

Plan Deductible LPPD/RPPO Base 1 – Screen

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

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Do you offer an Annual Deductible?
 Yes
 No

What is the amount of your Annual Deductible?
 Medicare-Defined Part A Deductible amount
 Medicare-Defined Part B Deductible amount
 Medicare-Defined Part A and B Deductible amount combined as a single deductible
 Other, Indicate amount

Indicate Annual Deductible Amount:

How is your combined Medicare-defined Part A and B Deductible applied?
 Single Deductible
 Differentially applied to Part A and Part B Medicare services, reflecting Original Medicare payment structure.

Note: LPPD and RPPO plans must include ALL OON Medicare-covered Services in the annual Deductible except they have the option to EXCLUDE 14a: Preventive Services. If you select to use the 2014 rates, please verify that any differential deductibles that you choose will not exceed the 2014 rates that will be released by CMS.

Do you include 14a as part of your OON Medicare-covered Services annual Deductible?
 Yes
 No

Select the Service Categories that apply to your annual Deductible:
 In-Network Medicare-covered benefits
 In-Network Non-Medicare-covered benefits
 Out-of-Network Non-Medicare-covered benefits

Does the annual Deductible apply to all In-Network Medicare-covered benefits?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

Plan Deductible LPPO/RPPO Base 2 – Screen

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Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Does the annual Deductible apply to all In-Network Non-Medicare-covered benefits?

Yes
 No

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

1a: Inpatient Hospital Acute:
1b: Inpatient Hospital Psychiatric:
2: Skilled Nursing Facility (SNF):
3: Cardiac Rehabilitation Services:
3: Intensive Cardiac Rehabilitation Services:
3: Pulmonary Rehabilitation Services:
4a: Emergency Care:
7b: Chiropractic Services:
7f: Podiatry Services:
9d: Outpatient Blood Services:
10b: Transportation Services:
13a: Acupuncture and Other Alternative Therapies:
13b: Over-the-Counter (OTC) Items:
13c: Meal Benefit:
13d: Other 1:
13e: Other 2:
13f: Other 3:
13g: Dual Eligible SNP with Highly Integrated Services:
14b: Annual Physical Exam:
14c: Supplemental Education/Health Management Programs:
15: Medicare Part B Rx Drugs:
16a: Preventive Dental:
16b: Comprehensive Dental:
17a: Eye Exams:
17b: Eye Wear:
18a: Hearing Exams:
18b: Hearing Aids:
20: Prescription Drugs (Cost Plans Only):

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Does the annual Deductible apply to all Out-of-Network Non-Medicare-covered benefits?

Yes
 No

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

1a: Inpatient Hospital Acute:
1b: Inpatient Hospital Psychiatric:
2: Skilled Nursing Facility (SNF):
3: Cardiac Rehabilitation Services:
3: Intensive Cardiac Rehabilitation Services:
3: Pulmonary Rehabilitation Services:
4a: Emergency Care:
7b: Chiropractic Services:
7f: Podiatry Services:
9d: Outpatient Blood Services:
10b: Transportation Services:
13a: Acupuncture and Other Alternative Therapies:
13b: Over-the-Counter (OTC) Items:
13c: Meal Benefit:
13d: Other 1:
13e: Other 2:
13f: Other 3:
13g: Dual Eligible SNP with Highly Integrated Services:
14b: Annual Physical Exam:
14c: Supplemental Education/Health Management Programs:
15: Medicare Part B Rx Drugs:
16a: Preventive Dental:
16b: Comprehensive Dental:
17a: Eye Exams:
17b: Eye Wear:
18a: Hearing Exams:
18b: Hearing Aids:
20: Prescription Drugs (Cost Plans Only):

Plan Deductible LPPD/RPPO Base 3 – Screen

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

Plan Deductible LPPD/RPPO Base 4 – Screen

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Indicate Differential Deductible Amounts for Inpatient Hospital Services including Acute Tiers 1, 2, and 3, where appropriate: <input type="text"/> <input type="text"/> <input type="text"/>	Indicate Differential Deductible Amount for Skilled Nursing Facility (SNF): <input type="text"/>	Note: No single Differential Deductible can be greater than the annual deductible. The total of all of the Differential Deductibles can be greater than the annual deductible.
Indicate Differential Deductible Amounts for Inpatient Psychiatric Hospital Services Tiers 1, 2, and 3, where appropriate: <input type="text"/> <input type="text"/> <input type="text"/>	Indicate Differential Deductible Amount for Cardiac and Pulmonary Rehabilitation Services: <input type="text"/>	
	Indicate Differential Deductible Amount for Emergency Care: <input type="text"/>	
	Indicate Differential Deductible Amount for Urgently Needed Services: <input type="text"/>	
	Indicate Differential Deductible Amount for Partial Hospitalization: <input type="text"/>	
	Indicate Differential Deductible Amount for Home Health Services: <input type="text"/>	
	Indicate Differential Deductible Amount for Primary Care Physician Services: <input type="text"/>	
	Indicate Differential Deductible Amount for Chiropractic Services: <input type="text"/>	
	Indicate Differential Deductible Amount for Occupational Therapy Services: <input type="text"/>	
	Indicate Differential Deductible Amount for Physician Specialist Services: <input type="text"/>	

Plan Deductible LPPD/RPPO Base 5 – Screen

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Indicate Differential Deductible Amount for Mental Health Specialty Services - Non-Psychiatric:	Indicate Differential Deductible Amount for Outpatient Diagnostic and Therapeutic Radiological Services:	Indicate Differential Deductible Amount for Transportation Services:	Indicate Differential Deductible Amount for DTC:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Differential Deductible Amount for Podiatry Services:	Indicate Differential Deductible Amount for Outpatient Hospital Services:	Indicate Differential Deductible Amount for Durable Medical Equipment (DME):	Indicate Differential Deductible Amount for Meal Benefit:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Differential Deductible Amount for Other Health Care Professional Services:	Indicate Differential Deductible Amount for Ambulatory Surgical Center (ASC) Services:	Indicate Differential Deductible Amount for Prosthetics/Medical Supplies:	Indicate Differential Deductible Amount for Other 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Differential Deductible Amount for Psychiatric Services:	Indicate Differential Deductible Amount for Outpatient Substance Abuse Services:	Indicate Differential Deductible Amount for Diabetic Supplies and Services:	Indicate Differential Deductible Amount for Other 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Differential Deductible Amount for Physical Therapy and Speech-Language Pathology Services:	Indicate Differential Deductible Amount for Outpatient Blood Services:	Indicate Differential Deductible Amount for End-Stage Renal Disease:	Indicate Differential Deductible Amount for Other 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Differential Deductible Amount for Outpatient Diagnostic Procedures and Test and Lab Services:	Indicate Differential Deductible Amount for Ambulance Services:	Indicate Differential Deductible Amount for Acupuncture and Other Alternative Therapies:	Indicate Differential Deductible Amount for Dual Eligible SNPs with Highly Integrated Services:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Plan Deductible LPPD/RPPO Base 6 – Screen

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

Plan Deductible (Combined) – Base 1 Screen

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

Yes
 No

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

Yes
 No

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

Select the benefits that apply to the Combined Deductible:

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

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

1a: Inpatient Hospital Acute:
1b: Inpatient Hospital Psychiatric:
2: Skilled Nursing Facility (SNF):
3: Cardiac Rehabilitation Services:
3: Intensive Cardiac Rehabilitation Services:
3: Pulmonary Rehabilitation Services:
5: Partial Hospitalization:
6: Home Health Services:

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

1a: Inpatient Hospital Acute:
1b: Inpatient Hospital Psychiatric:
2: Skilled Nursing Facility (SNF):
3: Cardiac Rehabilitation Services:
3: Intensive Cardiac Rehabilitation Services:
3: Pulmonary Rehabilitation Services:
4a: Emergency Care:
7b: Chiropractic Services:
7f: Podiatry Services:
9d: Outpatient Blood Services:
10b: Transportation Services:
13a: Acupuncture and Other Alternative Therapies:
13b: Over-the-Counter (OTC) Items:

Plan Deductible (Combined) – Base 2 Screen

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

Yes
 No

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diagnostic Procedures/Test/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:
- 8b3: Outpatient X-Rays:
- 9a: Outpatient Hospital Services:
- 9b: Ambulatory Surgical Center (ASC) Services:
- 9c: Outpatient Substance Abuse:

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

Plan Deductible (In-Network) Screen

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Go To: Plan Deductible (In-Network)

Is there an In-Network Plan Deductible?
 Yes
 No

Do you charge the Medicare-defined Part B Deductible amount?
 Yes
 No

Indicate In-Network Plan Deductible Amount:

Select the benefits that apply to the In-Network Deductible:
 In-Network Medicare-covered benefits
 In-Network Non-Medicare-covered benefits

Does the In-Network Deductible apply to all In-Network Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

Does the In-Network Deductible apply to all In-Network Non-Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4a: Emergency Care:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture and Other Alternative Therapies:
- 13b: Over-the-Counter (OTC) Items:

Plan Deductible (Out-of-Network) Screen

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Is there an Out-of-Network (OON) Plan Deductible?
 Yes
 No

Do you charge the Medicare-defined Part B Deductible amount? Indicate Out-of-Network Plan Deductible Amount:
 Yes
 No

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

Does the Out-of-Network Deductible apply to all Out-of-Network Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

Does the Out-of-Network Deductible apply to all Out-of-Network Non-Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4a: Emergency Care:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture and Other Alternative Therapies:
- 13b: Over-the-Counter (OTC) Items:

Plan Deductible (Non-Network) Screen

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Is there a Plan Deductible?
 Yes
 No

Do you charge the Medicare-defined Part B Deductible amount?
 Yes
 No

Indicate Plan Deductible Amount:

Select the benefits that apply to the Deductible:
 Medicare-covered benefits
 Non-Medicare-covered benefits

Does the Deductible apply to all Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

- 1a: Inpatient Hospital Acute;
- 1b: Inpatient Hospital Psychiatric;
- 2: Skilled Nursing Facility (SNF);
- 3: Cardiac Rehabilitation Services;
- 3: Intensive Cardiac Rehabilitation Services;
- 5: Pulmonary Rehabilitation Services;
- 6: Partial Hospitalization;
- 6: Home Health Services;

Does the Deductible apply to all Non-Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

- 1a: Inpatient Hospital Acute;
- 1b: Inpatient Hospital Psychiatric;
- 2: Skilled Nursing Facility (SNF);
- 3: Cardiac Rehabilitation Services;
- 3: Intensive Cardiac Rehabilitation Services;
- 3: Pulmonary Rehabilitation Services;
- 4a: Emergency Care;
- 7b: Chiropractic Services;
- 7f: Podiatry Services;
- 9d: Outpatient Blood Services;
- 10b: Transportation Services;
- 13a: Acupuncture and Other Alternative Therapies;
- 13b: Over-the-Counter (OTC) Items;

Max Enrollee Cost Limit (Combined) – Base 1 Screen

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

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Is there a Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost?

Yes
 No

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

Voluntary
 Mandatory

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

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

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

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

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4a: Emergency Care:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture and Other Alternative Therapies:
- 13b: Over-the-Counter (OTC) Items:

Max Enrollee Cost Limit (Combined) – Base 2 Screen

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

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

Yes
 No

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

Max Enrollee Cost Limit (In-Network) Screen

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

Yes
 No

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

Voluntary
 Mandatory

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

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

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

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

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

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4a: Emergency Care:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture and Other Alternative Therapies:

Max Enrollee Cost Limit (Out-of-Network) Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Max Enrollee Cost Limit (Out-of-Network)

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

Yes
 No

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

Voluntary
 Mandatory

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

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

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

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

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

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

- 1a: Inpatient Hospital Acute;
- 1b: Inpatient Hospital Psychiatric;
- 2: Skilled Nursing Facility (SNF);
- 3: Cardiac Rehabilitation Services;
- 3: Intensive Cardiac Rehabilitation Services;
- 3: Pulmonary Rehabilitation Services;
- 4a: Emergency Care;
- 7b: Chiropractic Services;
- 7f: Podiatry Services;
- 9d: Outpatient Blood Services;
- 10b: Transportation Services;
- 13a: Acupuncture and Other Alternative Therapies;

Max Enrollee Cost Limit (Non-Network) Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Max Enrollee Cost Limit (Non-Network)

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

Voluntary
 Mandatory

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

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

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

Medicare-covered benefits
 Non-Medicare-covered benefits

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

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

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

1a: Inpatient Hospital Acute:
 1b: Inpatient Hospital Psychiatric:
 2: Skilled Nursing Facility (SNF):
 3: Cardiac Rehabilitation Services:
 3: Intensive Cardiac Rehabilitation Services:
 3: Pulmonary Rehabilitation Services:
 4a: Emergency Care:
 7b: Chiropractic Services:
 7f: Podiatry Services:
 9d: Outpatient Blood Services:
 10b: Transportation Services:
 13a: Acupuncture and Other Alternative Therapies:

Max Plan Benefit Coverage Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Max Plan Benefit Coverage

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

Is there a Maximum Plan Benefit Coverage Amount?

Yes
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

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

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

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

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

1a: Inpatient Hospital Acute:
 1b: Inpatient Hospital Psychiatric:
 2: Skilled Nursing Facility (SNF):
 3: Cardiac Rehabilitation Services:
 3: Intensive Cardiac Rehabilitation Services:
 3: Pulmonary Rehabilitation Services:

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

1a: Inpatient Hospital Acute:
 1b: Inpatient Hospital Psychiatric:
 2: Skilled Nursing Facility (SNF):
 3: Cardiac Rehabilitation Services:
 3: Intensive Cardiac Rehabilitation Services:
 3: Pulmonary Rehabilitation Services:
 4a: Emergency Care:
 7b: Chiropractic Services:
 7f: Podiatry Services:

Max Plan Benefit Coverage (Non-Network) Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Max Plan Benefit Coverage (Non-Network)

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

Is there a Maximum Plan Benefit Coverage Amount?

Yes
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

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

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

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

1a: Inpatient Hospital Acute;
1b: Inpatient Hospital Psychiatric;
2: Skilled Nursing Facility (SNF);
3: Cardiac Rehabilitation Services;
3: Intensive Cardiac Rehabilitation Services;
3: Pulmonary Rehabilitation Services;

Plan Premium/Rebate Reduction Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Premium/Rebate Reduction

Indicate Plan Premium Amount (Part A/B):

Indicate Plan Premium Amount (B Only):

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

Yes
 No

Indicate the Part B Premium reduction amount:

PFFS Balance Billing Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: PFFS Balance Billing

Do you permit balance billing? Balance Billing is a percentage of plan payment rate provider may collect.

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Enter Minimum percentage for balance billing:

What category of providers do you permit to balance bill?

Enter Maximum percentage for balance billing:

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

MSA Annual Deductible/Deposit Screen

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

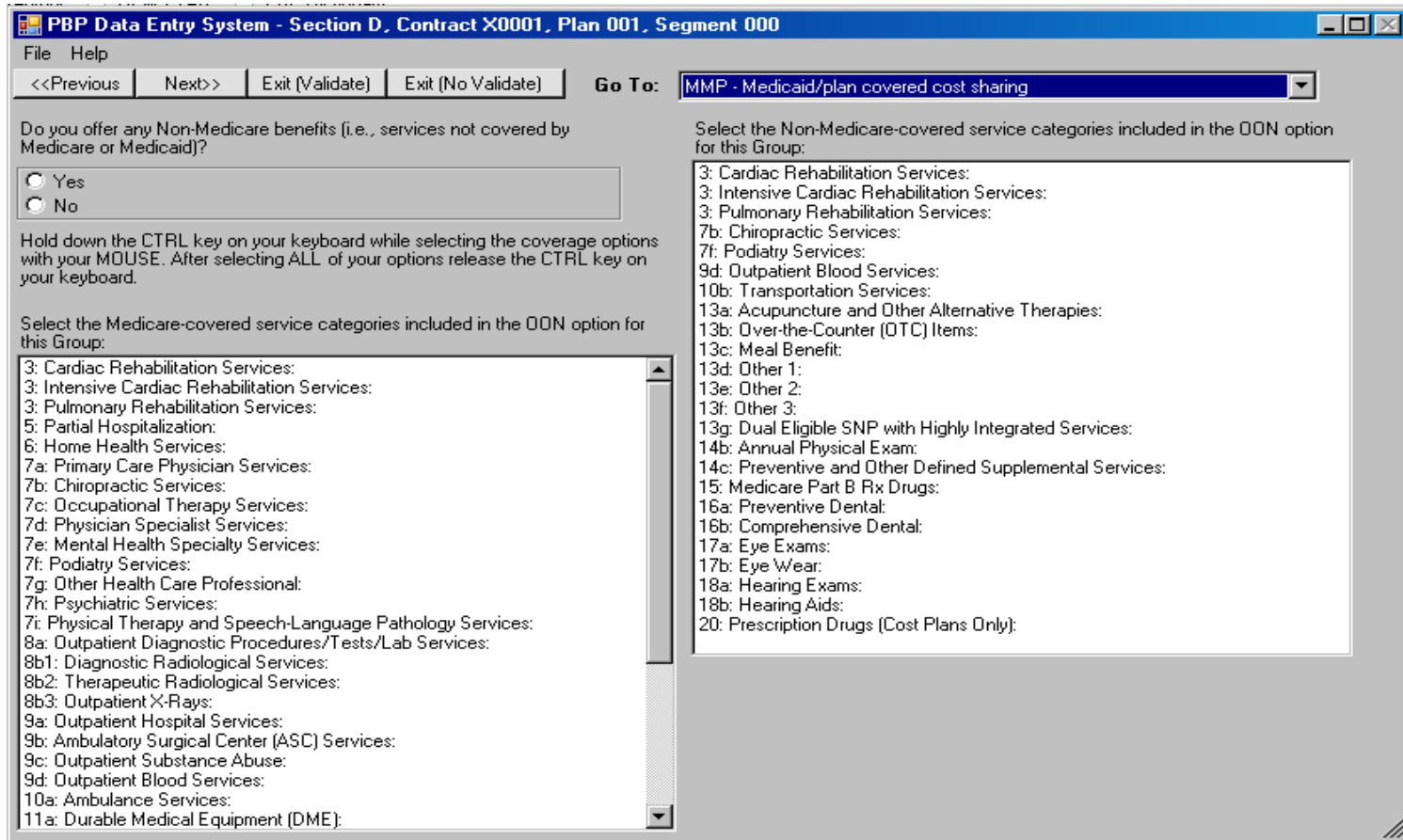
File Help

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

Indicate Annual MSA Deductible amount:

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

MMP - Medicaid/Plan covered cost sharing Screen



Notes Screen

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

File Help

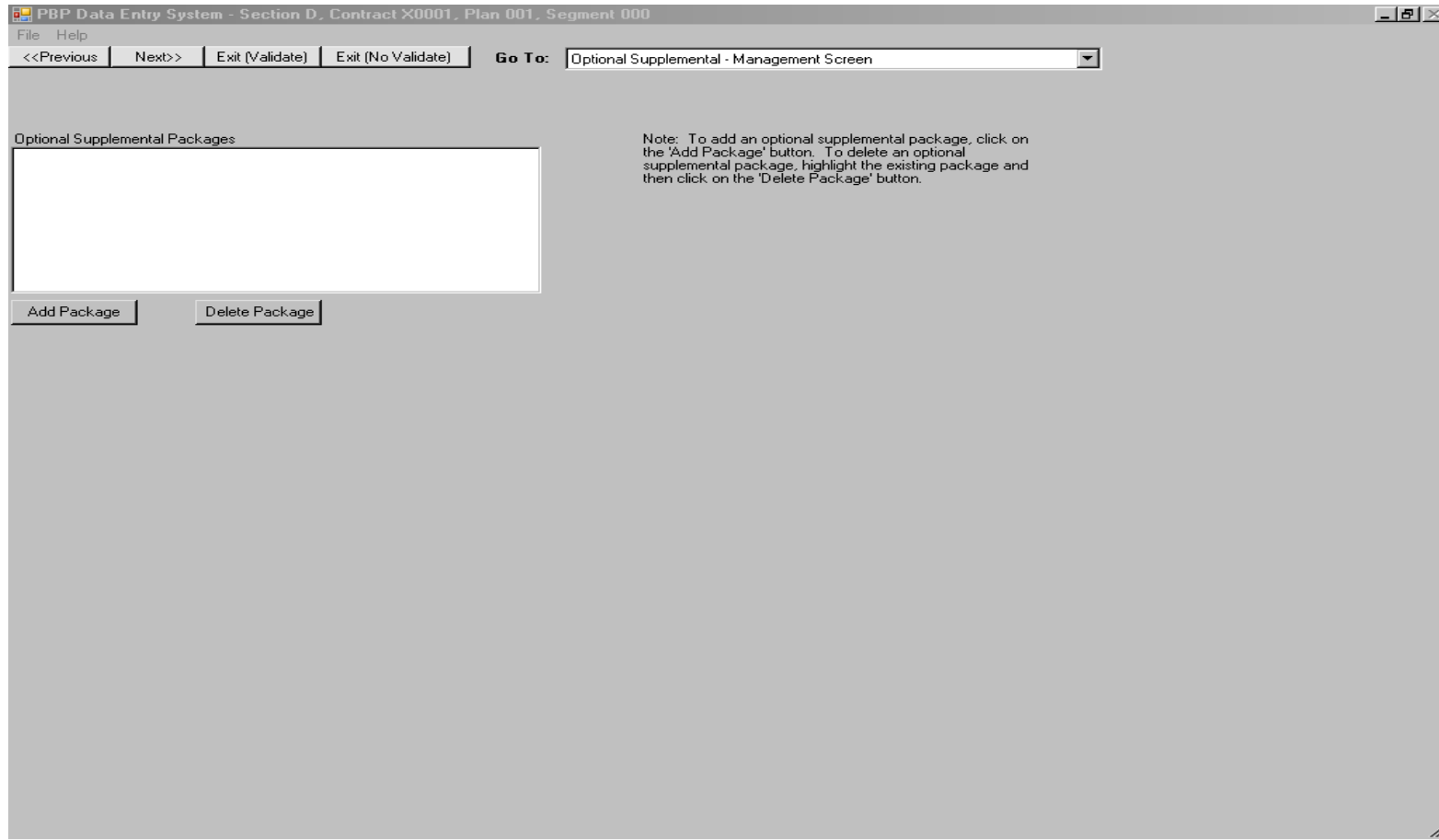
<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Notes

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

Notes (Optional):

Notes (Optional):

Optional Supplemental – Management Screen



Optional Supplemental – Label and Premium Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Optional Supplemental - Label and Premium

Optional Supplemental Benefits ID:

Optional Supplemental Package Description:

Indicate Optional Supplemental Premium Amount:

Is there a Maximum Plan Benefit Coverage Amount for this package?
 Yes
 No

Indicate Maximum Plan Benefit Coverage Amount for this package:

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

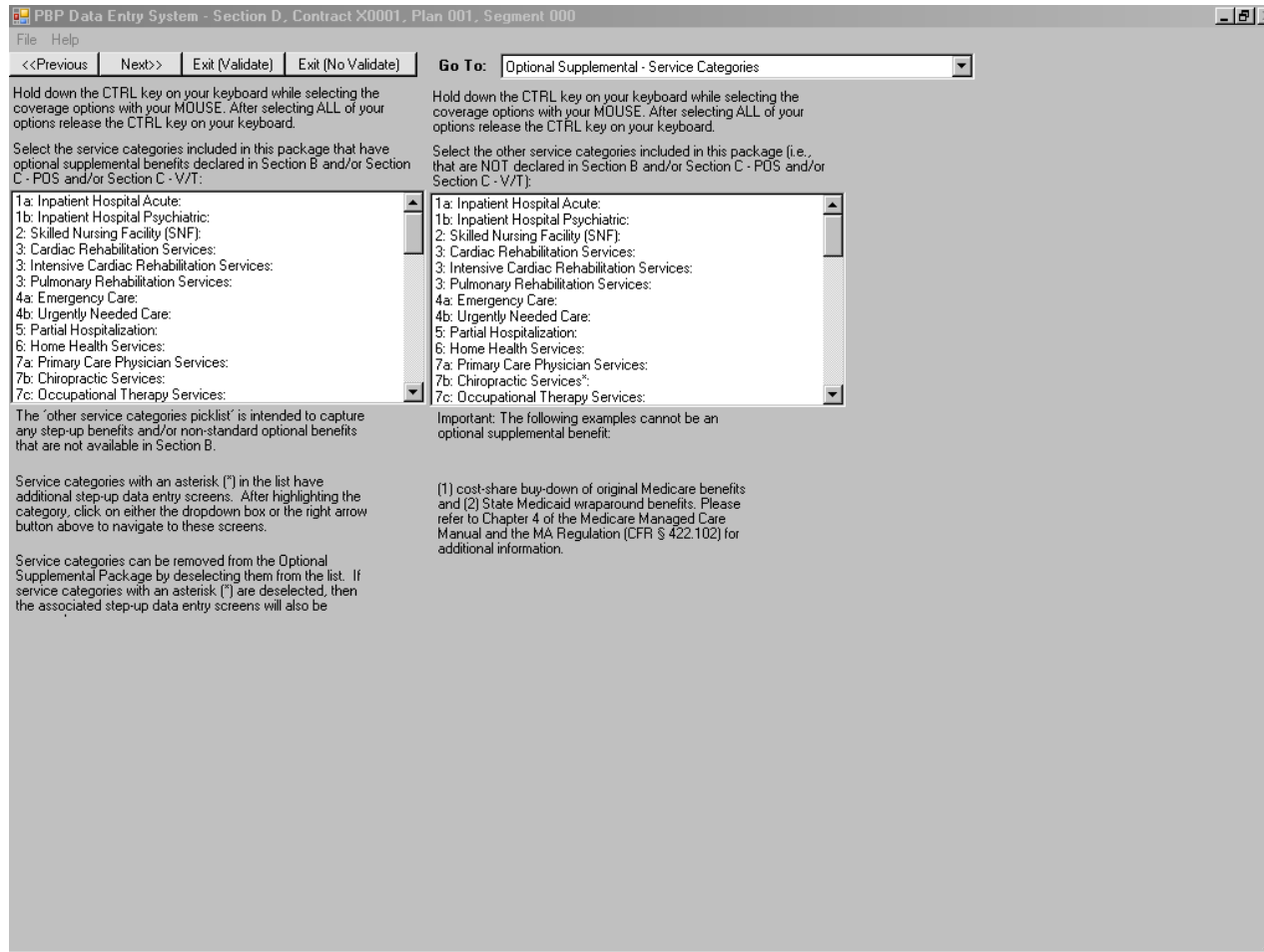
Is there an enrollee Deductible for this package?
 Yes
 No

Indicate Deductible Amount:

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

Notes:

Optional Supplemental – Service Categories Screen



Optional Supplemental – OON Stepup Screen

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

File Help

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

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

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

Is there an OON Copayment?
 Yes
 No

Enter Minimum Copayment Amount:
[]

Enter Maximum Copayment Amount:
[]

Is there an OON Coinsurance?
 Yes
 No

Enter Minimum Coinsurance Percentage:
[]

Enter Maximum Coinsurance Percentage:
[]

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

Notes:
[]

Step Up #10b Transportation Services – Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Step Up #10b Transportation Services – Base 2 Screen

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

File Help

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

Is there a service-specific Maximum Plan Benefit Coverage amount?
 Yes
 No
Indicate Maximum Plan Benefit Coverage amount:
[Text Field]

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:
[Text Field]

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:
[Text Field]

Is there an enrollee Deductible?
 Yes
 No
Indicate Deductible Amount:
[Text Field]

Step Up #10b Transportation Services – Base 3 Screen

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

File Help

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

Is there an enrollee Copayment?

Yes
 No

Indicate Copayment amount per trip:

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

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

Is a referral required for Transportation Services?

Yes
 No

Notes (Optional):

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

Step Up #16a Preventive Dental – Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Step Up #16a Preventive Dental – Base 2 Screen

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

File Help

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

Select type of benefit for Dental X-Rays:

Mandatory
 Optional

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

Yes
 No

Is this benefit unlimited for Dental X-Rays?

Yes
 No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

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

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

Step Up #16a Preventive Dental – Base 3 Screen

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

File Help

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

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Step Up #16a Preventive Dental – Base 4 Screen

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

File Help

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

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

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):

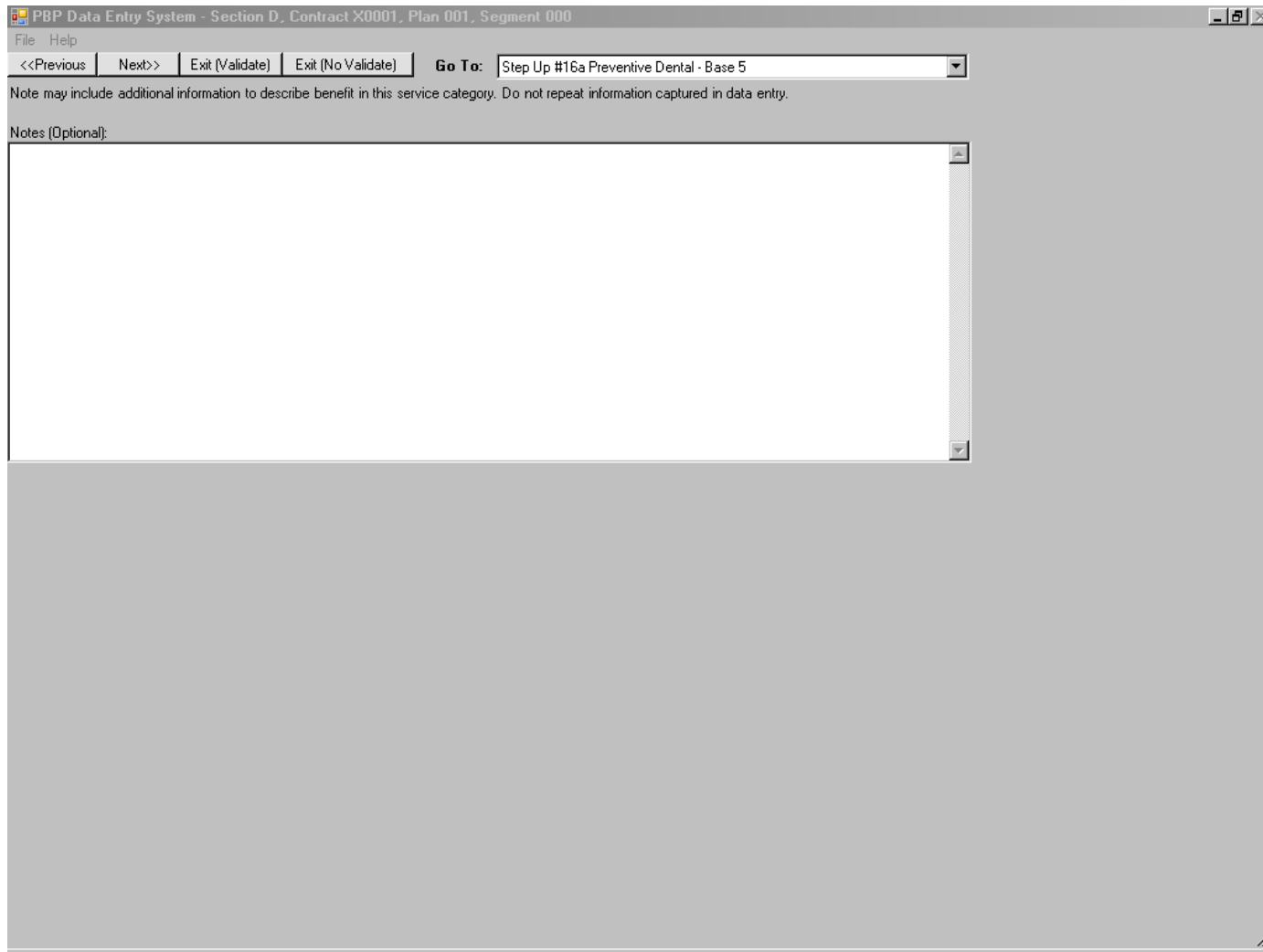
Indicate Minimum Copayment amount for Fluoride Treatment:

Indicate Maximum Copayment amount for Fluoride Treatment:

Indicate Minimum Copayment amount for Dental X-Rays:

Indicate Maximum Copayment amount for Dental X-Rays:

Step Up #16a Preventive Dental – Base 5 Screen



Step Up #16a Comprehensive Dental – Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Select type of benefit for Diagnostic Services:

Mandatory
 Optional

Is this benefit unlimited for Non-routine Services?

Yes
 No, indicate number

Is this benefit unlimited for Diagnostic Services?

Yes
 No, indicate number

Indicate number of visits for Non-routine Services:

Indicate number of visits for Diagnostic Services:

Select the Non-routine Services periodicity:

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

Select the Diagnostic Services periodicity:

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

Step Up #16a Comprehensive Dental – Base 2 Screen

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

File Help

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

Select type of benefit for Restorative Services: <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

Step Up #16a Comprehensive Dental – Base 3 Screen

Step Up #16a Comprehensive Dental – Base 4 Screen

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

File Help

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

Is there an enrollee Coinsurance?

Yes
 No

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:

Step Up #16a Comprehensive Dental – Base 5 Screen

File Help

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

Is there an enrollee Copayment?
 Yes
 No

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
 Prosthodontics, 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 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

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

Step Up #16a Comprehensive Dental – Base 6 Screen

The screenshot shows a software window titled "PBP Data Entry System - Section D, 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 "Step Up #16b Comprehensive Dental - Base 6".

The main content area contains the following sections:

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

Step Up #17a Eye Exams – Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Step Up #17a Eye Exams – Base 2 Screen

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

File Help

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

Is there an enrollee Coinsurance?
 Yes
 No

Select which Eye Exams have a Coinsurance (Select all that apply)
 Medicare-covered Benefits
 Routine Eye Exams

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Eye Exams:

Indicate Maximum Coinsurance percentage for Routine Eye Exams:

Is there an enrollee Copayment?
 Yes
 No

Select which Eye Exams have a Copayment (Select all that apply):
 Medicare-covered Benefits
 Routine Eye Exams

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount per Routine Eye Exam:

Indicate Maximum Copayment amount per Routine Eye Exam:

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Step Up #17a Eye Exams – Base 3 Screen

Step Up #17b Eye Wear – Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Step Up #17b Eye Wear – Base 2 Screen

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

File Help

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

Select type of benefit for Eye Glass Lenses:
 Mandatory
 Optional

Select type of benefit for Eye Glass Frames:
 Mandatory
 Optional

Is this benefit unlimited for Eye Glass Lenses?
 Yes
 No, indicate number

Is this benefit unlimited for Eye Glass Frames?
 Yes
 No, indicate number

Indicate quantity (number of pairs) for Eye Glass Lenses:

Indicate quantity for Eye Glass Frames:

Select Eye Glass Lenses periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, 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

Step Up #17b Eye Wear – Base 3 Screen

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

File Help

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

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

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

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

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

Indicate Combined Maximum Plan Benefit Coverage amount:

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

Step Up #17b Eye Wear – Base 4 Screen

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

File Help

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

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

Yes
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Step Up #17b Eye Wear – Base 5 Screen

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

File Help

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

Is there an enrollee Deductible?

Yes
 No

Indicate Deductible Amount:

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

Is there an enrollee Copayment?

Yes
 No

Indicate Copayment amount for Eye Glass Lenses:

Indicate Copayment amount for Eye Glass Frames:

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 Upgrades:

Step Up #17b Eye Wear – Base 6 Screen

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

File Help

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

Step Up #18a Hearing Exams – Base 1 Screen

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

File Help

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

Go To: Step Up #18a Hearing Exams - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Step Up #18a Hearing Exams – Base 2 Screen

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

File Help

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

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:</p> <p><input type="text"/></p>
<p>Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?</p> <p><input type="radio"/> In-network services only <input type="radio"/> Both In-network and Out-of-network services</p>	<p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <p><input type="text"/></p>	<p>Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:</p> <p><input type="text"/></p>
<p>Indicate Maximum Plan Benefit Coverage amount:</p> <p><input type="text"/></p>	<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Indicate Minimum Coinsurance percentage for Routine Hearing Exams:</p> <p><input type="text"/></p>
<p>Select the Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Indicate Maximum Coinsurance percentage for Routine Hearing Exams:</p> <p><input type="text"/></p>
<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Select which Hearing Exam Benefits have a Coinsurance (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Benefits <input type="checkbox"/> Routine Hearing Exams <input type="checkbox"/> Fitting/Evaluation for Hearing Aid</p>	<p>Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:</p> <p><input type="text"/></p>
<p>Indicate Deductible Amount:</p> <p><input type="text"/></p>		<p>Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:</p> <p><input type="text"/></p>

Step Up #18a Hearing Exams – Base 3 Screen

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

File Help

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

Is there an enrollee Copayment?

Yes
 No

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:

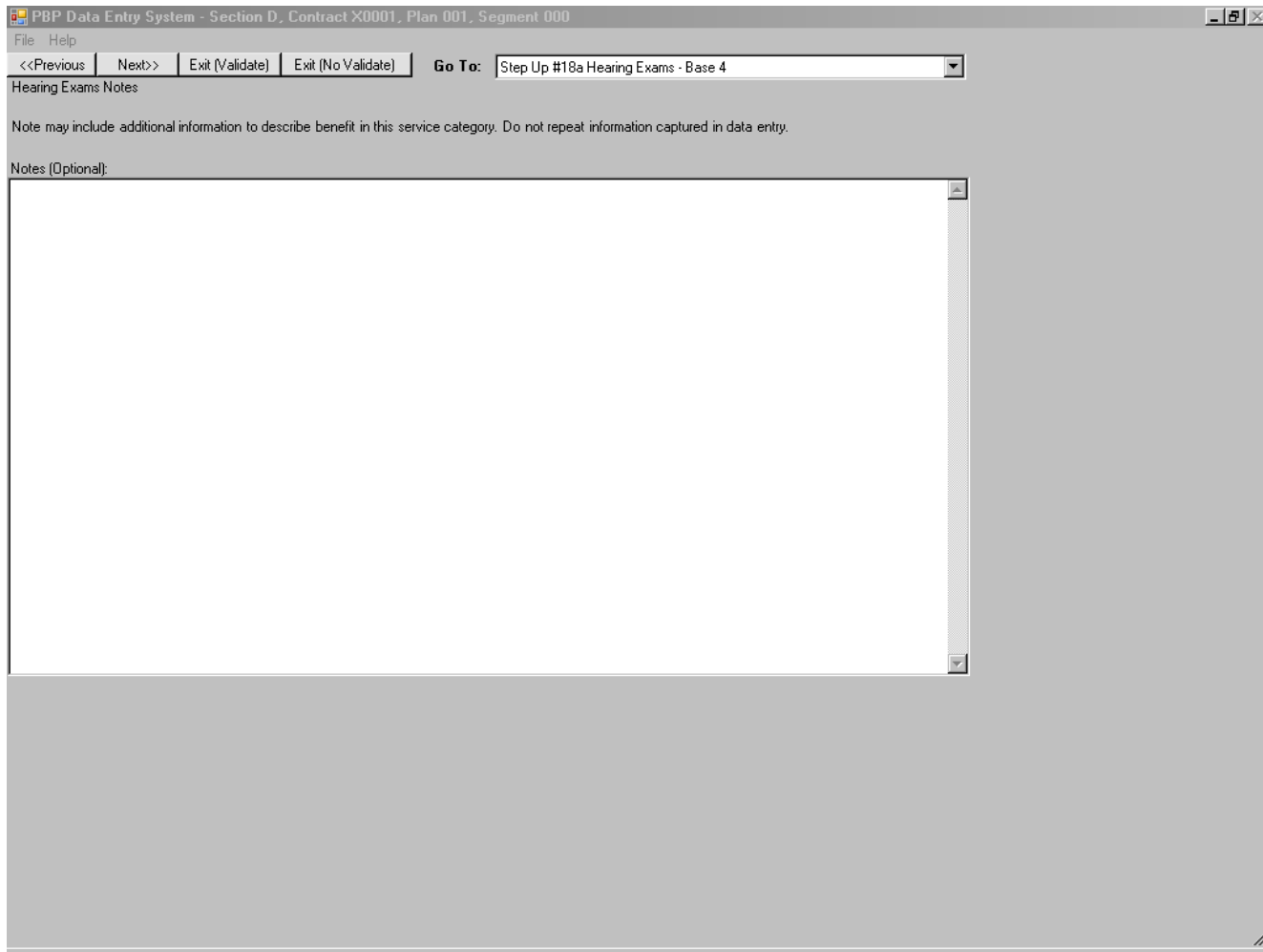
Enrollee must receive Authorization from one or more of the following:

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

Step Up #18a Hearing Exams – Base 4 Screen



Step Up #18b Hearing Aids – Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Step Up #18b Hearing Aids – Base 2 Screen

Step Up #18b Hearing Aids – Base 3 Screen

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

File Help

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

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

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

Step Up #18b Hearing Aids – Base 4 Screen

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

File Help

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

Is there an enrollee Copayment?

Yes
 No

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

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

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

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

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

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

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

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

Is there an enrollee Deductible?

Yes
 No

Indicate Deductible Amount:
[]

Step Up #18b Hearing Aids – Base 5 Screen

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

File Help

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

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

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

Is a referral required for Hearing Aids?

Yes

No

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]

Step Up #7b Chiropractic Services – Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Step Up #7b Chiropractic Services – Base 2 Screen

Step Up #7b Chiropractic Services – Base 3 Screen

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

File Help

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

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:
[]

Is there an enrollee Copayment?
 Yes
 No

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

Step Up #7b Chiropractic Services – Base 4 Screen



Step Up #7f Podiatry Services – Base 1 Screen

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Step Up #7f Podiatry Services – Base 2 Screen

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

File Help

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

Is there an enrollee Coinsurance?
 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:

Step Up #7f Podiatry Services – Base 3 Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #71 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):