

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Additional Days  
 Non-Medicare-covered Stay  
 Upgrades

Select type of benefit for Additional Days:

Mandatory  
 Optional

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

Indicate number of Additional Days per benefit period:

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

Mandatory  
 Optional

Select type of benefit for Upgrades:

Mandatory  
 Optional

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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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 the Maximum Enrollee Out-of-Pocket Cost amount:

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

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

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

Is there an enrollee Coinsurance?

Yes  
 No

Medicare-covered Coinsurance Cost Sharing for Tier 1:

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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Medicare-covered Coinsurance Cost Sharing for Tier 2:  
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare-covered Coinsurance Cost Sharing for Tier 3:  
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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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:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

	Coinsurance %	Interval Days			Coinsurance %	Interval Days			Coinsurance %	Interval Days	
		Begin Day	End Day			Begin Day	End Day			Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Interval 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Interval 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Interval 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Interval 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Interval 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Interval 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)

One

Two

Three

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

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

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

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

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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

Yes  
 No

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

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Indicate Coinsurance percentage for Upgrades:

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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Go To: #1a Inpatient Hospital-Acute - Base 7

Medicare-covered Copayment Cost Sharing for Tier 1:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

\_\_\_\_\_

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90). 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: \_\_\_\_\_  
 Copayment Amt Interval 3: \_\_\_\_\_ Begin Day Interval 3: \_\_\_\_\_ End Day Interval 3: \_\_\_\_\_

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount for Tier 1:

\_\_\_\_\_

Indicate Deductible Amount for Tier 2:

\_\_\_\_\_

Indicate Deductible Amount for Tier 3:

\_\_\_\_\_

Is there an enrollee Copayment?

Yes  
 No

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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Medicare-covered Copayment Cost Sharing for Tier 2:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90). 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 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:	Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:	Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare-covered Copayment Cost Sharing for Tier 3:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90). 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 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:	Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:	Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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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:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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:	<input type="text"/>	<input type="text"/>	Interval 1:	<input type="text"/>	<input type="text"/>	Interval 1:	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>	Interval 2:	<input type="text"/>	<input type="text"/>	Interval 2:	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>	Interval 3:	<input type="text"/>	<input type="text"/>	Interval 3:	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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

Yes  
 No

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

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

Indicate Copayment amount for Upgrades per stay:

Indicate Copayment amount for Upgrades per day:

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 – 1B - Inpatient Hospital Psychiatric – Base 12 Screen

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 12

Is a referral required for Inpatient Hospital - Acute Services?

Yes

No

Inpatient Hospital - Acute Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

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

Yes  
 No

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

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

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage per stay:

Indicate the number of day intervals for the stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per stay:

Indicate the number of day intervals for the stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

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

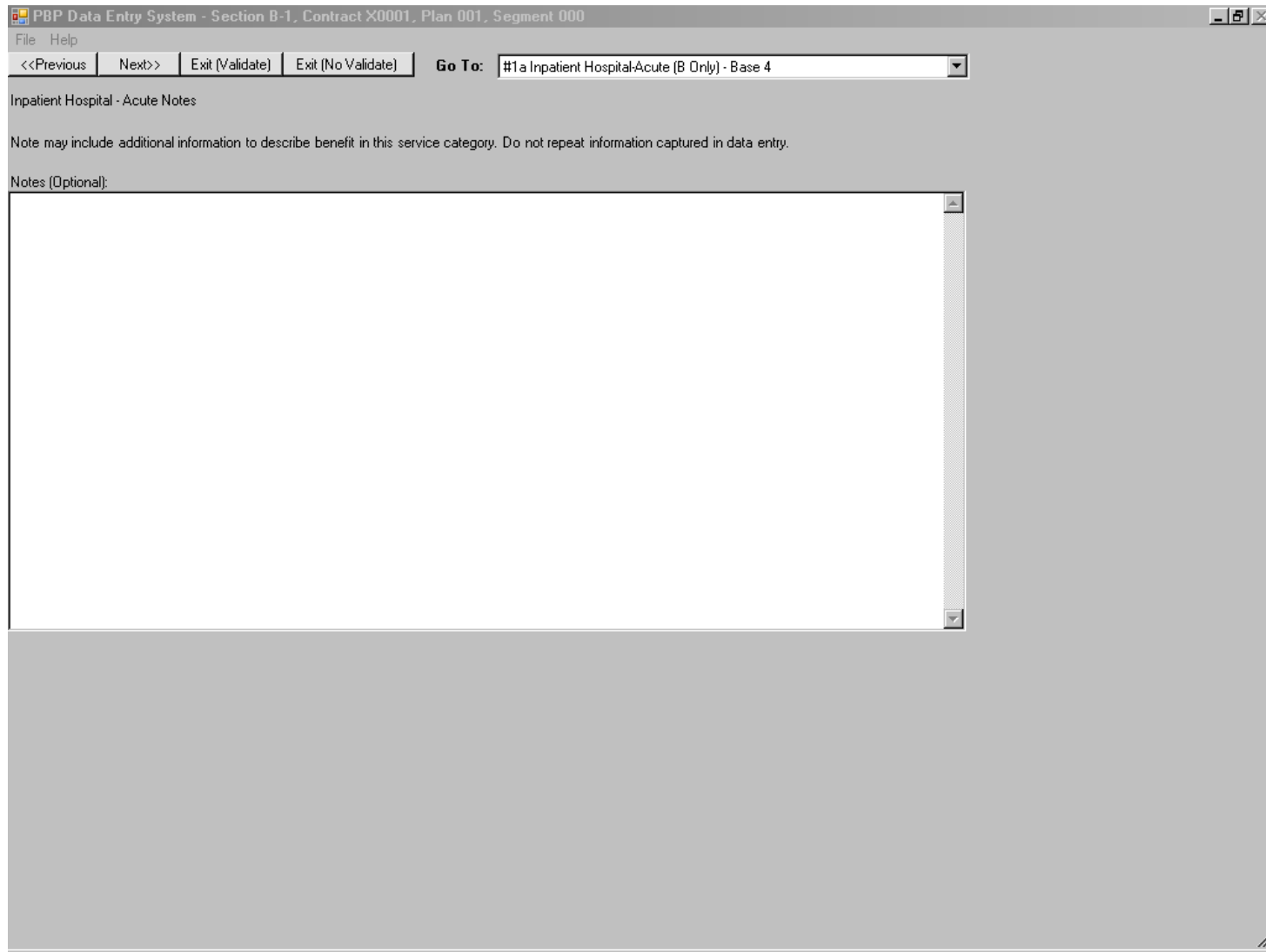
Enrollee must receive Authorization from one or more of the following:

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

Is a referral required for Inpatient Hospital - Acute Services?

Yes  
 No

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



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



PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Maximum Plan Benefit Coverage is not applicable for this Service Category

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Additional Days  
 Non-Medicare-covered Stay

Select type of benefit for Additional Days:

Mandatory  
 Optional

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

Indicate number of Additional Days per benefit period:

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

Mandatory  
 Optional

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

Yes  
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Medicare-covered Coinsurance Cost Sharing for Tier 1:

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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Medicare-covered Coinsurance Cost Sharing for Tier 2: Medicare-covered Coinsurance Cost Sharing for Tier 3:

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

Yes  No

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

Yes  No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

Zero (No Coinsurance per Day)  One  Two  Three

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

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

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 4 Screen

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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Medicare-covered Life Time Reserve Days Tier 1

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

	Coinsurance %	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare-covered Life Time Reserve Days Tier 2

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

	Coinsurance %	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare-covered Life Time Reserve Days Tier 3

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

	Coinsurance %	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

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<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 6

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

Yes  
 No

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

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

If you do not have a service-specific deductible for this benefit but offer a plan-specific, then enter the plan deductible in Section D.

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount for Tier 1:

Indicate Deductible Amount for Tier 2:

Indicate Deductible Amount for Tier 3:

Is there an enrollee Copayment?

Yes  
 No

Medicare-covered Copayment Cost Sharing for Tier 1:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90). For more information on cost share limitations please view the variable help.

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

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Medicare-covered Copayment Cost Sharing for Tier 2:

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

Yes  
 No

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

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90): 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 1:	Begin Day Interval 1:	End Day Interval 1:
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:	Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:	Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Medicare-covered Copayment Cost Sharing for Tier 3:

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

Yes  
 No

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

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.

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



PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

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:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Interval	Interval Days		
	Copay Amount	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Yes  
 No

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

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

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

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

Is a referral required for Inpatient Psychiatric Hospital Services?

Yes  
 No

Section B – 1B - Inpatient Hospital Psychiatric – Base 12 Screen

The screenshot shows a software window titled "PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000". The window contains a menu bar with "File" and "Help". Below the menu bar are navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". To the right of these buttons is a "Go To:" label followed by a dropdown menu currently displaying "#1b Inpatient Hospital Psychiatric - Base 12".

Below the navigation controls, the text "Inpatient Psychiatric Hospital Notes" is displayed. Underneath this, a note reads: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."

Further down, the text "Notes (Optional):" is shown above a large, empty text input area with a vertical scrollbar on the right side.

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer Inpatient Psychiatric Hospital Services as a benefit?

Yes  
 No

Select type of benefit for Inpatient Psychiatric Hospital Services:

Mandatory  
 Optional

Does this benefit have unlimited days?

Yes  
 No, indicate number

Indicate number of days per period:

Select the days periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

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

Yes  
 No

Select the Maximum Plan Benefit Coverage type:

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

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

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

Yes  
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage per stay:

Indicate the number of day intervals for the stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 4

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

Copayment Amt. Interval 1: Begin Day Interval 1: End Day Interval 1:

Copayment Amt. Interval 2: Begin Day Interval 2: End Day Interval 2:

Copayment Amt. Interval 3: Begin Day Interval 3: End Day Interval 3:

Is there an enrollee Deductible?

Yes

No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes

No

Indicate Copayment amount per stay:

Indicate the number of day intervals for the stay:

Zero (No Copayment per Day)

One

Two

Three

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

None

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

Physician Specialist

Organization Medical Director/Utilization Management/Utilization Review

Other, describe

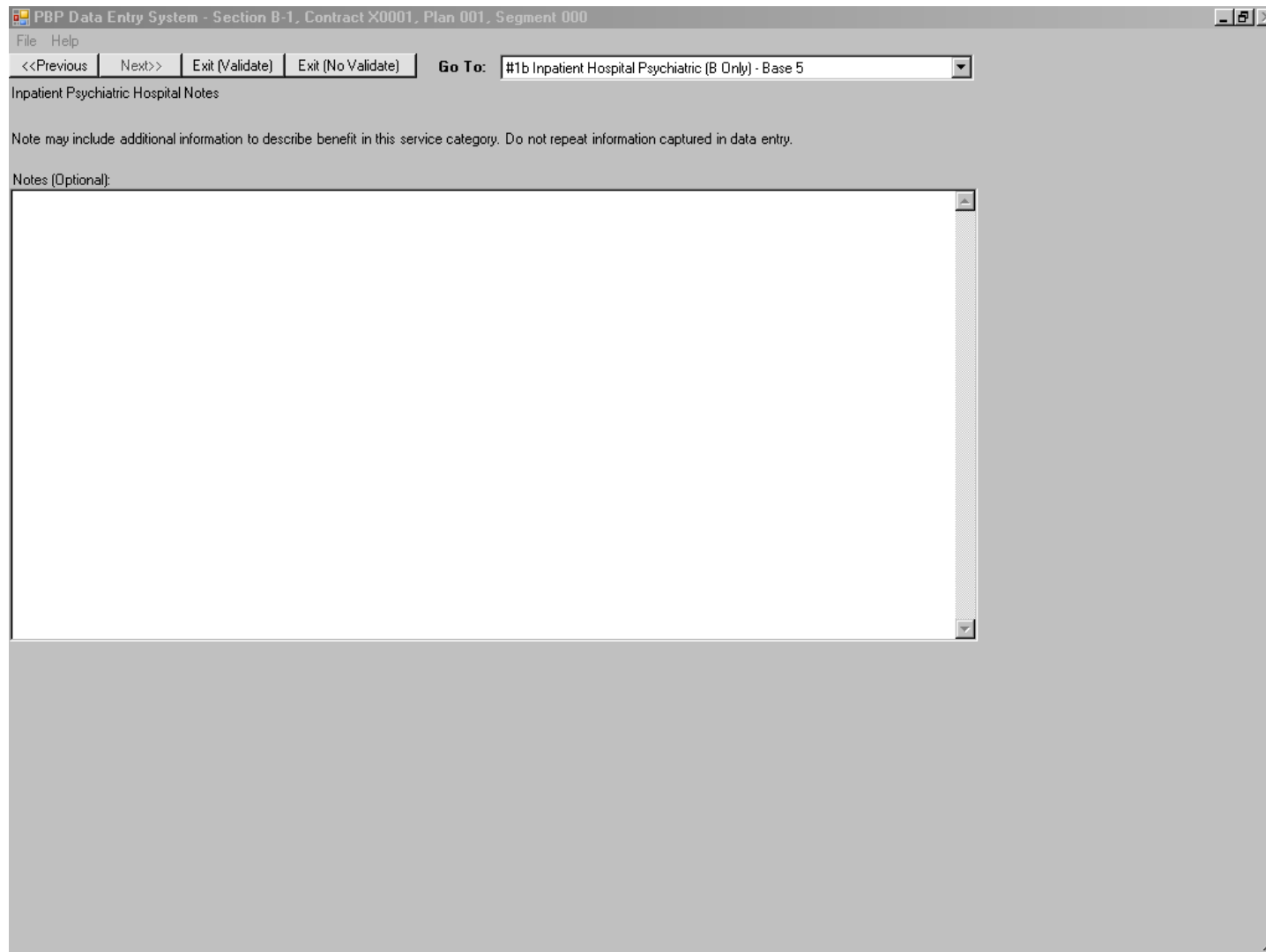
Is a referral required for Inpatient Psychiatric Hospital Services?

Yes

No

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





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

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Additional days beyond Medicare-covered  
 Non-Medicare-covered stay

Select type of benefit for Additional Days beyond Medicare-covered:

Mandatory  
 Optional

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

Indicate the number of Additional Days beyond Medicare-covered per benefit period.

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

Mandatory  
 Optional

Do you allow less than 3 day inpatient hospital stay prior to SNF admission?

Yes  
 No

Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):

Zero  
 One  
 Two

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

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

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #2 SNF - Base 2

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Stay  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for Medicare-covered stay (e.g.: 1 to 20; 21 to 100):

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF - Base 3

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for Additional Days  
(enter "999" if unlimited days are offered; e.g., 101 to 999):

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF - Base 4

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

Yes  
 No

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

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF - Base 5

Is there an enrollee Copayment?

Yes  
 No

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

Yes  
 No

Indicate Copayment amount for Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g.: 1 to 20; 21 to 100). 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:

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

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999):

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

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

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

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

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF - Base 6

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

Yes  
 No

Indicate Copayment amount for Non-Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

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

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

Is a referral required for SNF Services?

Yes  
 No

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



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



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

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

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

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

Yes  
 No

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

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

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Stay  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage:

Indicate the number of day intervals for the stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1: <input type="text"/>	Begin Day Interval 1: <input type="text"/>	End Day Interval 1: <input type="text"/>
Coinsurance % Interval 2: <input type="text"/>	Begin Day Interval 2: <input type="text"/>	End Day Interval 2: <input type="text"/>
Coinsurance % Interval 3: <input type="text"/>	Begin Day Interval 3: <input type="text"/>	End Day Interval 3: <input type="text"/>

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

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

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF (B Only) - Base 4

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

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

Is a referral required for SNF Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

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

Select type of benefit for Additional Cardiac Rehabilitation Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Cardiac Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Cardiac Rehabilitation Services:

Select the Additional Cardiac Rehabilitation Services periodicity:

Every 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:

Mandatory  
 Optional

Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Intensive Cardiac Rehabilitation Services:

Select the Additional Intensive Cardiac Rehabilitation Services periodicity:

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

Is this benefit unlimited for Additional Pulmonary Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Pulmonary Rehabilitation Services:

Select the Additional Pulmonary Rehabilitation Services periodicity:

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

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

PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 2

Maximum Plan Benefit Coverage is not applicable for this Service Category

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 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.

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Cardiac and Pulmonary Rehabilitation Services have a Coinsurance (Select all that apply):

- Medicare-covered Cardiac Rehabilitation Services
- Medicare-covered Intensive Cardiac Rehabilitation Services
- Medicare-covered Pulmonary Rehabilitation Services
- Additional Cardiac Rehabilitation Services
- Additional Intensive Cardiac Rehabilitation Services
- Additional Pulmonary Rehabilitation Services

	Minimum Coinsurance	Maximum Coinsurance
Indicate Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Additional Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Additional Pulmonary Rehabilitation Services:	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 3

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):

Medicare-covered Cardiac Rehabilitation Services  
 Medicare-covered Intensive Cardiac Rehabilitation Services  
 Medicare-covered Pulmonary Rehabilitation Services  
 Additional Cardiac Rehabilitation Services  
 Additional Intensive Cardiac Rehabilitation Services  
 Additional Pulmonary Rehabilitation Services

	Minimum Copayment	Maximum Copayment
Indicate Copayment amount for Medicare-covered Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Copayment amount for Medicare-covered Intensive Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Copayment amount for Additional Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Copayment amount for Additional Intensive Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 4

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

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

Cardiac and Pulmonary Rehabilitation Programs Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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



PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4a Emergency Care - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4a Emergency Care - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?

Yes  
 No

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

Days  
 Hours

Enter number of Days or Hours:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit [Validate] Exit [No Validate] Go To: #4a Emergency Care - Base 3

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?

Yes  
 No

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

Days  
 Hours

Enter number of Days or Hours:

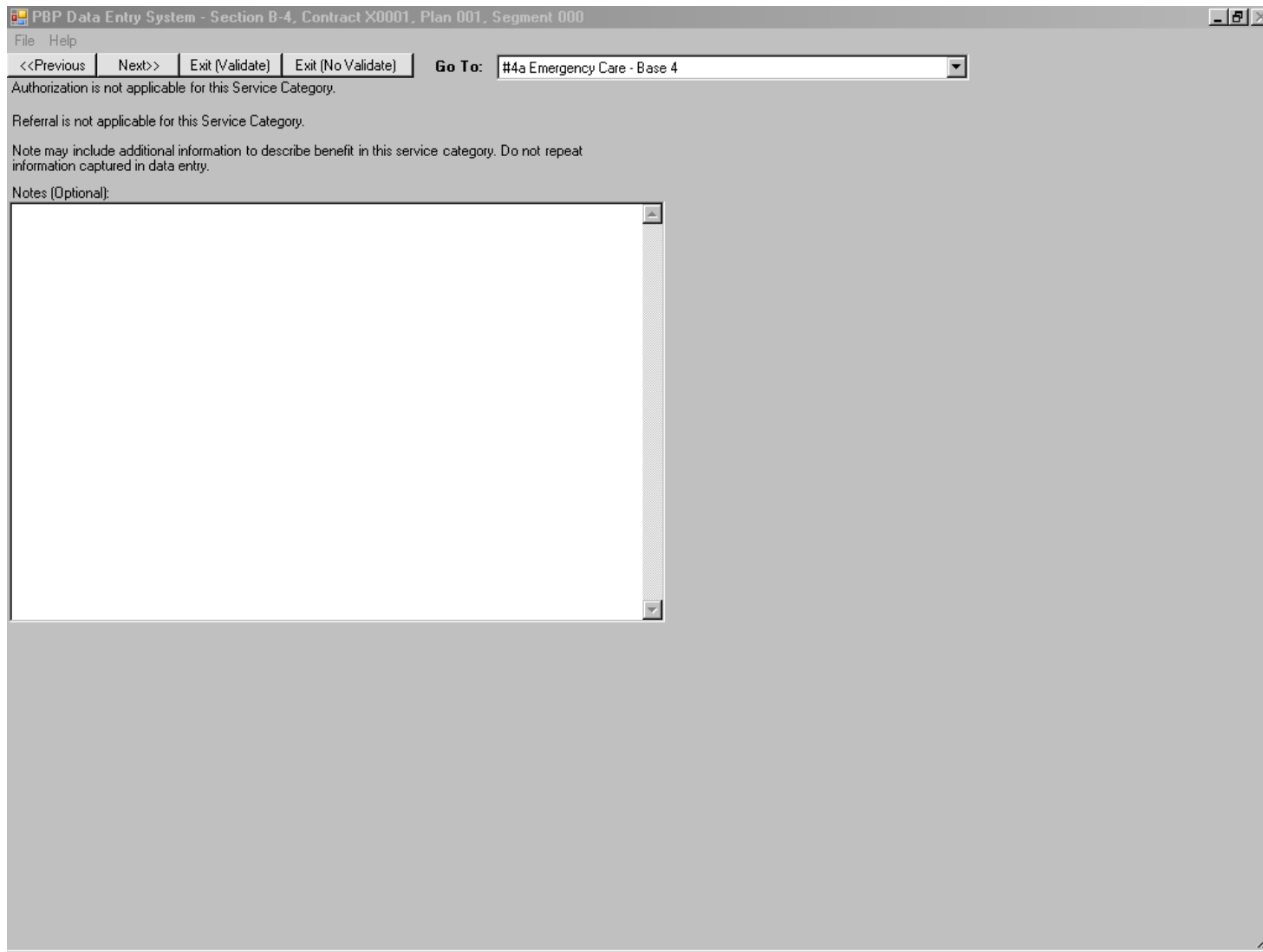
Does ER cost sharing count towards any plan-level deductibles?

Yes  
 No

Indicate the plan-level deductibles where ER cost sharing counts:

In-Network only  
 Out-of-Network only  
 Combined (In-Network and Out-of-Network)

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



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

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #4b Urgently Needed Care - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Yes  
 No

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

Covered under Emergency Care Service Category 4a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits

Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?

Yes  
 No

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

Days  
 Hours

Enter number of Days or Hours:

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

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4b Urgently Needed Care - Base 2

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[Text Box]

Is there an enrollee Copayment?  
 Yes  
 No

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

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

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

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

Enter number of Days or Hours:  
[Text Box]

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

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4b Urgently Needed Care - Base 3

Authorization is not applicable for this Service Category.

Referral is not applicable for this Service Category.

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

If you have entered a range of cost sharing, you must describe the reason for this range.

Notes (Optional):

[Empty text area with scrollbars]

Section B – 4C – Worldwide Coverage – Base 1

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next> Exit (Validate) Exit (No Validate) Go To: #4c Worldwide Coverage - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Emergency Care Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Worldwide Coverage

Select type of benefit for Worldwide Coverage:

Mandatory  
 Optional

Is there a Maximum Plan Benefit Coverage amount for Worldwide Coverage?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

\_\_\_\_\_

Select the Maximum Plan Benefit Coverage periodicity:

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

\_\_\_\_\_

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Section B – 4C – Worldwide Coverage – Base 2



PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4c Worldwide Coverage - Base 2

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount for Worldwide Coverage:  
[ ]

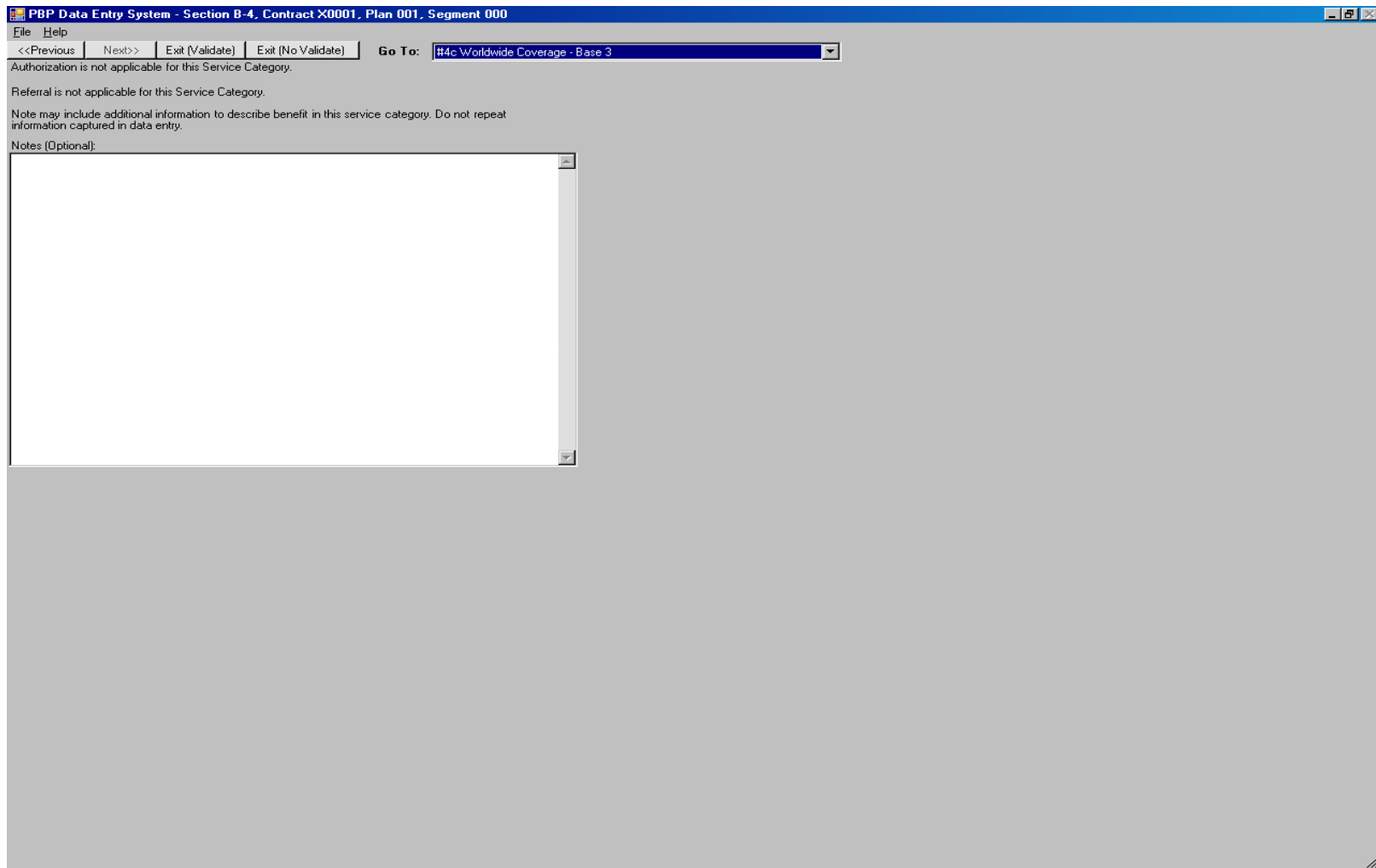
Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage for Worldwide Coverage:  
[ ]

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

Section B – 4C – Worldwide Coverage – Base 3



Section B – 5 – Partial Hospitalization – Base 1 Screen

PBP Data Entry System - Section B-5, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #5 Partial Hospitalization - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Section B – 5 – Partial Hospitalization – Base 2 Screen

PBP Data Entry System - Section B-5, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #5 Partial Hospitalization - Base 2

Is there an enrollee Copayment?

Yes

No

Indicate Copayment amount for Medicare-covered Benefits per day:

\_\_\_\_\_

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

None

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

Physician Specialist

Organization Medical Director/Utilization Management/Utilization Review

Other, describe

Is a referral required for Partial Hospitalization?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

\_\_\_\_\_

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

PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #6 Home Health Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

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

PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #6 Home Health Services - Base 2

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:

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

The screenshot shows a software window titled "PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help". Below the menu bar are navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "#6 Home Health Services - Base 3".

The main content area contains the following sections:

- Enrollee must receive Authorization from one or more of the following:**
  - None
  - Primary Care Physician (Internist/Family Practice, General Practice)
  - Physician Specialist
  - Organization Medical Director/Utilization Management/Utilization Review
  - Other, describe
- Is a referral required for Home Health Services?**
  - Yes
  - No
- Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.**
- Notes (Optional):** A large, empty text area with a scroll bar.

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

**PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #6 Home Health Services - MMP Services Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide non-Medicare Home Health Services?

Yes  
 No

Select Non-Medicare Home Health Services:

Additional hours of care  
 Personal Care Services  
 Other 1  
 Other 2

Enter name of Other 1 Service:  
\_\_\_\_\_

Enter name of Other 2 Service:  
\_\_\_\_\_

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

Yes  
 No

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

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Select which Non-Medicare Home Health Services have a Coinsurance (select that apply):

Additional hours of care  
 Personal Care Services  
 Other 1  
 Other 2

Indicate coinsurance percentage for one or more of the following services:	Minimum Coinsurance	Maximum Coinsurance
Additional hours of care	_____	_____
Personal Care Service	_____	_____
Other 1	_____	_____
Other 2	_____	_____

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



**PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #6 Home Health Services - MMP Services Base 2

Is there an enrollee Copayment?

Yes  
 No

Select which Non-Medicare Home Health Services have a Copayment (select all that apply):

Additional hours of care  
 Personal Care Services  
 Other 1  
 Other 2

Indicate copayment percentage for one or more of the following services:

	Minimum Copayment	Maximum Copayment
Additional hours of care	<input type="text"/>	<input type="text"/>
Personal Care Service	<input type="text"/>	<input type="text"/>
Other 1	<input type="text"/>	<input type="text"/>
Other 2	<input type="text"/>	<input type="text"/>

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

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

Is a referral required for Services?

Yes  
 No

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7a Primary Care Physician Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

Is there an enrollee Coinsurance?

Yes  
 No

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

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

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

Yes  
 No

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

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

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

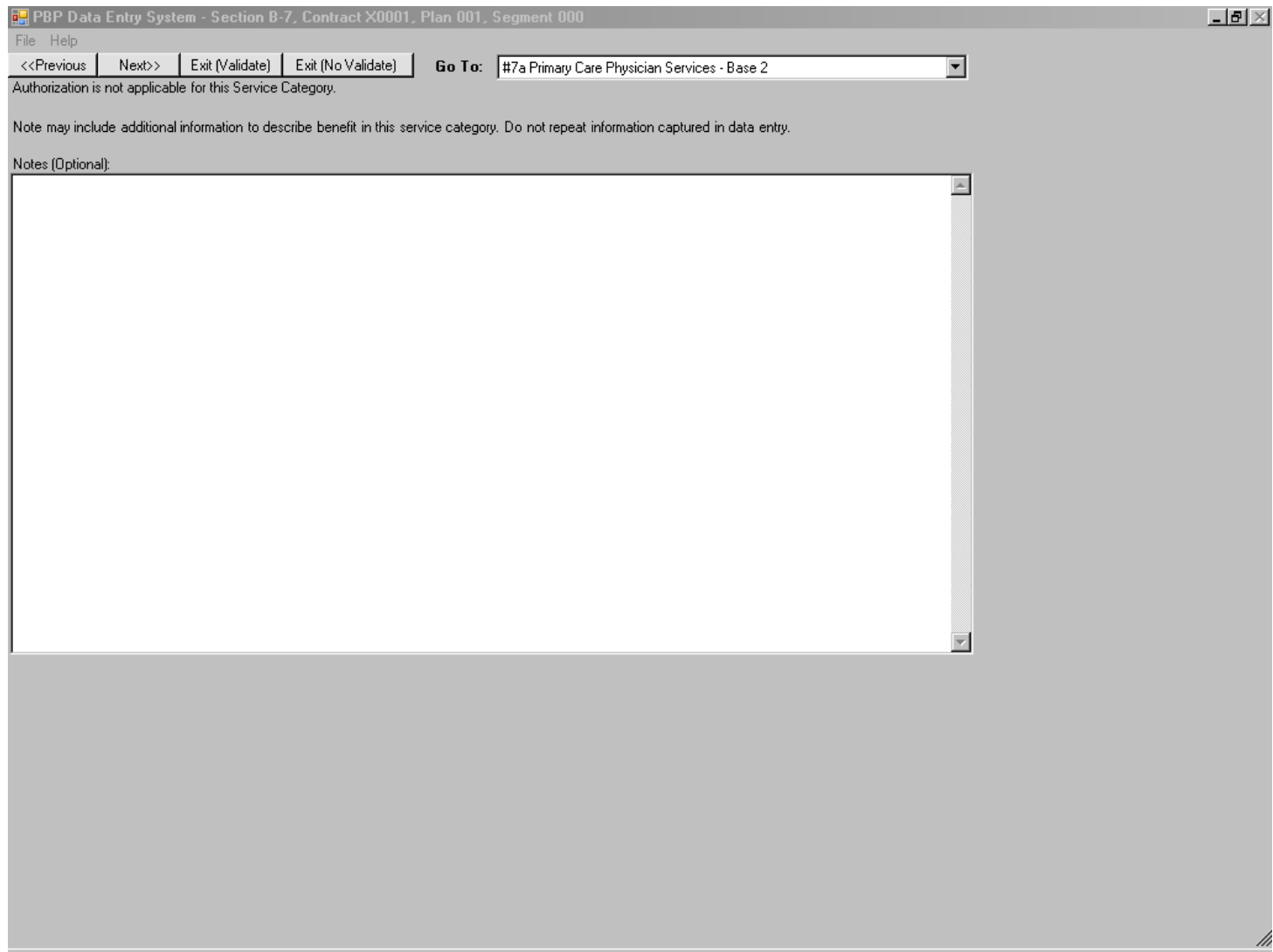
Is there an enrollee Copayment?

Yes  
 No

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

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

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



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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

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

**CLICK FOR DESCRIPTION OF BENEFIT**

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:  
 Routine Care

Select type of benefit for Routine Care:  
 Mandatory  
 Optional

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

Indicate number of visits for Routine Care:

Select Routine Care periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Coinsurance?

Yes  
 No

Select which Chiropractic Services have a Coinsurance (Select all that apply):

Medicare-covered Chiropractic Services  
 Routine Care

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

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

Indicate the Minimum Coinsurance percentage per visit for Routine Care:

Indicate the Maximum Coinsurance percentage per visit for Routine Care:

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?

Yes  
 No

Select which Chiropractic Services have a Copayment (Select all that apply):

Medicare-covered Chiropractic Services  
 Routine Care

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

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

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

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

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

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

Is a referral required for Chiropractic Services?

Yes  
 No

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

The screenshot shows a software window titled "PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000". The window has a menu bar with "File" and "Help". Below the menu bar are navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". To the right of these buttons is a "Go To:" label followed by a dropdown menu currently displaying "#7b Chiropractic Services - Base 4".

Below the navigation controls is the heading "Chiropractic Services Notes". Underneath this heading is a line of instructional text: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."

Below the instructional text is the label "Notes (Optional):" followed by a large, empty text area with a vertical scrollbar on the right side, intended for entering notes.

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7c Occupational Therapy Services - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Enhanced Benefits are not applicable for this Service Category.

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

Do you apply the Medicare coverage limit?

Yes  
 No

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage per visit for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per visit for Medicare-covered Benefits:

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



PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7c Occupational Therapy Services - Base 2

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

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

Is a referral required for Occupational Therapy Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

**PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7c Occupational Therapy Services - MMP Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide non-Medicare Occupational Therapy Services?

Yes  
 No

Enter name of Non-Medicare Occupational Therapy Service:

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

Yes  
 No

Indicate Maximum Plan Benefit Cost amount

Select Maximum Plan Benefit Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance Percentage:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment Amount:

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

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

Is a referral required for services?

Yes  
 No

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7d Physician Specialist Services - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7d Physician Specialist Services - Base 2

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

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

Is a referral required for Physician Specialist Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Empty text area for notes]

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7e Mental Health Specialty Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7e Mental Health Specialty Services - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

Select which Mental Health Specialty Services have a Coinsurance (Select all that apply):

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

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

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

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

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

Is there an enrollee Copayment?

Yes  
 No

Select which Mental Health Specialty Services have a Copayment (Select all that apply):

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

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

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

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

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next> Exit (Validate) Exit (No Validate) Go To: #7e Mental Health Specialty Services - Base 3

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

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

Is a referral required for Mental Health Specialty Services - Non-Physician?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Empty text area for notes]

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

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

**CLICK FOR DESCRIPTION OF BENEFIT**

Does the plan provide Podiatry Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Routine Footcare

Select type of benefit for Routine Footcare:

Mandatory  
 Optional

Is this benefit unlimited for Routine Footcare?

Yes  
 No

Indicate number of Routine Footcare visits:

Select the Routine Footcare periodicity:

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

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

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



PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Podiatry Services have a Coinsurance (Select all that apply):  
 Medicare-covered Podiatry Services  
 Routine Footcare

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Footcare:

Indicate Maximum Coinsurance percentage for Routine Footcare:

Is there an enrollee Copayment?  
 Yes  
 No

Select which Podiatry Services have a Copayment (Select all that apply):  
 Medicare-covered Podiatry Services  
 Routine Footcare

Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:

Indicate Minimum Copayment amount per visit for Routine Footcare:

Indicate Maximum Copayment amount per visit for Routine Footcare:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

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

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

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

Is a referral required for Podiatrist Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7g Other Health Care Professional - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7g Other Health Care Professional - Base 2

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

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

Is a referral required for Other Health Care Professional Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7h Psychiatric Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Coinsurance?

Yes  
 No

Select which Psychiatric Services have a Coinsurance (Select all that apply):

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

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

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

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

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

Is there an enrollee Copayment?

Yes  
 No

Select which Psychiatric Services have a Copayment (Select all that apply):

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

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

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

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

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

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

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7h Psychiatric Services - Base 3

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

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

Is a referral required for Psychiatric Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

Section B – 71 – Physical Therapy and Speech Language Pathology Services – Base 1 Screen

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #71 PT and SP Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

You must include total cost sharing to the beneficiary, including any facility cost sharing.

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage per visit for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per visit for Medicare-covered Benefits:

Section B – 71 – Physical Therapy and Speech Language Pathology Services – Base 2 Screen



PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #71 PT and SP Services - Base 2

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

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

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

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

Section B – 71 – Physical Therapy and Speech Language Pathology Services – MMP Services – Base 1 Screen

**PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous    Next>>    Exit (Validate)    Exit (No Validate)    Go To: #71 PT and ST - MMP Services - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Does this plan provide non-Medicare Physical and/or Speech Therapy services?

Yes  
 No

Select non-Medicare Physical and/or Speech Therapy Services

Other 1  
 Other 2

Enter name of Other 1 Service:  
\_\_\_\_\_

Enter name of Other 2 Service:  
\_\_\_\_\_

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

Yes  
 No

Indicate Maximum Plan Benefit Cost amount  
\_\_\_\_\_

Is there an enrollee Coinsurance?

Yes  
 No

Select which Non-Medicare Home Health Services have a Coinsurance (select all that apply):

Other 1  
 Other 2

Indicate coinsurance percentage for one or more of the following services:	Minimum Coinsurance	Maximum Coinsurance
Other 1	_____	_____
Other 2	_____	_____

Select Maximum Plan Benefit Cost periodicity:

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

Section B – 71 – Physical Therapy and Speech Language Pathology Services – MMP Services – Base 2 Screen

**PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous    Next>>    Exit (Validate)    Exit (No Validate)    Go To: #71 PT and ST - MMP Services - Base 2

Is there an enrollee Copayment?  
 Yes  
 No

Select which Non-Medicare Home Health Services have a Copayment (select all that apply):  
 Other 1  
 Other 2

Indicate copayment percentage for one or more of the following services:

	Minimum Copayment	Maximum Copayment
Other 1	<input type="text"/>	<input type="text"/>
Other 2	<input type="text"/>	<input type="text"/>

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Services?  
 Yes  
 No

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

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 2

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Indicate Minimum Coinsurance percentage for Medicare-covered Lab Services

Is there an enrollee Coinsurance?

Yes

No

Indicate Maximum Coinsurance percentage for Medicare-covered Lab Services

Select which Outpatient Diag Procs/Tests/Lab Services have a Coinsurance (Select all that apply):

Medicare-covered Diagnostic Procedures/Tests

Medicare-covered Lab Services

Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests:

Indicate Maximum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests:

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

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 3

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?

Yes  
 No

Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):

Medicare-covered Diagnostic Procedures/Tests  
 Medicare-covered Lab Services

Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:  
[ ]

Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:  
[ ]

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

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

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

Sometimes, describe  
 No

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

Yes  
 No

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

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

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

Yes  
 No

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

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

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

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 4

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

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

Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Enter Notes for Medicare-covered Diagnostic Procedures/Tests (Optional):

Enter Notes for Medicare-covered Lab Services (Optional):

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

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Select which Outpatient Diag/Therapeutic Rad Services have a Coinsurance (Select all that apply):

Medicare-covered X-Ray Services  
 Medicare-covered Diagnostic Radiological Services  
 Medicare-covered Therapeutic Radiological Services

Indicate Minimum Coinsurance percentage for Medicare-covered X-Ray Services:

Indicate Maximum Coinsurance percentage for Medicare-covered X-Ray Services:

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

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

Indicate Minimum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services:

Indicate Maximum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services:



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

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 2

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

Select which Outpatient Diag/Theapeutic Rad Services have a Copayment (Select all that apply):  
 Medicare-covered X-Ray Services  
 Medicare-covered Diagnostic Radiological Services  
 Medicare-covered Therapeutic Radiological Services

Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:  
[ ]

Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:  
[ ]

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

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

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

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

Indicate whether a separate physician/professional service cost share applies:  
 Sometimes, describe [ ]  
 No

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

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

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

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

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

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

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

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 3

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

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

Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?

Yes

No

Outpatient Diagnostic and Therapeutic Radiological Services Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Enter Notes for Medicare-covered X-Ray Services (Optional):

Enter Notes for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.) (Optional):

Enter Notes for Medicare-covered Therapeutic Radiological Services (Optional):

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

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

\_\_\_\_\_

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 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.

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

\_\_\_\_\_

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

\_\_\_\_\_

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

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9a Outpatient Hospital Services - Base 2

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?

Yes  
 No

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

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

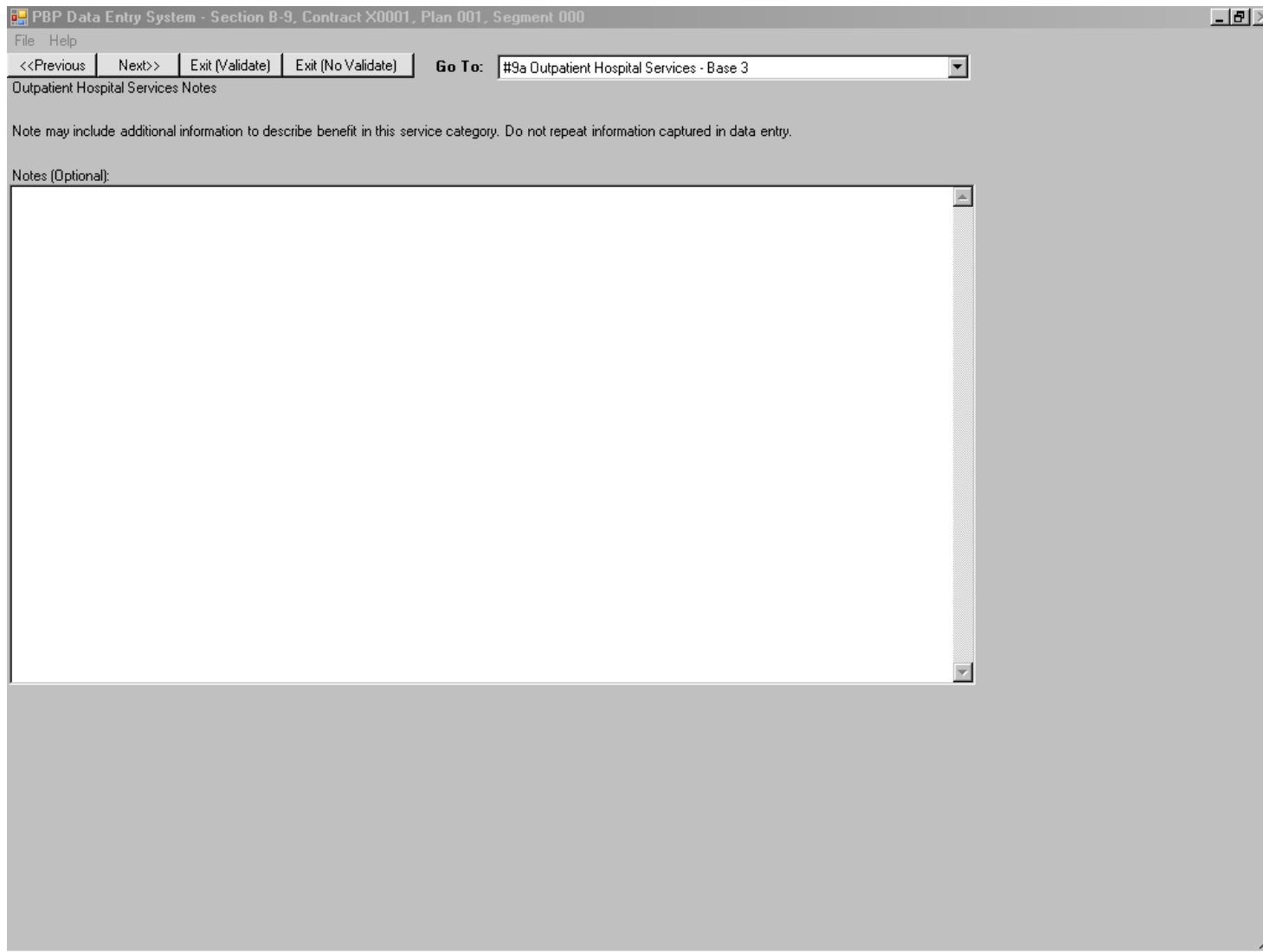
Enrollee must receive Authorization from one or more of the following:

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

Is a referral required for Outpatient Hospital Services?

Yes  
 No

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



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

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9b ASC Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

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

Covered under Outpatient Hospital Services Category 9a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

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

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9b ASC Services - Base 2

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

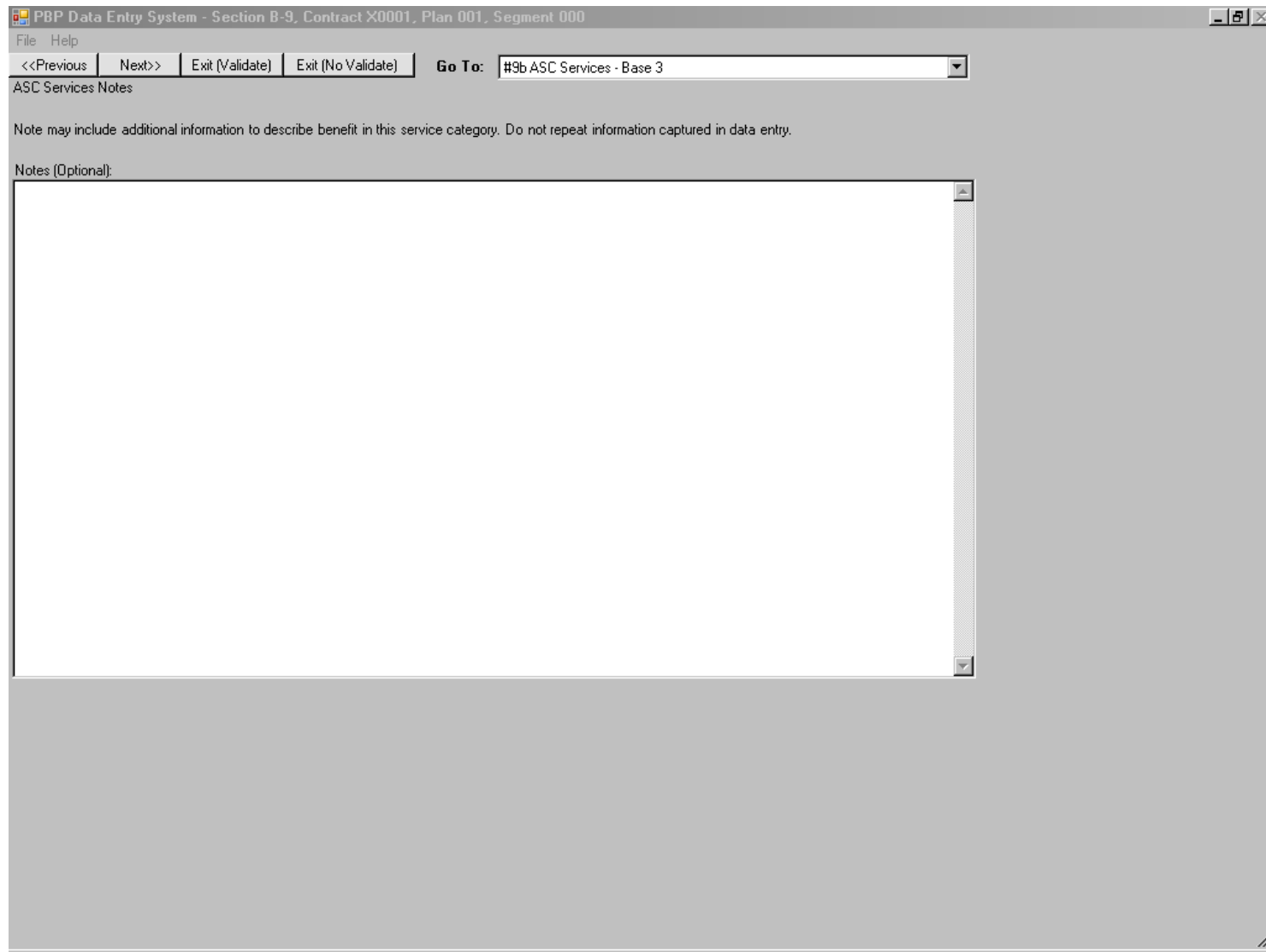
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:  
[ ]

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

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Ambulatory Surgical Center Services?  
 Yes  
 No

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



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



PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9c Outpatient Substance Abuse - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

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

Covered under Outpatient Hospital Services Category 9a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9c Outpatient Substance Abuse - Base 2

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Select which Outpatient Substance Abuse Services have a Coinsurance (Select all that apply):

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate minimum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:

Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Select which Outpatient Substance Abuse Services have a Copayment (Select all that apply):

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate maximum Copayment amount for Medicare-covered Individual Sessions:

Indicate minimum Copayment amount for Medicare-covered Group Sessions:

Indicate maximum Copayment amount for Medicare-covered Group Sessions:

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

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9c Outpatient Substance Abuse - Base 3

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

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

Is a referral required for Outpatient Substance Abuse Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9d Outpatient Blood Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Three (3) pint deductible waived

Select type of benefit for Three (3) Pint Deductible Waived:

Mandatory  
 Optional

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage per unit for Medicare-covered Benefits:

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

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9d Outpatient Blood Services - Base 2

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per unit for Medicare-covered Benefits:

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

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

Is a referral required for Outpatient Blood Services?

Yes  
 No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #10a Ambulance Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

Is there an enrollee Coinsurance?

Yes  
 No

Is there an enrollee Copayment?

Yes  
 No

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

Yes  
 No

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Copayment amount for Medicare-covered Benefits:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is this Coinsurance waived if admitted to hospital?

Yes  
 No

Is this Copayment waived if admitted to hospital?

Yes  
 No

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #10a Ambulance Services - Base 2

Enrollee must receive Authorization for non-emergency Medicare services from one or more of the following:

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

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #10b Transportation Services - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Does the plan provide Transportation Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Plan-approved Location  
 Any Location

Select type of benefit for Plan-approved Location:

Mandatory  
 Optional

Is this benefit unlimited for number of trips for Plan-approved Location?

Yes  
 No

Indicate number of trips for Plan-approved Location:

Select Plan-approved Location Trips periodicity:

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

Select Type of Transportation for Plan-approved Location:

One-way  
 Round Trip  
 Days  
 Other, describe

Indicate number of days for Plan-approved Location:

Select Mode of Transportation for Plan-approved Location:

Taxi  
 Bus/Subway  
 Van  
 Medical Transport  
 Other, describe

Select type of benefit for Any Location:

Mandatory  
 Optional

Is this benefit unlimited for number of trips for Any Location?

Yes  
 No

Indicate number of trips for Any Location:

Select Any Location Trips periodicity:

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

Select Type of Transportation for Any Location:

One-way  
 Round Trip  
 Days  
 Other, describe

Indicate number of days for Any Location:

Select Mode of Transportation for Any Location:

Taxi  
 Bus/Subway  
 Van  
 Medical Transport  
 Other, describe

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



PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

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

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

\_\_\_\_\_

Select Maximum Plan Benefit Coverage periodicity:

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

\_\_\_\_\_

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage:

\_\_\_\_\_

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

\_\_\_\_\_

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

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #10b Transportation Services - Base 3

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per trip:

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

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

Is a referral required for Transportation Services?

Yes  
 No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11a DME - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee 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:

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

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

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11a DME - Base 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

Yes  
 No

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

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

Notes (Optional):

Referral is not applicable for this Service Category.

Section B – 11A – Durable Medical Equipment – MMP Services - Base 1 Screen

**PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11a DME - MMP Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide non-Medicare Durable Medical Equipment?

Yes  
 No

Select Non-Medicare Durable Medical Equipment:

Durable Medical Equipment for use outside the home  
 Other 1  
 Other 2

Enter name of Other 1 Service:  
[Text Box]

Enter name of Other 2 Service:  
[Text Box]

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

Yes  
 No

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

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Select which Non-Medicare Durable Medical Equipment(s) (select all that apply):

Durable Medical Equipment for use outside the home  
 Other 1  
 Other 2

Indicate coinsurance percentage for one or more of the following services:	Minimum Coinsurance	Maximum Coinsurance
Durable Medical Equipment for use outside the home	[Text Box]	[Text Box]
Other 1	[Text Box]	[Text Box]
Other 2	[Text Box]	[Text Box]

Section B – 11A – Durable Medical Equipment – MMP Services - Base 2 Screen

**PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous    Next>>    Exit (Validate)    Exit (No Validate)    Go To: #11a DME - MMP Services - Base 2

Is there an enrollee Copayment?

Yes  
 No

Select which Non-Medicare Durable Medical Equipment(s) have a Copayment (select all that apply):

Durable Medical Equipment for use outside the home  
 Other 1  
 Other 2

Indicate copayment percentage for one or more of the following services:

	Minimum Copayment	Maximum Copayment
Durable Medical Equipment for use outside the home	<input type="text"/>	<input type="text"/>
Other 1	<input type="text"/>	<input type="text"/>
Other 2	<input type="text"/>	<input type="text"/>

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

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

Is a referral required for Services?

Yes  
 No

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

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

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11b Prosthetics/Medical Supplies - Base 2

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?

Yes  
 No

Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):

Medicare-covered Prosthetic Devices  
 Medicare-covered Medical Supplies

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

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

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

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

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



PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11b Prosthetics/Medical Supplies - Base 3

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

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

Referral is not applicable for this Service Category.

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

Section B – 11B – Prosthetics/Medical Supplies – MMP Services - Base 1 Screen

**PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11b Prosthetics/Medical Supplies - MMP Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide non-Medicare Prosthetics/Medical Supplies?

Yes  
 No

Enter name of Non-Medicare Service:

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance Percentage:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment Amount:

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

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

Is a referral required for Services?

Yes  
 No

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

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11c Diabetic Supplies and Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Select Maximum Enrollee Out-of-Pocket Cost type:

Covered under DME Category 11a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Select which Diabetic Supplies and Services have a Coinsurance (Select all that apply):

Medicare-covered Diabetic Supplies  
 Medicare-covered Diabetic Therapeutic Shoes or Inserts

Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Supplies:

Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Supplies:

Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11c Diabetic Supplies and Services - Base 2

Is there an enrollee Copayment?

Yes  
 No

Select which Diabetic Supplies and Services have a Copayment (Select all that apply):

Medicare-covered Diabetes Supplies  
 Medicare-covered Diabetic Therapeutic Shoes or Inserts

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

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

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

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

Do you limit Diabetic Supplies and Services to those from specified manufacturers?

Yes  
 No

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

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

Referral is not applicable for this Service Category.

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

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

PBP Data Entry System - Section B-12, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #12 End-Stage Renal Disease - Base 2

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

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

Is a referral required for End-Stage Renal Disease services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

Section B – 13A –Acupuncture and Other Alternative Therapies – Base 1 Screen

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13a Acupuncture and Other Alternative Therapies - Base 1

CLICK FOR DESCRIPTION OF BENE

Does the plan provide Acupuncture and Other Alternative Therapies Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:  
 Number of Treatments

Select type of benefit for Number of Treatments:  
 Mandatory  
 Optional

Is this benefit unlimited for Number of Treatments?  
 Yes  
 No

Indicate limit for Number of Treatments:

Indicate Number of Treatments periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Section B – 13A –Acupuncture and Other Alternative Therapies – Base 2 Screen

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13a Acupuncture and Other Alternative Therapies - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount per treatment:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Acupuncture and Other Alternative Therapies Services?  
 Yes  
 No

Section B – 13A –Acupuncture and Other Alternative Therapies – Base 3 Screen



PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13a Acupuncture and Other Alternative Therapies - Base 3

Acupuncture and Other Alternative Therapies Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

Section B – 13B – OTC Items and Services – Base 1 Screen

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13b OTC Items and Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Medicare/Medicaid plans may not use this section to provide benefit information about any OTC drugs or items that are submitted under the integrated formulary. Information about those benefits will be entered in the Rx section of the PBP. This section should only be used to provide benefit information about OTC drugs and items that are covered as a supplemental benefit.

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Yes  
 No

Select type of benefit for OTC items and services:

Mandatory  
 Optional

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every month

Section B – 13B – OTC Items and Services – Base 2 Screen

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13b OTC Items and Services - Base 2

Is there an enrollee Coinsurance?

Yes  No

Indicate Coinsurance percentage:

Does this cover all of the CMS OTC list?

Yes  No

Authorization is not applicable for this service category.

Referral is not applicable for this service category.

Is there an enrollee Deductible?

Yes  No

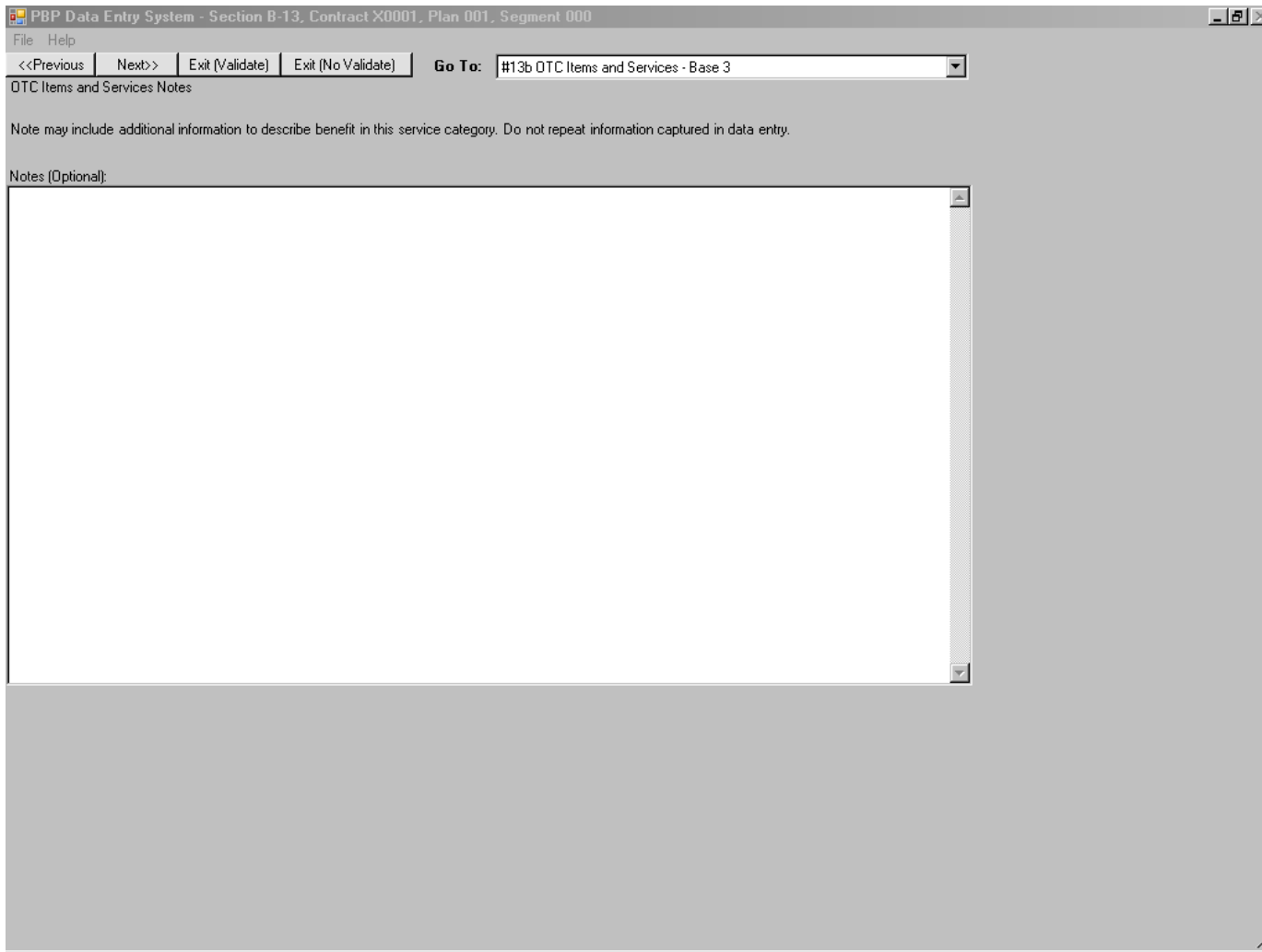
Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  No

Indicate Copayment amount:

Section B – 13B – OTC Items and Services – Base 3 Screen



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

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13c Meal Benefit - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

Yes  
 No

Select type of benefit:

Mandatory  
 Optional

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

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

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

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13c Meal Benefit - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

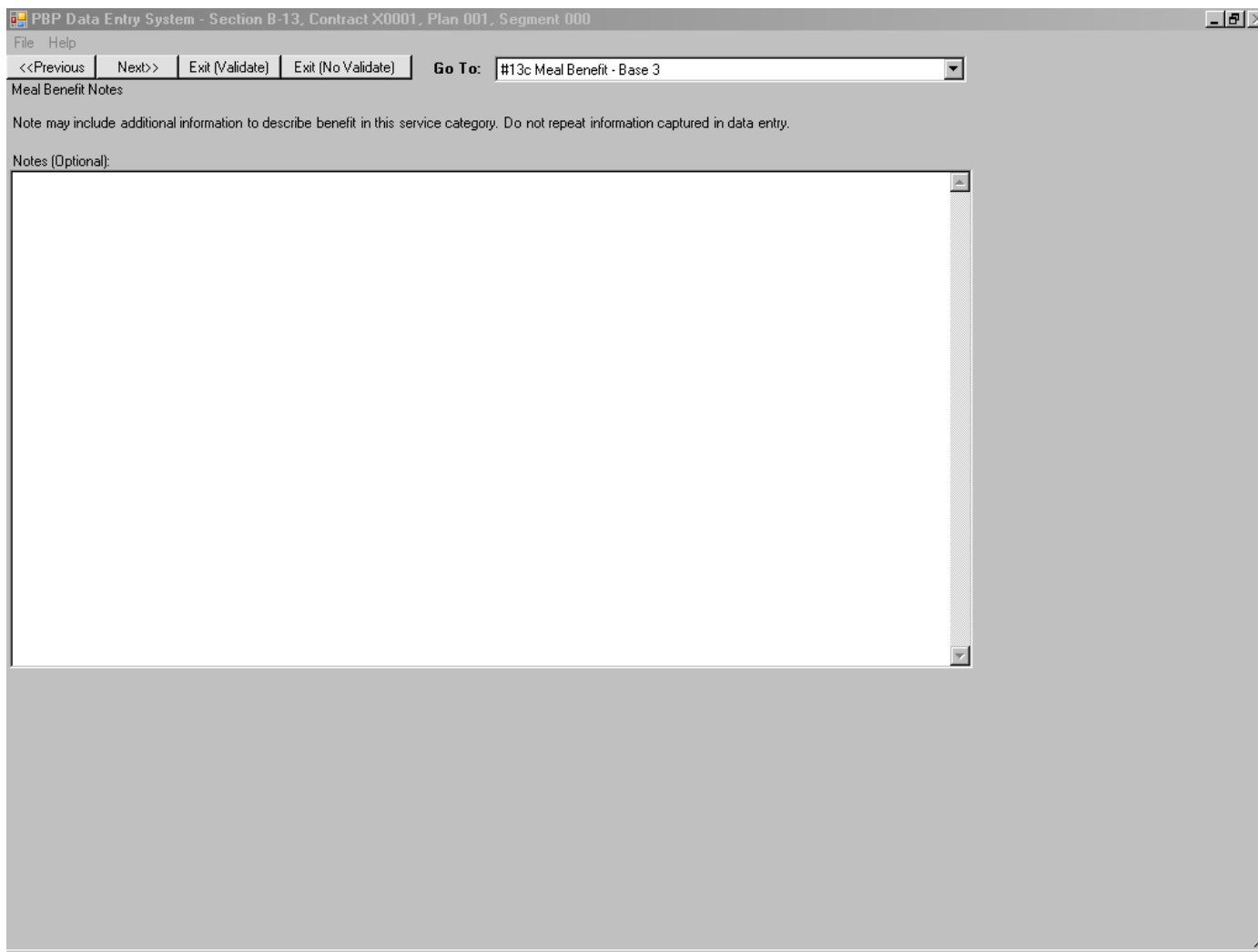
Enrollee must receive Authorization from one or more of the following:

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

Is a referral required for the Meal Benefit?

Yes  
 No

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



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

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13d Other 1 - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

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.

Enter name of Service (Optional):

Select type of benefit:

Mandatory

Optional

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

Yes

No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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



PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13d Other 1 - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount:

Is there an enrollee Deductible?  
 Yes  
 No

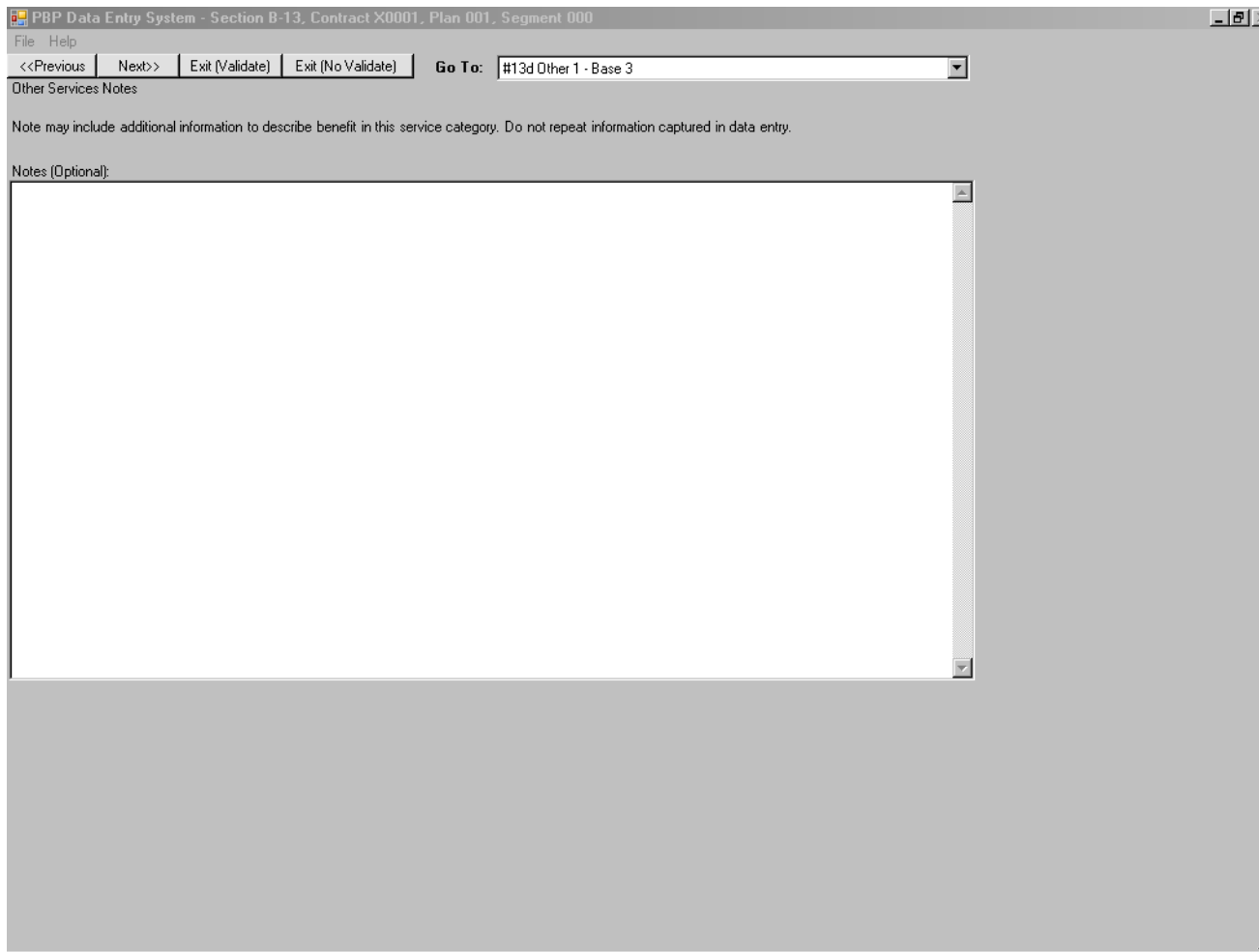
Indicate Deductible Amount:

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

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

Is a referral required for Other Services?  
 Yes  
 No

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



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

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13e Other 2 - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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-13B.

If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.

Enter name of Service (Optional):

Select type of benefit:

Mandatory

Optional

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

Yes

No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13e Other 2 - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

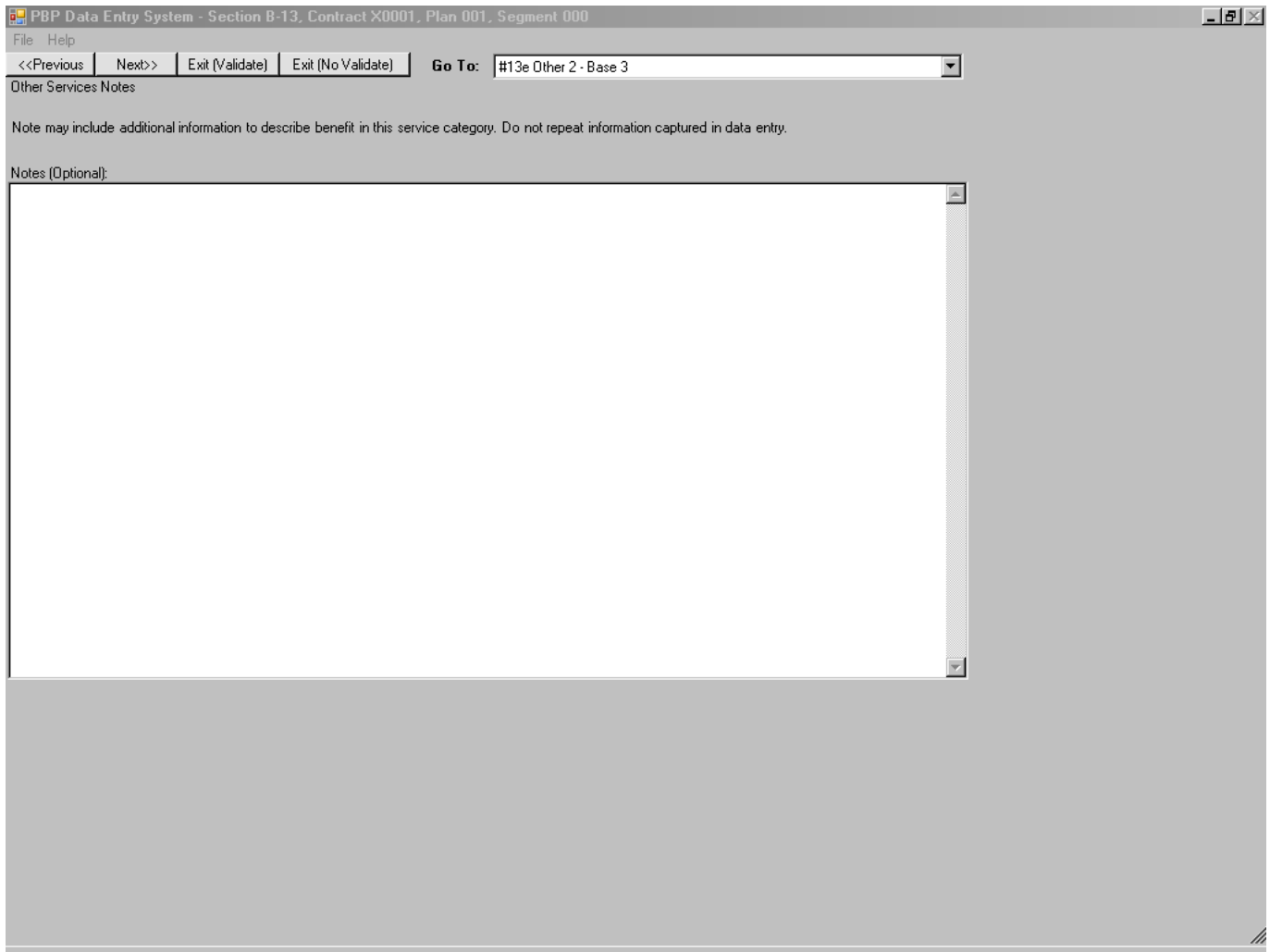
Indicate Copayment amount:

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

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

Is a referral required for Other Services?  
 Yes  
 No

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



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

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13F Other 3 - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

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-13B.

If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.

Enter name of Service (Optional):

Select type of benefit:

Mandatory

Optional

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

Yes

No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13f Other 3 - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

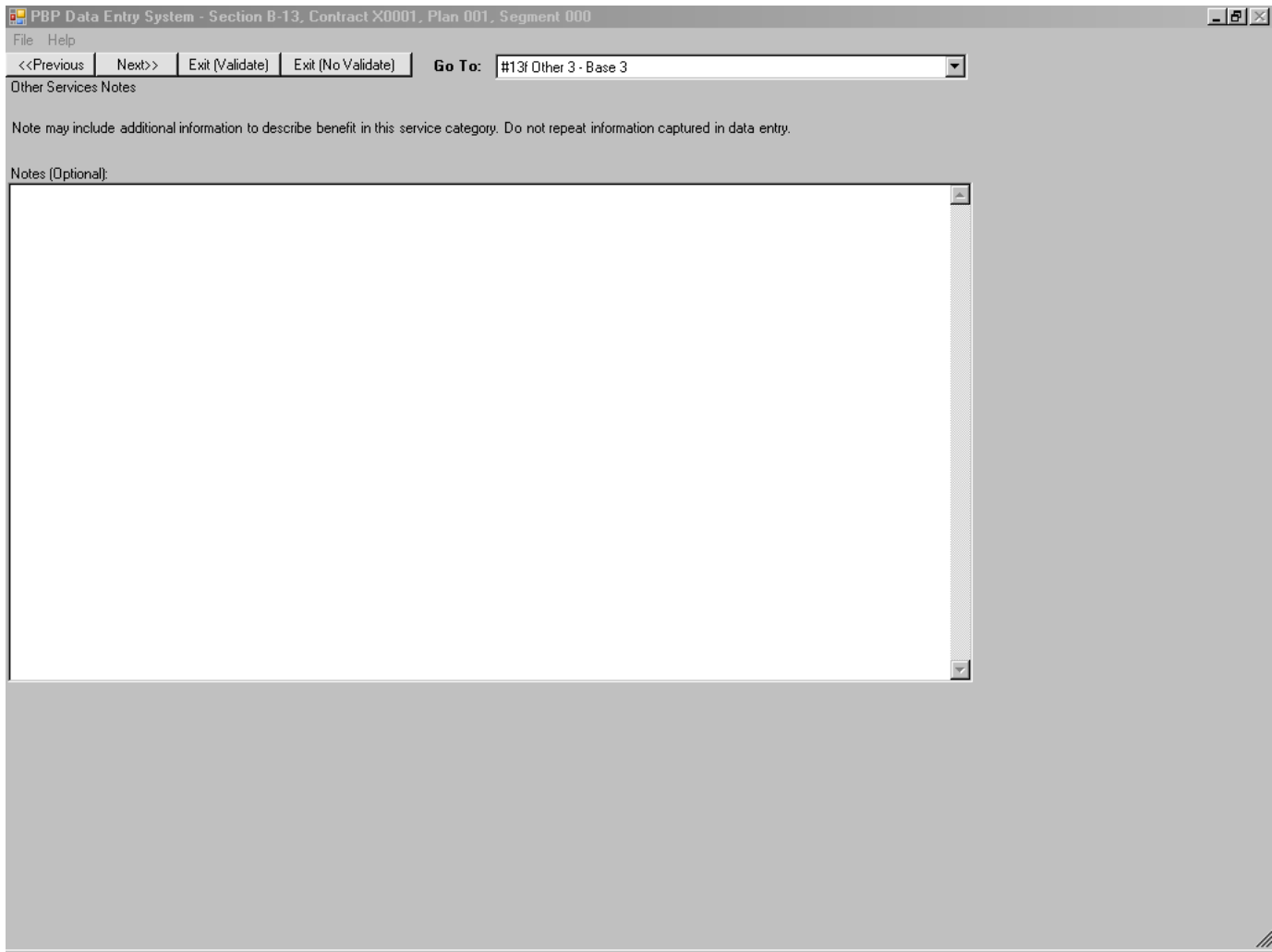
Indicate Copayment amount:

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

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

Is a referral required for Other Services?  
 Yes  
 No

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



Section B – 13G – Dual Eligible SNPs with Highly Integrated Services – Base 1 Screen



PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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 Dual Eligible SNPs with Highly Integrated Services.

Dual Eligible SNPs with Highly Integrated Services Benefit Attestation

I attest that I have received written notification from CMS that this individual SNP plan qualifies for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services for CY 2014. I further attest that the additional supplemental benefit(s) that the SNP describes in this section of the PBP do not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside.

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.

Enter name of Service (Optional):

Select type of benefit:

Mandatory

Optional

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

Yes

No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

Section B – 13G – Dual Eligible SNPs with Highly Integrated Services – Base 2 Screen

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Minimum Coinsurance percentage:  
[ ]

Indicate Maximum Coinsurance percentage:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Minimum Copayment amount:  
[ ]

Indicate Maximum Copayment amount:  
[ ]

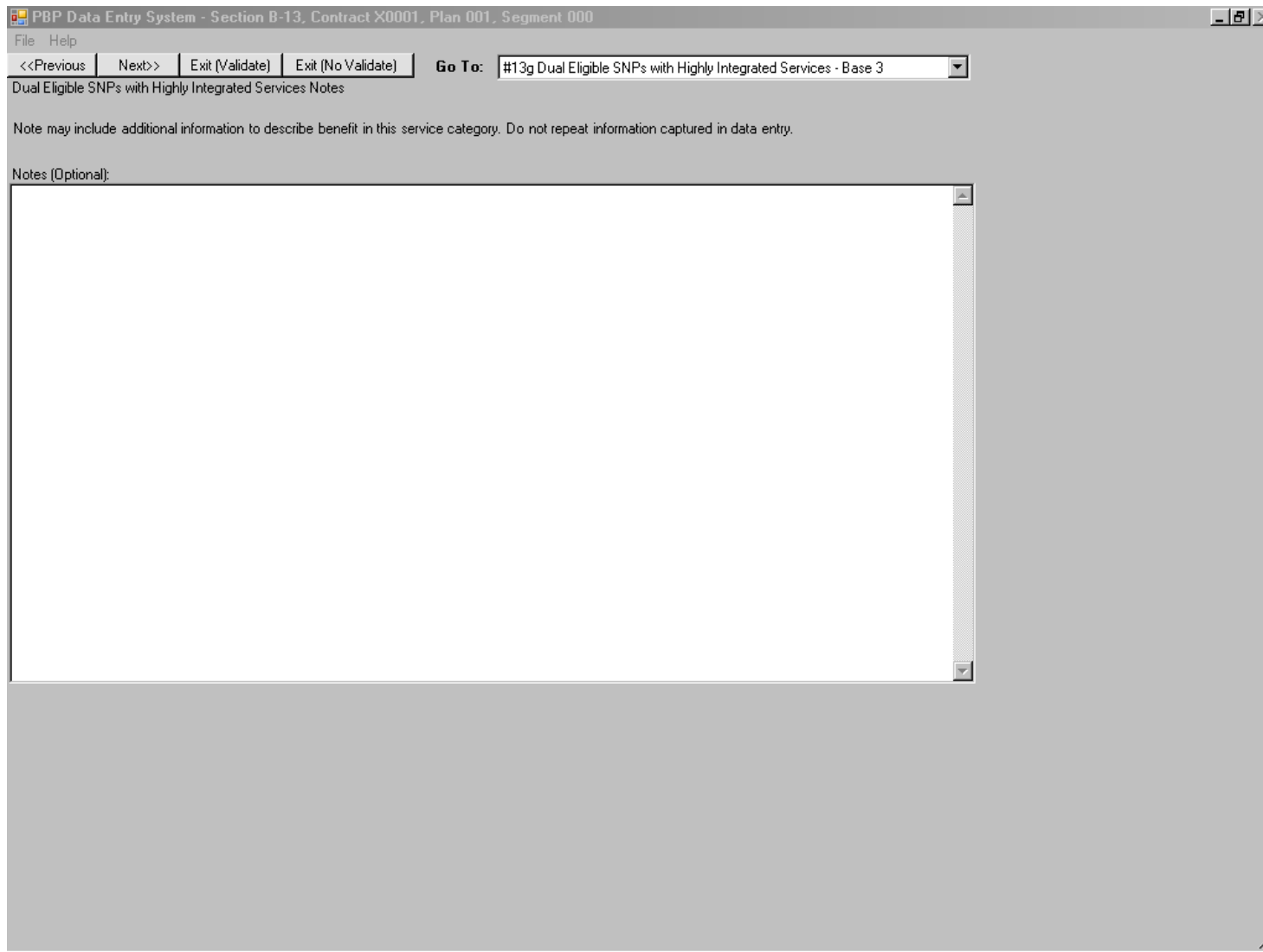
Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Other Services?  
 Yes  
 No

Section B – 13G – Dual Eligible SNPs with Highly Integrated Services – Base 3 Screen



Section B – 13H – Additional Services – Base 1 Screen

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Additional Services?

Yes  
 No

Select Additional Services (select all that apply):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for the Mentally Retarded
- Case Management
- Other 1
- Other 2
- Other 3

Enter name of Other 1 Service:

Enter name of Other 2 Service:

Enter name of Other 3 Service:

Section B – 13H – Additional Services – Base 2 Screen

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 2

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Select which Additional Services have a Coinsurance (Select all that apply)

Indicate Coinsurance for one or more of the following services.	Minimum Coinsurance	Maximum Coinsurance
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	<input type="text"/>	<input type="text"/>
Tobacco Cessation Counseling for Pregnant Women	<input type="text"/>	<input type="text"/>
Freestanding Birth Center Services	<input type="text"/>	<input type="text"/>
Respiratory Care Services	<input type="text"/>	<input type="text"/>
Family Planning Services	<input type="text"/>	<input type="text"/>
Nursing Home Services	<input type="text"/>	<input type="text"/>
Home and Community Based Services	<input type="text"/>	<input type="text"/>
Personal Care Services	<input type="text"/>	<input type="text"/>
Self-Directed Personal Assistance Services	<input type="text"/>	<input type="text"/>
Private Duty Nursing Services	<input type="text"/>	<input type="text"/>
Case Management (Long Term Care)	<input type="text"/>	<input type="text"/>
Institution for Mental Disease Services for Individuals 65 or Older	<input type="text"/>	<input type="text"/>
Services in an Intermediate Care Facility for the Mentally Retarded	<input type="text"/>	<input type="text"/>
Case Management	<input type="text"/>	<input type="text"/>
Other 1	<input type="text"/>	<input type="text"/>
Other 2	<input type="text"/>	<input type="text"/>
Other 3	<input type="text"/>	<input type="text"/>

Section B – 13H – Additional Services – Base 3 Screen

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 3

Is there an enrollee Copayment?

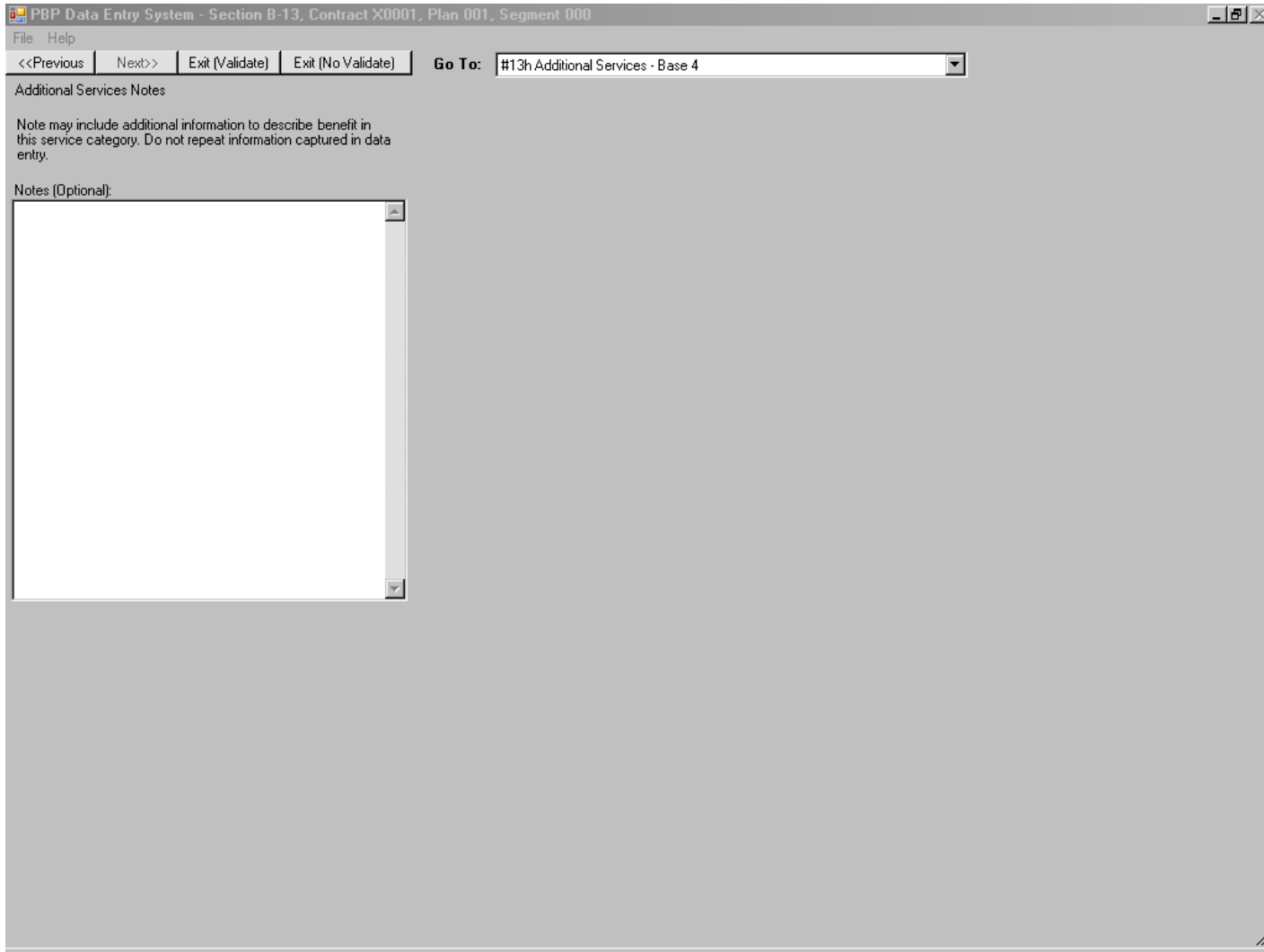
Yes

No

Select which Additional Services have a Copayment (Select all that apply):

Indicate Copayment for one or more of the following services.	Minimum Copayment	Maximum Copayment
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	<input type="text"/>	<input type="text"/>
Tobacco Cessation Counseling for Pregnant Women	<input type="text"/>	<input type="text"/>
Freestanding Birth Center Services	<input type="text"/>	<input type="text"/>
Respiratory Care Services	<input type="text"/>	<input type="text"/>
Family Planning Services	<input type="text"/>	<input type="text"/>
Nursing Home Services	<input type="text"/>	<input type="text"/>
Home and Community Based Services	<input type="text"/>	<input type="text"/>
Personal Care Services	<input type="text"/>	<input type="text"/>
Self-Directed Personal Assistance Services	<input type="text"/>	<input type="text"/>
Private Duty Nursing Services	<input type="text"/>	<input type="text"/>
Case Management (Long Term Care)	<input type="text"/>	<input type="text"/>
Institution for Mental Disease Services for Individuals 65 or Older	<input type="text"/>	<input type="text"/>
Services in an Intermediate Care Facility for the Mentally Retarded	<input type="text"/>	<input type="text"/>
Case Management	<input type="text"/>	<input type="text"/>
Other 1	<input type="text"/>	<input type="text"/>
Other 2	<input type="text"/>	<input type="text"/>
Other 3	<input type="text"/>	<input type="text"/>

Section B – 13H – Additional Services – Base 4 Screen



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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14a Medicare-covered Preventive Services

CLICK FOR DESCRIPTION OF BENEFIT

Medicare-covered Preventive Services Attestation

I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.

Note: Plan may not require an authorization or referral for certain \$0 cost sharing preventive services, for example, screening mammograms.

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?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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



PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14b Annual Physical Exam - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enter Medicare-covered preventive services at \$0 cost sharing in PBP service category 14a.

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, and consequently they are not appropriate as a supplemental benefit.

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

Yes  
 No

Select type of benefit for the Annual Physical Exam:

Mandatory  
 Optional

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14b Annual Physical Exam - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage for each Annual Physical Exam:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount for each Annual Physical Exam:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14b Annual Physical Exam - Base 3

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

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

Is a referral required for the Annual Physical Exam?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes:

[Empty text area for notes]

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Supplemental Education/Health Management Programs as a benefit under Part C?

Yes  
 No

Select enhanced benefit (Select all that apply):

Health Education  
 Nutritional Benefit  
 Additional Smoking and Tobacco Use Cessation  
 Membership in Health Club/Fitness Classes  
 Nursing Hotline

Select type of benefit for Health Education:

Mandatory  
 Optional

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

Mandatory  
 Optional

Select type of benefit for Nutritional Benefit:

Mandatory  
 Optional

Select type of benefit for Nursing Hotline:

Mandatory  
 Optional

Select type of benefit for Additional Smoking and Tobacco Use Cessation:

Mandatory  
 Optional

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14c Supplemental Education/Health Management Programs - Base 2

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

\_\_\_\_\_

Select the Maximum Plan Benefit Coverage periodicity:

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

\_\_\_\_\_

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

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

Section B – 14C – Supplemental Education/Health Management Programs – Base 3 Screen

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14c Supplemental Education/Health Management Programs - Base 3

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Select which Supplemental Education/Health Management Programs have a Coinsurance (Select all that apply):

- Health Education
- Nutritional Benefit
- Additional Smoking and Tobacco Use Cessation
- Membership in Health Club/Fitness classes
- Nursing Hotline

Indicate Minimum Coinsurance percentage for Health Education:

Indicate Maximum Coinsurance percentage for Health Education:

Indicate Coinsurance percentage for Nutritional Benefit:

Indicate Coinsurance percentage for Additional Smoking and Tobacco Use Cessation:

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

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

Indicate Coinsurance percentage for Nursing Hotline:

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14c Supplemental Education/Health Management Programs - Base 4

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?

Yes  
 No

Select which Supplemental Education/Health Management Programs have a Copayment (Select all that apply):

Health Education  
 Nutritional Benefit  
 Additional Smoking and Tobacco Use Cessation  
 Membership in Health Club/Fitness classes  
 Nursing Hotline

Indicate Copayment amount for Health Education:  
[ ]

Indicate Copayment amount for Nutritional Benefit:  
[ ]

Indicate Copayment amount for Additional Smoking and Tobacco Use Cessation:  
[ ]

Indicate Minimum Copayment amount for Membership in Health Club/Fitness Classes:  
[ ]

Indicate Maximum Copayment amount for Membership in Health Club/Fitness Classes:  
[ ]

Indicate Copayment amount for Nursing Hotline:  
[ ]

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14c Supplemental Education/Health Management Programs - Base 5

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

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

Supplemental Education/Health Management Programs Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

Is a referral required for Supplemental Education/Health Management Programs?

Yes

No

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



PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14d - Kidney Disease Education Services Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 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.

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14d - Kidney Disease Education Services Base 2

Is there an enrollee Deductible?

Yes

No

Indicate Deductible Amount:

\_\_\_\_\_

Is there an enrollee Copayment?

Yes

No

Indicate Minimum Copayment amount for Medicare-covered Benefits:

\_\_\_\_\_

Indicate Maximum Copayment amount for Medicare-covered Benefits:

\_\_\_\_\_

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

None

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

Physician Specialist

Organization Medical Director/Utilization Management/Utilization Review

Other, describe

Is a referral required for Kidney Disease Education Services?

Yes

No

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



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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next> Exit (Validate) Exit (No Validate) Go To: #14e Diabetes Self-Management Training - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

\_\_\_\_\_

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

\_\_\_\_\_

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

\_\_\_\_\_

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

\_\_\_\_\_

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14e Diabetes Self-Management Training - Base 2

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

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

Sometimes, describe  
 No

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

Yes  
 No

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

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

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

Yes  
 No

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

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

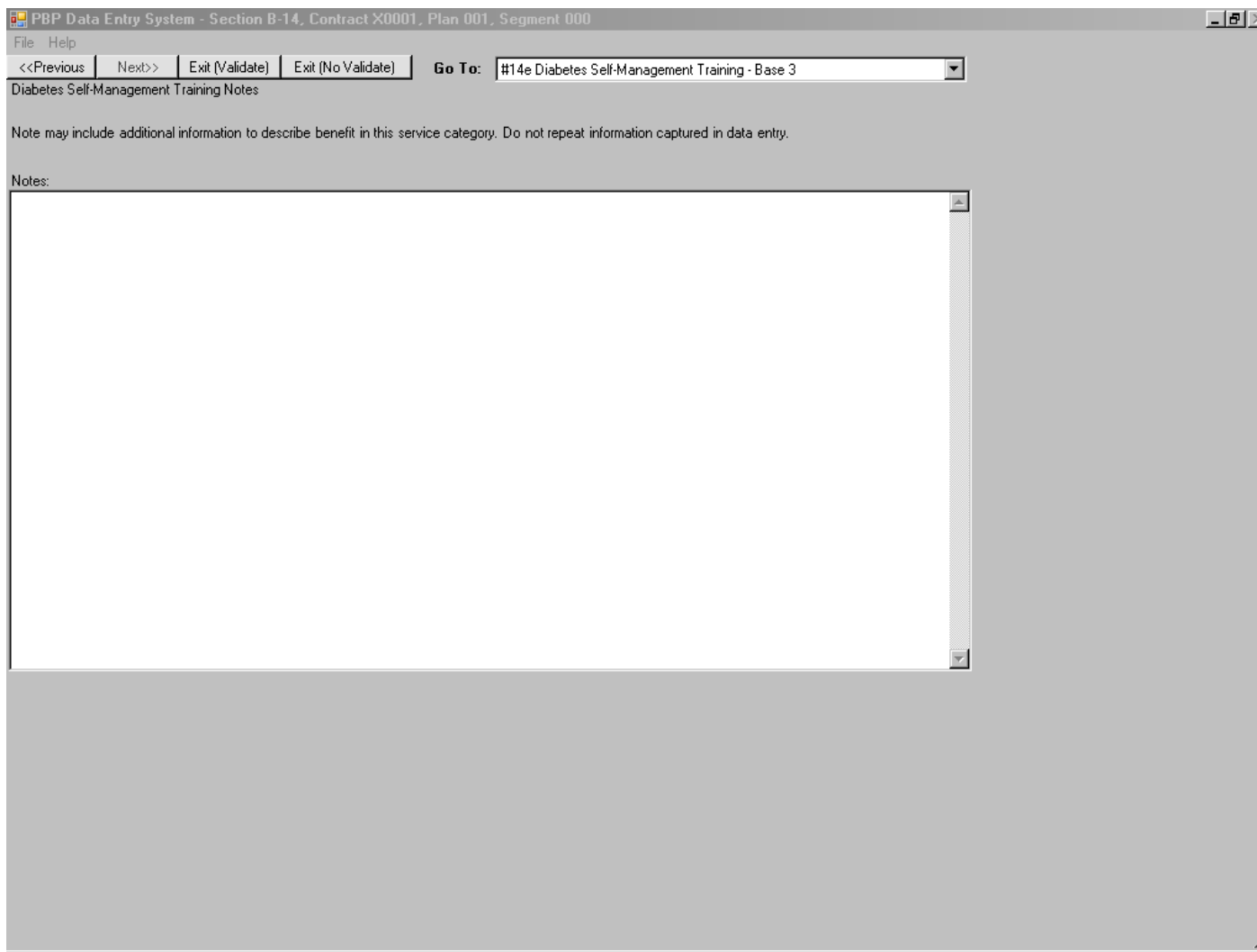
Enrollee must receive Authorization from one or more of the following:

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

Is a referral required for Diabetes Self-Management Training?

Yes  
 No

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



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

PBP Data Entry System - Section B-15, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #15 Medicare Part B Rx Drugs - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost Amount:  
[ ]

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

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every month  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Select which Medicare Part B Rx Drugs have a Coinsurance (Select all that apply):

Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:  
[ ]

Indicate the Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:  
[ ]

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:  
[ ]

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:  
[ ]

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

PBP Data Entry System - Section B-15, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #15 Medicare Part B Rx Drugs - Base 2

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Select which Medicare Part B Rx Drugs have a Copayment  
(Select all that apply):

Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Indicate Minimum Copayment Amount for  
Medicare Part B Chemotherapy Drugs:

Indicate Maximum Copayment Amount for  
Medicare Part B Chemotherapy Drugs:

Indicate Minimum Copayment Amount for  
other Medicare Part B Drugs:

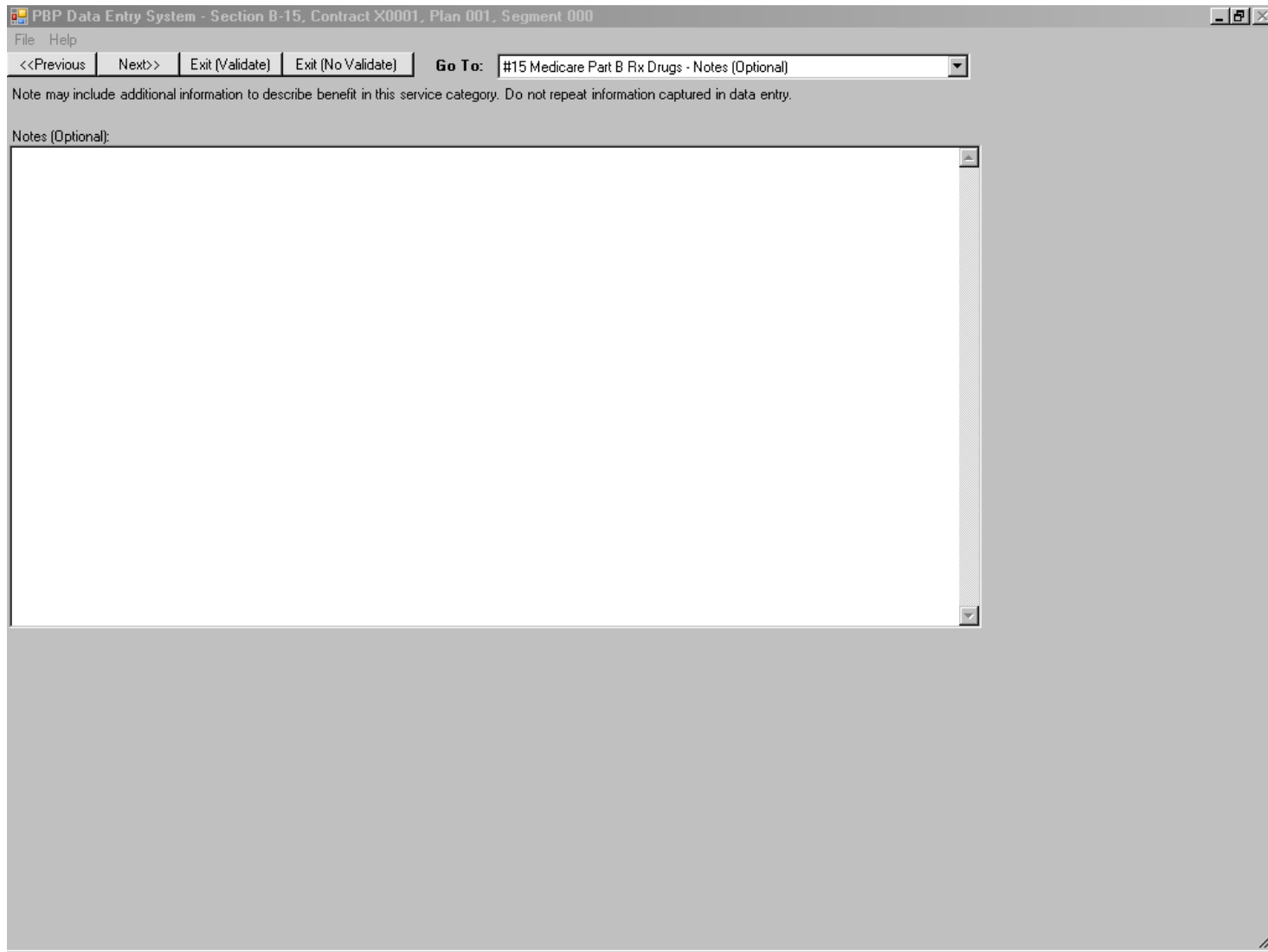
Indicate Maximum Copayment Amount for  
other Medicare Part B Drugs:

Is Authorization Required?

Yes  
 No

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





Section B – 15 – Home Infusion Bundled Services Screen

PBP Data Entry System - Section B-15, Contract X0001, Plan 001, Segment 000

File Help

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

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?

Yes  
 No

Does the plan pay for Part D drug home infusion services and supplies as a Medicaid benefit?

Yes  
 No

If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 8, 2012 at 12:00pm Eastern Time.

You must also ensure that your benefit includes not only the home infusion drug, but any services and supplies associated with the home infusion drug's administration.

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

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

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

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

Select type of benefit for Oral Exams:

Mandatory  
 Optional

Is this benefit unlimited for Oral Exams?

Yes  
 No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

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

Select type of benefit for Prophylaxis (Cleaning):

Mandatory  
 Optional

Is this benefit unlimited for Prophylaxis (Cleaning)?

Yes  
 No, indicate number

Indicate number of visits for Prophylaxis (Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

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

Select type of benefit for Fluoride Treatment:

Mandatory  
 Optional

Is this benefit unlimited for Fluoride Treatment?

Yes  
 No, indicate number

Indicate number of visits for Fluoride Treatment:

Select the Fluoride Treatment periodicity:

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

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

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

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

Select type of benefit for Dental X-Rays:

Mandatory

Optional

Is this benefit unlimited for Dental X-Rays?

Yes

No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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

Yes

No

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

In-network services only

Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #16a Preventive Dental - Base 3

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Preventive Dental Services have a Coinsurance (Select all that apply):  
 Oral Exams  
 Prophylaxis (Cleaning)  
 Fluoride Treatment  
 Dental X-Rays

Is there a combination of services included in a single cost per Office Visit?  
 Yes  
 No

Select which combination of services are included in a single cost per Office Visit:  
 Oral Exams  
 Prophylaxis (Cleaning)  
 Fluoride Treatment  
 Dental X-Rays

Indicate Coinsurance percentage for Office Visit:

Indicate Minimum Coinsurance percentage for Oral Exams:

Indicate Maximum Coinsurance percentage for Oral Exams:

Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Minimum Coinsurance percentage for Fluoride Treatment:

Indicate Maximum Coinsurance percentage for Fluoride Treatment:

Indicate Minimum Coinsurance percentage for Dental X-Rays:

Indicate Maximum Coinsurance percentage for Dental X-Rays:

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

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

Select which Preventive Dental Services have a Copayment (Select all that apply):  
 Oral Exams  
 Prophylaxis (Cleaning)  
 Fluoride Treatment  
 Dental X-Rays

Is there a combination of services included in a single cost per Office Visit?  
 Yes  
 No

Select which combination of services are included in a single cost per Office Visit:  
 Oral Exams  
 Prophylaxis (Cleaning)  
 Fluoride Treatment  
 Dental X-Rays

Indicate Copayment amount for Office Visit:  
[ ]

Indicate Minimum Copayment amount for Oral Exams:  
[ ]

Indicate Maximum Copayment amount for Oral Exams:  
[ ]

Indicate Minimum Copayment amount for Prophylaxis (Cleaning):  
[ ]

Indicate Maximum Copayment amount for Prophylaxis (Cleaning):  
[ ]

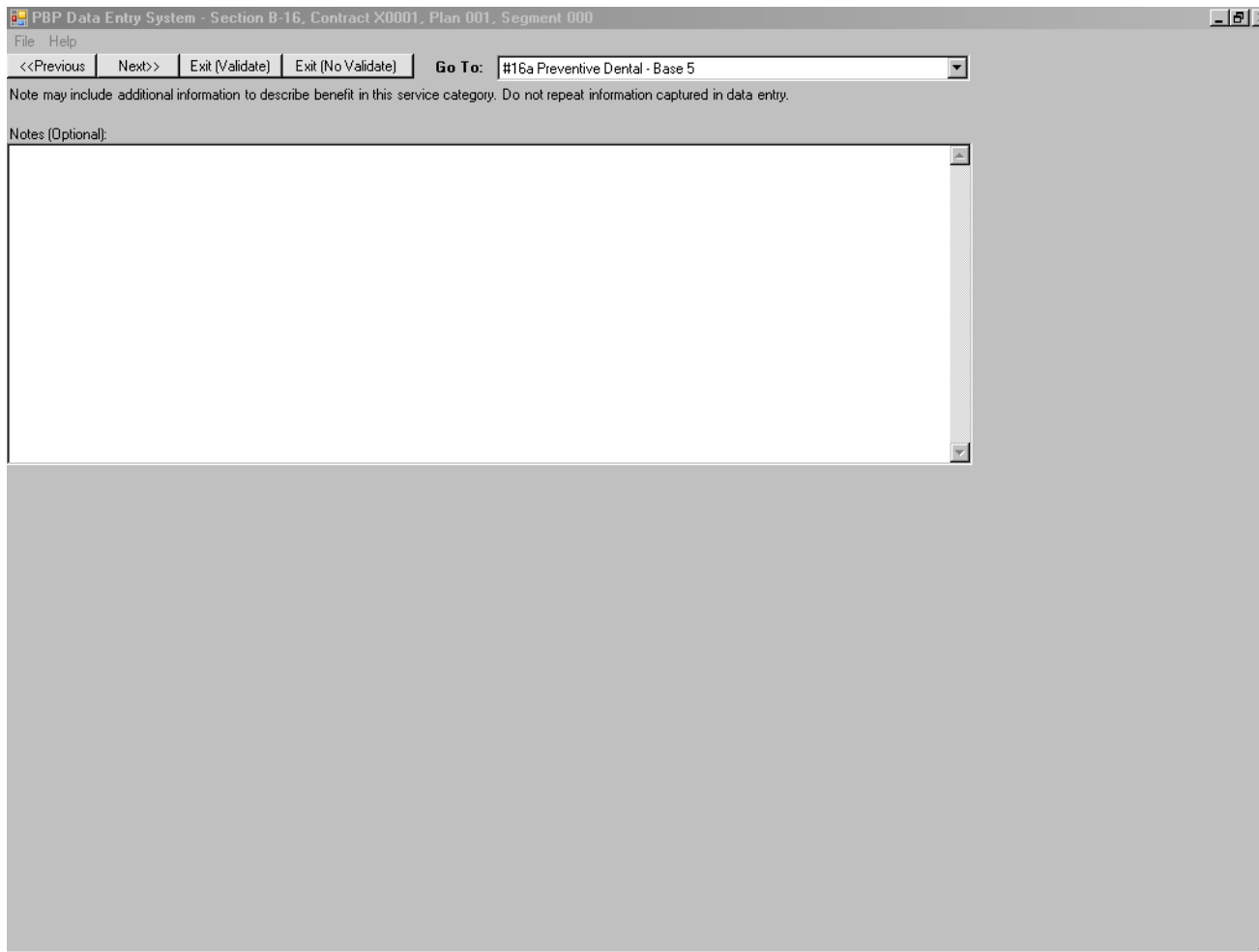
Indicate Minimum Copayment amount for Fluoride Treatment:  
[ ]

Indicate Maximum Copayment amount for Fluoride Treatment:  
[ ]

Indicate Minimum Copayment amount for Dental X-Rays:  
[ ]

Indicate Maximum Copayment amount for Dental X-Rays:  
[ ]

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



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

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16b Comprehensive Dental - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Non-routine Services  
 Diagnostic Services  
 Restorative Services  
 Endodontics/Periodontics/Extractions  
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory  
 Optional

Is this benefit unlimited for Non-routine Services?

Yes  
 No, indicate number

Indicate number of visits for Non-routine Services:

Select the Non-routine Services periodicity:

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

Select type of benefit for Diagnostic Services:

Mandatory  
 Optional

Is this benefit unlimited for Diagnostic Services?

Yes  
 No, indicate number

Indicate number of visits for Diagnostic Services:

Select the Diagnostic Services periodicity:

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

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



PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16b Comprehensive Dental - Base 2

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

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

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16b Comprehensive Dental - Base 3

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

Yes  
 No

Select the Maximum Plan Benefit Coverage type:

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

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

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

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

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

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

Yes  
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Coinsurance?

Yes  
 No

Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):

Medicare-covered Benefits  
 Non-routine Services  
 Diagnostic Services  
 Restorative Services  
 Endodontics/Periodontics/Extractions  
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Non-routine Services:

Indicate Maximum Coinsurance percentage for Non-routine Services:

Indicate Minimum Coinsurance percentage for Diagnostic Services:

Indicate Maximum Coinsurance percentage for Diagnostic Services:

Indicate Minimum Coinsurance percentage for Restorative Services:

Indicate Maximum Coinsurance percentage for Restorative Services:

Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions:

Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:

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

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Copayment?  
 Yes  
 No

Select which Comprehensive Dental Services have a Copayment (Select all that apply):  
 Medicare-covered Benefits  
 Non-routine Services  
 Diagnostic Services  
 Restorative Services  
 Endodontics/Periodontics/Extractions  
 Prosthetics, Other Oral/Maxillofacial Surgery, Other Services

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

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

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

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

Indicate Minimum Copayment amount for Diagnostic Services: [ ]

Indicate Maximum Copayment amount for Diagnostic Services: [ ]

Indicate Minimum Copayment amount for Restorative Services: [ ]

Indicate Maximum Copayment amount for Restorative Services: [ ]

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

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

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

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

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

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

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

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

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

Is a referral required for Comprehensive Dental Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

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

**CLICK FOR DESCRIPTION OF BENEFIT**

Does the plan provide Eye Exams as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Routine Eye Exams

Select type of benefit for Routine Eye Exams:

Mandatory  
 Optional

Is this benefit unlimited for Routine Eye Exams?

Yes  
 No, indicate number

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

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

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

Yes  
 No

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

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

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

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

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Is there an enrollee Copayment?  
 Yes  
 No

Select which Eye Exams have a Coinsurance (Select all that apply):  
 Medicare-covered Benefits  
 Routine Eye Exams

Select which Eye Exams have a Copayment (Select all that apply):  
 Medicare-covered Benefits  
 Routine Eye Exams

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?  
 Yes  
 No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

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

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

Sometimes, describe  
 No

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

Yes  
 No

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

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

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

Yes  
 No

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

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

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):  
[ ]

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



PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

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

**CLICK FOR DESCRIPTION OF BENEFIT**

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

Does the plan provide Eye Wear as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

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

Select type of benefit for Contact Lenses:

Mandatory  
 Optional

Is this benefit unlimited for Contact Lenses?

Yes  
 No, indicate number

Indicate quantity (number of pairs) for Contact Lenses:

Select Contact Lenses periodicity:

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

Select type of benefit for Eye Glasses (Lenses and Frames):

Mandatory  
 Optional

Is this benefit unlimited for Eye Glasses (Lenses and Frames)?

Yes  
 No, indicate number

Indicate quantity for Eye Glasses (Lenses and Frames):

Select Eye Glasses (Lenses and Frames) periodicity:

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

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

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

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

Select type of benefit for Eye Glass Lenses:  
 Mandatory  
 Optional

Select type of benefit for Eye Glass Frames:  
 Mandatory  
 Optional

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

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

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

Indicate quantity for Eye Glass Frames:

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

Select Eye Glass Frames periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select type of benefit for Upgrades:  
 Mandatory  
 Optional

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

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

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

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

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

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

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

Indicate Combined Maximum Plan Benefit Coverage amount:

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

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

Indicate Max Plan Benefit Coverage amount for Contact Lenses:

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

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

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

Indicate Max Plan Benefit Coverage amount for Eye Glass Frames:

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

Indicate Max Plan Benefit Coverage amount for Eye Glass Lenses:

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

Indicate Max Plan Benefit Coverage amount for Upgrades:

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

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

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

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

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

Yes  
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, 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 Glasses (Lenses and Frames)  
 Eye Glass Lenses  
 Eye Glass Frames  
 Upgrades

Indicate Coinsurance percentage for Medicare-covered Benefits:

Indicate Coinsurance percentage for Contact Lenses:

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

Indicate Coinsurance percentage for Eye Glass Lenses:

Indicate Coinsurance percentage for Eye Glass Frames:

Indicate Coinsurance percentage for Upgrades:

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

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Select which Eye Wear Benefits have a Copayment (Select all that apply):  
 Medicare-covered Benefits  
 Contact Lenses  
 Eye Glasses (Lenses and Frames)  
 Eye Glass Lenses  
 Eye Glass Frames  
 Upgrades

Indicate Copayment amount for Medicare-covered Benefits:

Indicate Copayment amount for Contact Lenses:

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

Indicate Copayment amount for Eye Glass Lenses:

Indicate Copayment amount for Eye Glass Frames:

Indicate Copayment amount for Upgrades:

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

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

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

Eye Wear Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

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

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

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

**CLICK FOR DESCRIPTION OF BENEFIT**

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

Does the plan provide Hearing Exams as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Routine Hearing Exams  
 Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Exams:

Mandatory  
 Optional

Is this benefit unlimited for Routine Hearing Exams?

Yes  
 No, indicate number

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

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

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

Mandatory  
 Optional

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

Yes  
 No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

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

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

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

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

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Hearing Exam Benefits have a Coinsurance (Select all that apply):  
 Medicare-covered Benefits  
 Routine Hearing Exams  
 Fitting/Evaluation for Hearing Aid

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Hearing Exams:

Indicate Maximum Coinsurance percentage for Routine Hearing Exams:

Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

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



PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #18a Hearing Exams - Base 3

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

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

Is there an enrollee Copayment?

Yes  
 No

Select which Hearing Exam Benefits have a Copayment(Select all that apply):

Medicare-covered Benefits  
 Routine Hearing Exams  
 Fitting/Evaluation for Hearing Aid

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Routine Hearing Exams:

Indicate Maximum Copayment amount for Routine Hearing Exams:

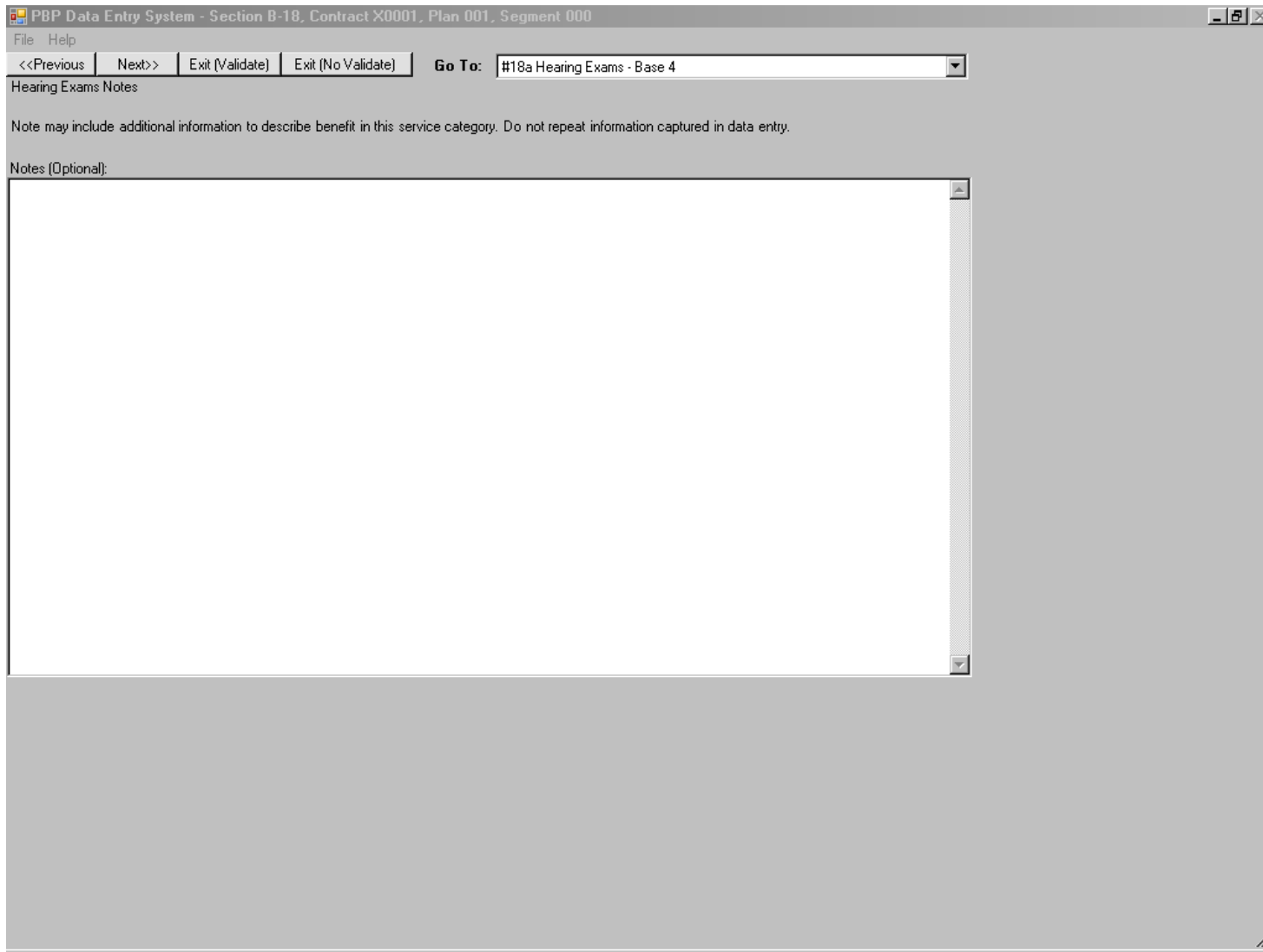
Enrollee must receive Authorization from one or more of the following:

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

Is a referral required for Hearing Exams?

Yes  
 No

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



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

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Hearing Aids as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

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

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

Mandatory  
 Optional

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

Yes  
 No, indicate number

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity:

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

Select type of benefit for Hearing Aids - Inner Ear:

Mandatory  
 Optional

Is this benefit unlimited for Hearing Aids - Inner Ear?

Yes  
 No, indicate number

Indicate quantity for Hearing Aids - Inner Ear:

Select Hearing Aids - Inner Ear periodicity:

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

Select type of benefit for Hearing Aids - Outer Ear:

Mandatory  
 Optional

Is this benefit unlimited for Hearing Aids - Outer Ear?

Yes  
 No, indicate number

Indicate quantity for Hearing Aids - Outer Ear:

Select Hearing Aids - Outer Ear periodicity:

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

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

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

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

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

Mandatory  
 Optional

Select the Maximum Plan Benefit Coverage type:

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

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

Yes  
 No, indicate number

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

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

Indicate quantity for Hearing Aids - Over the Ear:

Indicate Maximum Plan Benefit Coverage amount:

Select Hearing Aids - Over the Ear periodicity:

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

Indicate Maximum Plan Benefit Coverage periodicity:

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

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

Yes  
 No

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

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

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

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

Indicate Coinsurance percentage for Hearing Aids (all types):  
[ ]

Select the Maximum Enrollee Out-of-Pocket Cost type:  
 Covered under Hearing Exams Category - 18a  
 Plan-specified amount per period

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

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

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

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

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Hearing Aids Benefits have a Coinsurance (Select all that apply):  
 Hearing Aids - Inner Ear  
 Hearing Aids - Outer Ear  
 Hearing Aids - Over the Ear

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

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Copayment?  
 Yes  
 No

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

Select which Hearing Aids Benefits have a Copayment (Select all that apply):  
 Hearing Aid - Inner Ear  
 Hearing Aid - Outer Ear  
 Hearing Aids - Over the Ear

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

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

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

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

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

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

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

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

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

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

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

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

Is a referral required for Hearing Aids?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Large empty text area for notes]

Section B – 20 – Outpatient Drugs – Base 1 Screen

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Outpatient Drugs as a supplemental benefit under Part C?

Yes  
 No

Select type of benefit:

Mandatory  
 Optional

Indicate the number of drug groupings that are offered:

1  
 2  
 3  
 4  
 5

Is there a Maximum Plan Benefit Coverage amount for drugs?

Yes  
 No

Indicate type of Maximum Plan Benefit Coverage:

All drug groups covered by plan  
 Combination of drug groups  
 Individual drug groups

Is the Maximum Plan Benefit Coverage net of the enrollee copay?

Yes  
 No

Indicate Maximum Plan Benefit Coverage periodicity for drugs:

Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Other, describe

Indicate Max Plan Benefit Coverage amount annually for drugs: \_\_\_\_\_

Indicate Max Plan Benefit Coverage amount semi-annually for drugs: \_\_\_\_\_

Indicate Max Plan Benefit Coverage amount quarterly for drugs: \_\_\_\_\_

Indicate Max Plan Benefit Coverage amount monthly for drugs: \_\_\_\_\_

Indicate Max Plan Benefit Coverage amount for Other for drugs: \_\_\_\_\_

Section B – 20 – Outpatient Drugs – Base 2 Screen



PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

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

Can any unused amounts be carried forward to the next period within the contract period?

Yes  
 No

Select what combination of drug groups are included in the Maximum Plan Benefit:

Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5

Indicate Maximum Plan Benefit Coverage periodicity for combination of drug groups:

Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Other, describe

Indicate Max Plan Benefit Coverage amount annually for combination of drug groups:  
[ ]

Indicate Max Plan Benefit Coverage amount semi-annually for combination of drug groups:  
[ ]

Indicate Max Plan Benefit Coverage amount quarterly for combination of drug groups:  
[ ]

Indicate Max Plan Benefit Coverage amount monthly for combination of drug groups:  
[ ]

Indicate Max Plan Benefit Coverage amount for Other for combination of drug groups:  
[ ]

Section B – 20 – Outpatient Drugs – Base 3 Screen

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Base 3

Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached?

Yes  
 No

Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived:

Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5

Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available?

Yes  
 No

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

Yes  
 No

Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost:

Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5  
 Medicare Covered Benefits

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Every year  
 Every six months  
 Every three months

Is there an enrollee Coinsurance for Medicare-covered Benefits?

Yes  
 No

Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply):

Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:

Section B – 20 – Outpatient Drugs – Base 4 Screen

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Base 4

Is there an enrollee Deductible?

Yes  
 No

Select what combination of drug groups applies for Deductible:

Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5  
 Medicare Covered Benefits

Indicate Deductible amount:

Is there an enrollee Copayment for Medicare-covered Benefits?

Yes  
 No

Select which Medicare-covered Outpatient Drugs have a Copayment (Select all that apply):

Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Indicate Minimum Copayment amount for Medicare Part B Chemotherapy Drugs:

Indicate Maximum Copayment amount for Medicare Part B Chemotherapy Drugs:

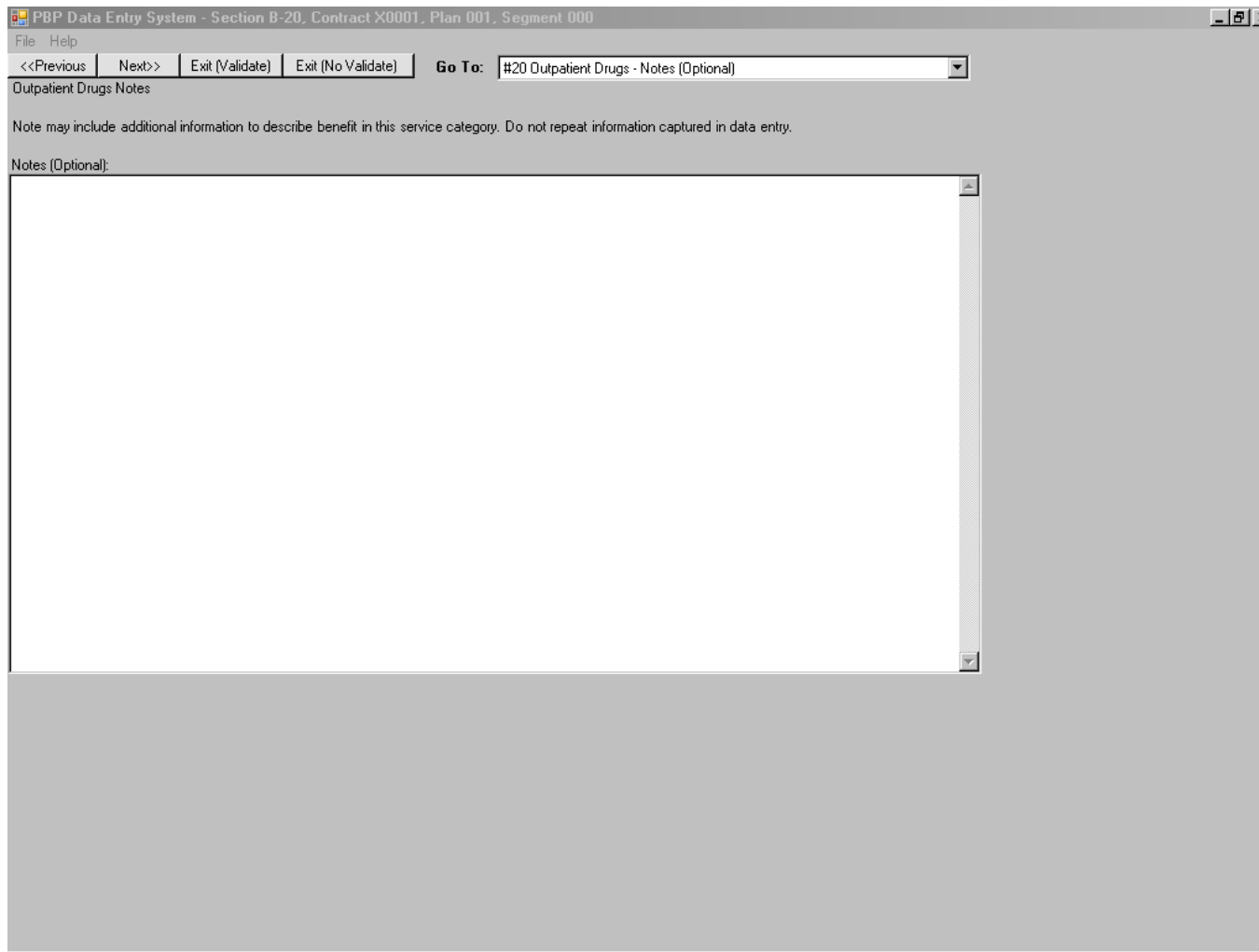
Indicate Minimum Copayment for other Medicare Part B Drugs:

Indicate Maximum Copayment for other Medicare Part B Drugs:

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

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

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



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

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 1 - Base 1

Select a label for Group 1:

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

- Generic
- Preferred Brand
- Brand

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

Yes

No

Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 1:

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

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:

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

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

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 1 - Base 2

Select from where Group 1 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 1?  
 Yes  
 No

Is there an enrollee Copayment for Group 1?  
 Yes  
 No

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

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

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 2 - Base 1

Select a label for Group 2: [ ]

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

Select the drug type(s) covered for Group 2:

Generic

Preferred Brand

Brand

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2: [ ]

Is there a Maximum Plan Benefit Coverage amount for Group 2?

Yes

No

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

Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:

Annually

Semi-annually

Quarterly

Monthly

Per Prescription

Other, describe

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

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

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

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

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

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

Select from where Group 2 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 2?  
 Yes  
 No

Is there an enrollee Copayment for Group 2?  
 Yes  
 No

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

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



PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 3 - Base 1

Select a label for Group 3: [dropdown]  
Indicate Maximum Plan Benefit Coverage annual amount for Group 3: [input]

Select the drug type(s) covered for Group 3:  
 Generic  
 Preferred Brand  
 Brand  
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 3: [input]

Is there a Maximum Plan Benefit Coverage amount for Group 3?  
 Yes  
 No  
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3: [input]

Indicate Maximum Plan Benefit Coverage Group 3 periodicity:  
 Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Per Prescription  
 Other, describe  
Indicate Maximum Plan Benefit Coverage monthly amount for Group 3: [input]

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

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

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

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 3 - Base 2

Select from where Group 3 Drugs can be acquired:

Designated Retail Pharmacy  
 HMO-Owned Pharmacy  
 Mail Order  
 Other, describe

Is there an enrollee Coinsurance for Group 3?  
 Yes  
 No

Is there an enrollee Copayment for Group 3?  
 Yes  
 No

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

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

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 4 - Base 1

Select a label for Group 4:  
[Dropdown]

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

Indicate Maximum Plan Benefit Coverage annual amount for Group 4:  
[Text Box]

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 4:  
[Text Box]

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

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4:  
[Text Box]

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

Indicate Maximum Plan Benefit Coverage monthly amount for Group 4:  
[Text Box]

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 4:  
[Text Box]

Indicate Maximum Plan Benefit Coverage amount for Other for Group 4:  
[Text Box]

Section B – 20 – Outpatient Drugs-Group 4 – Base 2 Screen

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 4 - Base 2

Select from where Group 4 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 4?  
 Yes  
 No

Is there an enrollee Copayment for Group 4?  
 Yes  
 No

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

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

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 5 - Base 1

Select a label for Group 5: [Dropdown]

Indicate Maximum Plan Benefit Coverage annual amount for Group 5: [Text Box]

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

- Generic
- Preferred Brand
- Brand

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 5: [Text Box]

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

Yes  No

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5: [Text Box]

Indicate Maximum Plan Benefit Coverage monthly amount for Group 5: [Text Box]

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 5: [Text Box]

Indicate Maximum Plan Benefit Coverage amount for Other for Group 5: [Text Box]

Indicate Maximum Plan Benefit Coverage for Group 5 periodicity:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

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

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 5 - Base 2

Select from where Group 5 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 5?  Yes  No

Is there an enrollee Copayment for Group 5?  Yes  No

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

Section B – 20 – Home Infusion Bundled Services – Screen

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Home Infusion Bundled Services

Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?

Yes  
 No

If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 8, 2012 at 12:00pm Eastern Time.

You must also ensure that your benefit includes not only the home infusion drug, but any services and supplies associated with the home infusion drug's administration.

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