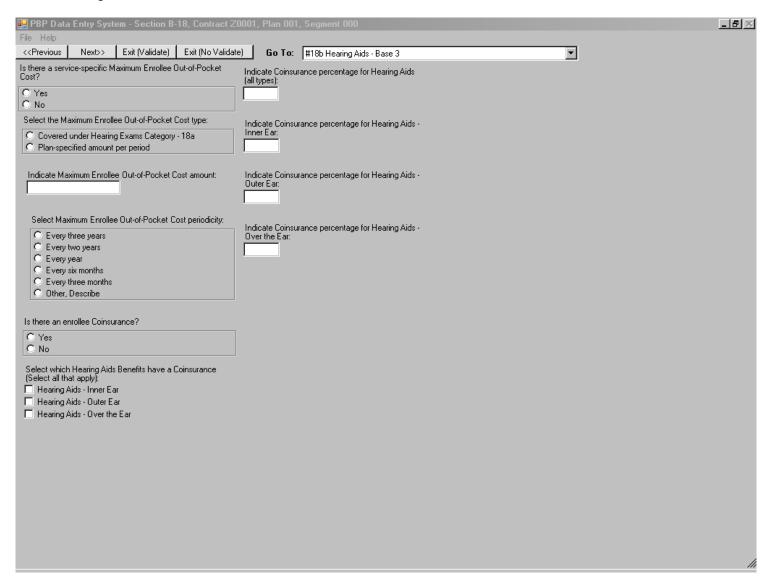
Section B – 18B–Hearing Aids–Base 1 Screen

🔛 PBP Data Entry System - Section B-18, Co	ntract Z0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre><<pre><<pre></pre></pre></pre>	NoValidate) GoTo : #18b Hearing Ai		
CLICK FOR DESCRIPTION OF BENEFIT	Select Hearing Aids (all types) periodicity:	Select Hearing Aids - Inner Ear periodicity:	
Does the plan provide Hearing Aids Items as a supplemental benefit under Part C? Yes No	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months Other, Describe	
Select enhanced benefits: Hearing Aids (all types)	Select type of benefit for Hearing Aids -	Select type of benefit for Hearing Aids - Duter Ear:	
Hearing Aids - Inner Ear Hearing Aids - Outer Ear	Inner Ear:	○ Mandatory ○ Optional	
☐ Hearing Aids - Over the Ear Select type of benefit for Hearing Aids (all types):	O Optional	Is this benefit unlimited for Hearing Aids - Outer Ear?	
C Mandatory	Is this benefit unlimited for Hearing Aids - Inner Ear?	O Yes O No, indicate number	
C Optional	O Yes O 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		
C Yes C No, indicate number	Ear:	Select Hearing Aids - Outer Ear periodicity: © Every three years	
Indicate quantity for Hearing Aids (all types):		C Every two years	
malcate quality for Freating Alas (all types).		C Every year C Every six months	
		C Every three months	
		Other, Describe	

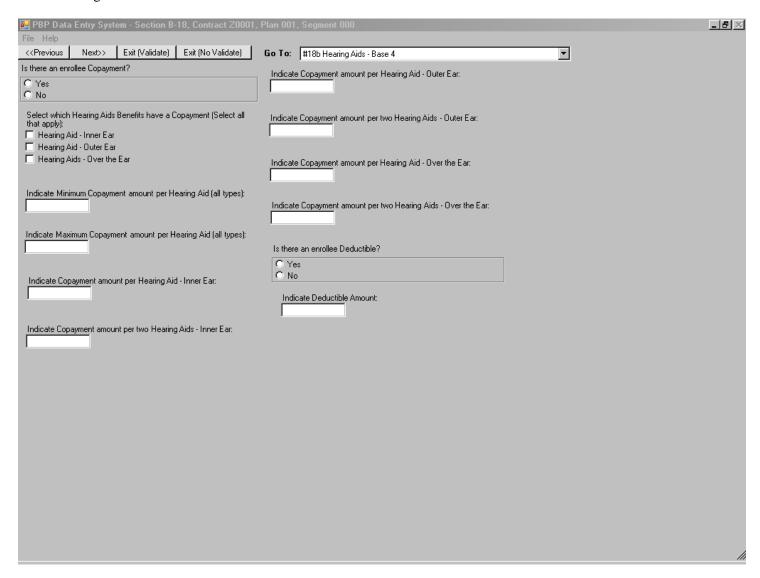
Section B – 18B–Hearing Aids–Base 2 Screen

🔛 PBP Data Entry System - Section B-18, Contract Z	20001, Plan 001, Segment 000	_ B ×
File Help		
< <pre><<pre>revious Next>> Exit (Validate) Exit (No Validate)</pre></pre>	te) 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:	
Mandatory Optional	C Covered under Hearing Exams Category - 18a C Plan-specified amount per period	
Is this benefit unlimited for Hearing Aids - Over the Ear? C Yes C No, indicate number Indicate quantity for Hearing Aids - Over the Ear:	Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services? C In-network services only C Both In-network and Out-of-network services Indicate Maximum Plan Benefit Coverage amount:	
Select Hearing Aids - Over the Ear periodicity:		
C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes No	Indicate Maximum Plan Benefit Coverage periodicity: © Every three years © Every two years © Every year © Every six months © Every three months © Other, Describe	

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

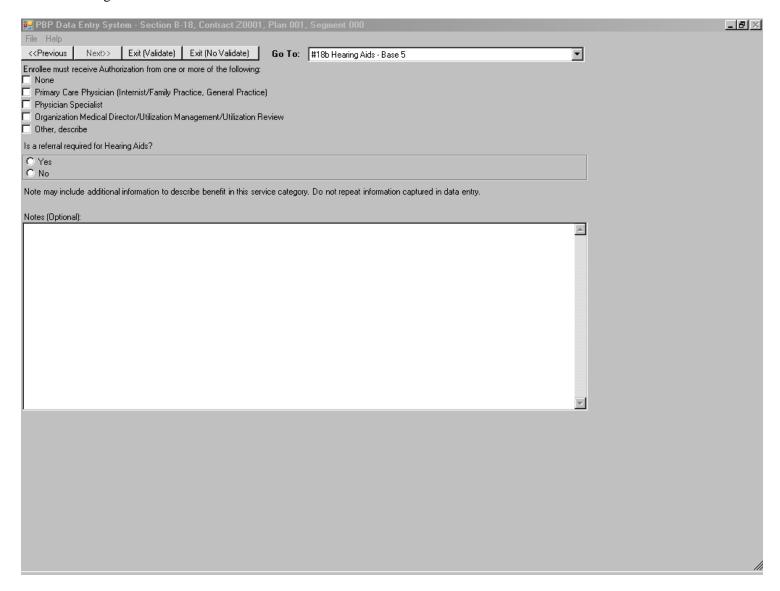


Section B – 18B–Hearing Aids–Base 4 Screen



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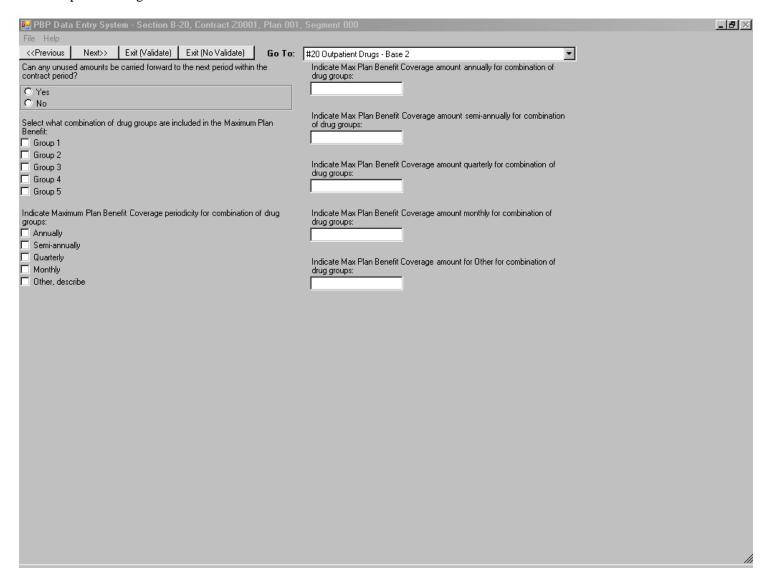
Section B – 18B–Hearing Aids–Base 5 Screen



Section B – 20–Outpatient Drugs–Base 1 Screen

🔐 PBP Data Entry System - Section B-20, C	ontract Z0001, Plan 001, Segment 000		_ B ×
File Help			
< <pre><<pre><<pre>revious</pre> <pre>Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit</pre></pre></pre>	(No Validate) Go To: #20 Outpatient	Drugs - Base 1 ▼	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a Maximum Plan Benefit Coverage amount for drugs?	Indicate Max Plan Benefit Coverage amount annually for drugs:	
Does the plan provide Outpatient Drugs Items as a supplemental benefit under Part C?	C Yes C No	Indicate Max Plan Benefit Coverage amount semi-annually for	
C Yes C No	Indicate type of Maximum Plan Benefit Coverage:	drugs:	
Select type of benefit:	Combination of drug groups	Indicate Max Plan Benefit Coverage amount quarterly for drugs:	
Mandatory 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 Coverage amount monthly for drugs:	
① 1 ② 2	C Yes C No	Indicate Max Plan Benefit Coverage amount for Other for drugs:	
© 3 © 4 © 5	Indicate Maximum Plan Benefit Coverage periodicity for drugs:		
	☐ Semi-annually		
	☐ Quarterly ☐ Monthly		
	Other, describe		

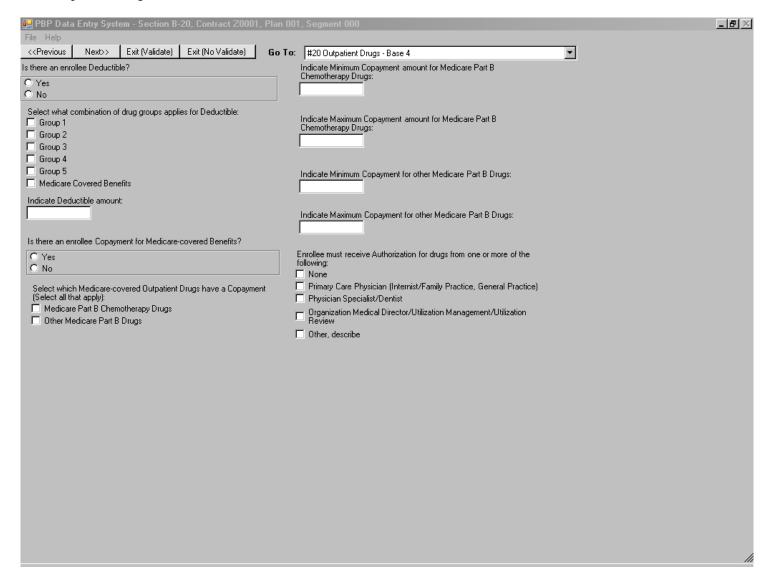
Section B – 20–Outpatient Drugs–Base 2 Screen



Section B – 20–Outpatient Drugs–Base 3 Screen

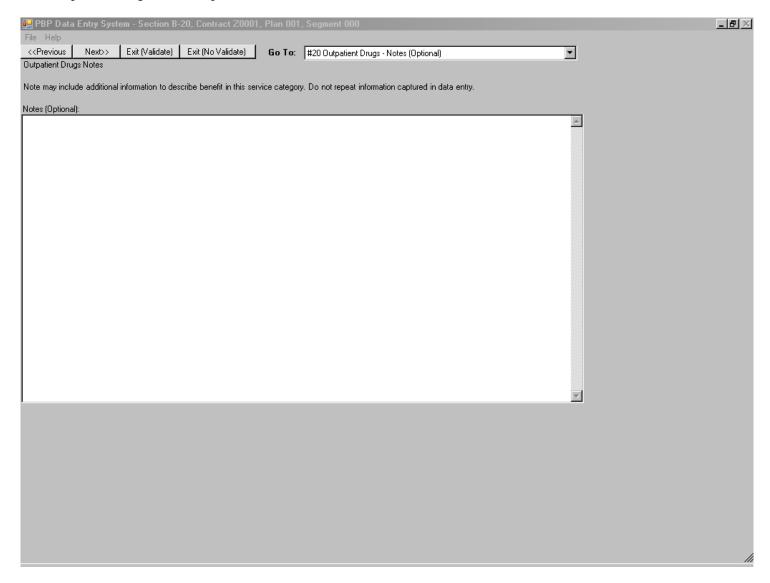
📴 PBP Data Entry System - Section B-20, Contract Z0001, Plan	001, Segment 000	_ (B) ×
File Help		
< <pre><<pre><<pre>revious</pre> Next>></pre> <pre>Exit (Validate)</pre> <pre>Exit (No Validate)</pre> <pre>Go</pre></pre>	To: #20 Outpatient Drugs - Base 3	-
Is a selected group unlimited after the combination 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	Is there an enrollee Coinsurance for Medicare-covered Benefits?	
Group 4	© Yes	
☐ Group 5	○ No	
Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available?	Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply): Medicare Part B Chemotherapy Drugs	
© Yes	Other Medicare Part B Drugs Indicate Minimum Coinsurance percentage for Medicare Part B	
O No	Chemotherapy Drugs:	
Is there a Maximum Enrollee Out-of-Pocket Cost?		
C Yes C 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	
Group 3	Drugs:	
☐ Group 4		
☐ Group 5 ☐ Medicare Covered Benefits	Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:	
	,	

Section B – 20–Outpatient Drugs–Base 4 Screen



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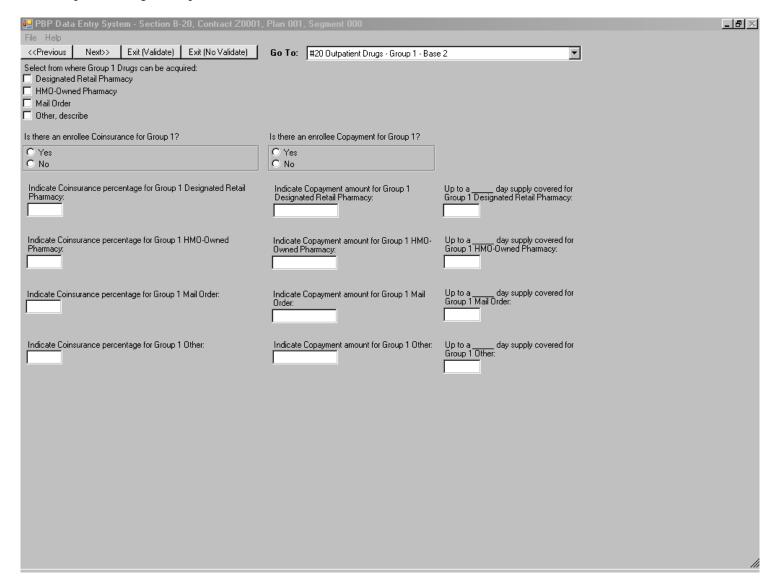
Section B – 20–Outpatient Drugs–Notes (Optional) Screen



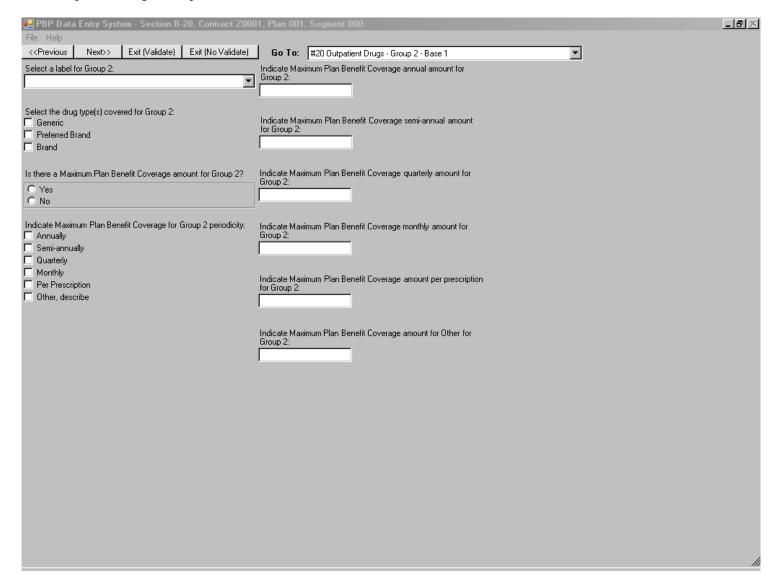
Section B – 20–Outpatient Drugs-Group 1–Base 1 Screen

🔛 PBP Data Entry System - Section B-20, Contract Z0001,	Plan 001, Segment 000	_ B ×
File Help		
< <pre><<pre><<pre> <pre></pre></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:	
	aroup r.	
Select the drug type(s) covered for Group 1:	Indicate Maximum Plan Benefit Coverage semi-annual amount	
☐ Generic	for Group 1:	
☐ Preferred Brand ☐ Brand		
Brand	Indicate Maximum Plan Benefit Coverage quarterly amount for	
	Group 1:	
Is there a Maximum Plan Benefit Coverage amount for Group 1?		
O Yes O 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 prescription for Group 1:	
☐ Monthly ☐ Per Prescription		
Other, describe		
	Indicate Maximum Plan Benefit Coverage amount for Other for	
	Group 1:	

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



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



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

🔛 PBP Data Entry System - Section B-20, Con	tract Z0001, Plan 001, Segment 000		_ <i>B</i> ×
File Help			
	o Validate) Go To: #20 Outpatient Drugs - Grou	up 2 - Base 2	
Select from where Group 2 Drugs can be acquired: Designated Retail Pharmacy			
☐ HMO-Owned Pharmacy			
Mail Order			
Other, describe			
Is there an enrollee Coinsurance for Group 2?			
C Yes	Is there an enrollee Copayment for Group 2?		
O Yes	O Yes O No		
<i>5</i> 110	♥ 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 HMD-Owned Pharmacy:	Indicate Copayment amount for Group 2 HMO- Owned Pharmacy:	Up to a day supply covered for Group 2 HMO-Owned Pharmacy:	
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:	
Indicate Coinsurance percentage for Group 2 for Other:	Indicate Copayment amount for Group 2 Other:	Up to a day supply covered for Group 2 Other:	
			//

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



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

🔛 PBP Data Entry System - Section B-20, Contract Z0			_ & ×
File Help			
< <pre><<pre><<pre></pre></pre></pre>	Go To: #20 Outpatient Drugs - Group 3 -	- Base 2	
Select from where Group 3 Drugs can be acquired:			
Designated Retail Pharmacy			
HMO-Owned Pharmacy			
Mail Order			
Other, describe			
Is there an enrollee Coinsurance for Group 3?	Is there an enrollee Copayment for Group 3?		
O Yes	C Yes		
○ 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:	
			li.

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

PBP Data Entry System - Section B-20, Contract Z000	01, Plan 001, Segment 000	_ B ×
File Help < <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 C 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	0001, Plan 001, Segment 000		_ B ×
File Help	_,		
< <pre><<pre><<pre>c<pre></pre></pre>Next>></pre></pre>	e) Go To: #20 Outpatient Drugs - Group 4 - E	Base 2	
Select from where Group 4 Drugs can be acquired:			
☐ Designated Retail Pharmacy ☐ HMO-Owned Pharmacy			
Mail Order			
Other, describe			
Is there an enrollee Coinsurance for Group 4?	Is there an enrollee Copayment for Group 4?		
O Yes	O Yes		
O No	C No		
Indicate Coinsurance percentage for Group 4 Designated Retail Pharmacy:	Indicate Copayment amount for Group 4 Designated Retail Pharmacy:	Up to a day supply covered for Group 4 Designated Retail Pharmacy:	
netali Frialillacy.	Designated Retail Pharmacy:	Group 4 Designated Retail Fharmacy:	
		<u> </u>	
Indicate Coinsurance percentage for Group 4 HMO-Owned	Indicate Copayment amount for Group 4 HMO-	Up to a day supply covered for	
Pharmacy:	Owned Pharmacy:	Up to a day supply covered for Group 4 HMO-Owned Pharmacy:	
Indicate Coinsurance percentage for Group 4 Mail Order:			
maicate consulance percentage for droup 4 Mail order.	Indicate Copayment amount for Group 4 Mail Order:	Up to a day supply covered for Group 4 Mail Order:	
	order.	aloup 4 Mail Glack	
	<u> </u>		
Indicate Coinsurance percentage for Group 4 Other:		He to a device on the device of the	
	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



Section B – 20–Outpatient Drugs-Group 5–Base 2 Screen

🔛 PBP Data Entry System - Section B-20, Contract Z0	0001, Plan 001, Segment 000		_ B ×
File Help			
Kertovious Next>> Exit (Validate) Exit (No Validate Select from where Group 5 Drugs can be acquired: Designated Retail Pharmacy HMO-Owned Pharmacy	B Go To: #20 Outpatient Drugs - Group 5	- Base 2 ▼	
Mail Order Other, describe			
Is there an enrollee Coinsurance for Group 5? C Yes No	Is there an enrollee Copayment for Group 5? Yes No		
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:	
Indicate Coinsurance percentage for Group 5 HMO- Owned Pharmacy:	Indicate Copayment amount for Group 5 HMO- Owned Pharmacy:	Up to aday 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:	
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–Home Infusion Bundled Services– Screen

