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

Fu Associates, Ltd.

🔡 PBP Data Entry System - Section B-1, Contract X0001, Plan 001, S	Segment 000	_8×
File Help		
	#1a Inpatient Hospital-Acute - Base 1 Select type of benefit for Non-Medicare-covered stay:	
CLICK FOR DESCRIPTION OF BENEFIT		
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	O Optional	
C Yes	Select type of benefit for Upgrades:	
C No Select enhanced benefits:	O Mandatory	
Additional Days	C Optional	
Non-Medicare-covered Stay		
Upgrades		
Select type of benefit for Additional Days:		
C Mandatory C Optional		
Is this benefit unlimited for Additional Days?		
C Yes C No, indicate number		
Indicate number of Additional Days per benefit period:		
		//

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

K Next> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient HospitalAcute - Base 2   aximum Plan Benefit Coverage is not applicable for this Service Category. Is there an enrollee Coinsurance?   Yes No   No Medicare-covered Coinsurance Cost Sharing for Tier 1:   ndicate the Maximum Enrollee Out-of-Pocket Cost amount: Do you charge the Medicare-defined cost shares? [These are the total charges for all services provided to the enrollee in the inpatient facility.]   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Ves   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Ves   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Ves   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Ves   Select the maximum Enrollee Out-of-Pocket Cost periodicity:   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Ves   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Ves   Every three months   Every three months   Every three months   Every Strap   Other, Describe   Other, Describe   Other, Describe   Three Three Three	PBP Data Entry System - Section B-1, Contract X0001, Plan 00	1, Segment 000	_ 8
aximum Plan Benefit Coverage is not applicable for this Service Category.       Is there an enrollee Consurance?         Yes       No         No       Medicare-covered Coinsurance?         Yes       No         Select the Maximum Enrollee Out-of-Pocket Cost amount:       Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)         Select the Maximum Enrollee Out-of-Pocket Cost periodicity:       Yes         Select the Maximum Enrollee Out-of-Pocket Cost periodicity:       Indicate Coinsurance percentage for the Medicare-covered stay:         Every three months       Coinsurance (Interval 2)       Medicare-covered stay:         Select the spain's cost sharing vary by hospital(s) in which an enrollee obtains ref?       Three         Indicate the coinsurance (s Interval 1: Begin Day Interval 1: End Day Interval 1: Coinsurance (s Interval 2: Begin Day Interval 2: End Day Interval 2: End Day Interval 3: End Day	File Help		
there a service-specific Maximum Enrollee Out-of-Pocket Cost?       Yes         No       Medicare-covered Coinsurance Cost Sharing for Tier 1:         ndicate the Maximum Enrollee Out-of-Pocket Cost amount:       Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)         Select the Maximum Enrollee Out-of-Pocket Cost periodicity:       Yes         E very three years       Yes         E very three years       No         E very three years       No         E very three years       No         E very three months       No         E very three months       Zero (No Coinsurance percentage for the Medicare-covered stay:         E very three months       Zero (No Coinsurance per Day)         E very three months       Tree         Indicate the coinsurance percentage for the Medicare-covered stay:         Zero (No Coinsurance per Day)       Tree         Three       Tree         Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay:         Yes       One         No       Tree         How many cost sharing vary by hospital(s) in which an enrollee obtains re?         Yes       One         No       Coinsurance % Interval 1:         Begin Day Interval 2:       End Da			
there a service-specific Maximum Enrollee Out-of-Pocket Cost?   No   Indicate the Maximum Enrollee Out-of-Pocket Cost amount:   Select the Maximum Enrollee Out-of-Pocket Cost periodicity:   Every three years   Every three years   Every three months   Every three dotains   modicate the coinsurance percentage and day intervals) for the Medicare-covered stay:   Vest   No   How many cost sharing vary by hospital(s) in which an enrollee obtains re?   Yes   No   How many cost sharing vary by nospital(s) in which an enrollee obtains re?   Mot is your lowest cost tier?   What is	faximum Plan Benefit Coverage is not applicable for this Service Category.		
Yes       Medicare-covered Coinsurance Cost Sharing for Tier 1:         Indicate the Maximum Enrollee Out-of-Pocket Cost amount:       Do you charge the Medicare-defined cost shares? [These are the total charges for all services provided to the enrollee in the inpatient facility.]         Select the Maximum Enrollee Out-of-Pocket Cost periodicity:       Yes         Every three years       Indicate Coinsurance percentage for the Medicare-covered stay:         Every three months       Indicate Coinsurance percentage for the Medicare-covered stay:         Every three months       Zero [No Coinsurance per Day]         Every the months       Zero [No Coinsurance per Day]         One       Three         Indicate the coinsurance percentage and day intervals for the Medicare-covered stay:         Yes       One         Three       Three         No       Three         How many cost sharing vary by hospital(s) in which an enrollee obtains te?       Three         Yes       Indicate the coinsurance percentage and day interval[s] for the Medicare-covered stay (e.g., 1 to 30; 31 to 90);         Yes       Coinsurance % Interval 1:       Begin Day Interval 2:         Most is your lowest cost tier?       Coinsurance % Interval 2:       Begin Day Interval 3:         End Day Interval 3:       End Day Interval 3:       End Day Interval 3:	there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
Indicate the Maximum Enrollee Dut-of-Pocket Cost amount:       Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)         Select the Maximum Enrollee Dut-of-Pocket Cost periodicity:	C Yes		
Do you charges for all services provided to the encles in the inpatient facility.)         Select the Maximum Encollee Dut-of-Pocket Cost periodicity:         Every three years         Every three years         Every three years         Every three years         Every three months         Every	O No	Medicare-covered Coinsurance Cost Sharing for Tier 1:	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity: <ul> <li>No</li> <li>Indicate Coinsurance percentage for the Medicare-covered stay:</li> <li>Every three months</li> <li>Every three months</li> <li>Every three months</li> <li>Every stay</li> <li>Other, Describe</li> </ul> <li>Indicate the number of day intervals for the Medicare-covered stay:</li> <li>Zero (No Coinsurance per Day)</li> <li>Cervery stay</li> <li>Other, Describe</li> <li>Zero (No Coinsurance per Day)</li> <li>One</li> <li>Two</li> <li>Tree</li> <li>Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay:</li> <li>Coinsurance % Interval 1: End Day Interval 1:</li> <li>End Day Interval 2:</li> <li>End Day Interval 2:</li> <li>End Day Interval 2:</li> <li>End Day Interval 3:</li> <li>End Day Interval 3:</li>	Indicate the Maximum Enrollee Out-of-Pocket Cost amount:	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
Every two years       Indicate Consurance percentage for the Medicare-covered stay:         Every year       Indicate Consurance percentage for the Medicare-covered stay:         Every three months       Indicate the number of day intervals for the Medicare-covered stay:         Every three months       Zero (No Consurance per Day)         Other, Describe       Two         Three       Indicate the consurance percentage and day interval(s) for the Medicare-covered stay:         Yes       Indicate the consurance percentage and day interval(s) for the Medicare-covered stay:         Yes       Indicate the consurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 30);         Yes       Indicate the consurance percentage and day interval 1:         How many cost sharing tiers do you offer?       Consurance % Interval 1:       Begin Day Interval 1:         What is your lowest cost tier?       Coinsurance % Interval 3:       Begin Day Interval 3:       End Day Interval 3:         Tier 2       Coinsurance % Interval 3:       Begin Day Interval 3:       End Day Interval 3:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:		
Every war       Indicate the number of day intervals for the Medicare-covered stay:         Every brew three months       Czero (No Coinsurance per Day)         Every brew three months       Czero (No Coinsurance per Day)         Every brew three months       Czero (No Coinsurance per Day)         Every brew three months       Czero (No Coinsurance per Day)         Deter, Describe       O ne         Two       Two         Three       Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):         Yes       Indicate the coinsurance & Interval 1:       End Day Interval 1:         How many cost sharing tiers do you offer?       Coinsurance % Interval 1:       Begin Day Interval 2:         What is your lowest cost tier?       Coinsurance % Interval 3:       Begin Day Interval 3:       End Day Interval 3:         Tier 1       Coinsurance % Interval 3:       Begin Day Interval 3:       End Day Interval 3:		Indicate Coinsurance percentage for the Medicare-covered staur	
Every six months       Indicate the number of day intervals for the Medicare-covered stay:         Every Brenith Period       Czero (No Coinsurance per Day)         Every Brenith Period       One         Other, Describe       Three         Indicate the coinsurance per Caty)       Three         Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay:       Three         Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay:       Coinsurance % Interval 1:         How many cost sharing tiers do you offer?       Coinsurance % Interval 1:       End Day Interval 1:         What is your lowest cost tier?       Coinsurance % Interval 2:       Begin Day Interval 2:       End Day Interval 2:         Tier 1       Coinsurance % Interval 3:       Begin Day Interval 3:       End Day Interval 3:			
C Every three months       C Every three months         C Every Break Period       C Zero (No Consurance per Day)         C Drey Stay       O ne         O ther, Describe       Three         res this plan's cost sharing vary by hospital(s) in which an enrollee obtains re?       Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 30);         Yes       Indicate the coinsurance percentage and day interval 1:         How many cost sharing tiers do you offer?       Coinsurance % Interval 1:         What is your lowest cost tier?       Coinsurance % Interval 2:         Tier 1       Coinsurance % Interval 3:         Coinsurance % Interval 3:       Begin Day Interval 3:			
© Every Benefit Period       © Zero (No Coinsurance per Day)         © Other, Describe       © Two         © Other, Describe       © Two         © Three       Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 30);         Yes       Indicate the coinsurance extended and y interval 1:         No       Eoinsurance % Interval 1:         How many cost sharing tiers do you offer?       Eoinsurance % Interval 2:         What is your lowest cost tier?       Coinsurance % Interval 2:         © Tier 1       Coinsurance % Interval 3:         Coinsurance % Interval 3:       Begin Day Interval 3:		Indicate the number of day intervals for the Medicare-covered stay:	
© Every Stay       © One         © Under, Describe       © Two         or ther, Describe       © Two         or three       Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 50);         Yes       Indicate the coinsurance & Interval 1:         How many cost sharing tiers do you offer?       © Cinsurance % Interval 1:         What is your lowest cost tier?       © Coinsurance % Interval 2:         © Tier 1       © Coinsurance % Interval 3:         Coinsurance % Interval 3:       Begin Day Interval 3:		Zero (No Coinsurance per Day)	
O Dther, Describe         Describe         Describe         Describe         Differ, Describe         Describe         Differ, Describe         Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 30;         Differ, Describe         No         No         No         How many cost sharing tiers do you offer?         Differ, Describe         Coinsurance % Interval 1:         Begin Day Interval 2:         End Day Interval 2:         End Day Interval 3:         End Day Interval 3:		O One	
Consurance % Interval 2:     Consurance % Interval 3:     Consurance % Interval 4:     Consurance		C Two	
we?     Indicate the coinsurance percentage and day interval(s) for the Medicare- covered stay (e.g., 1 to 30; 31 to 30);       Yes     Coinsurance % Interval 1:       How many cost sharing tiers do you offer?     Coinsurance % Interval 1:       What is your lowest cost tier?     Coinsurance % Interval 2:       Tier 1     Coinsurance % Interval 3:       Coinsurance % Interval 3:     End Day Interval 3:		O Three	
No     Coinsurance % Interval 1:     Begin Day Interval 1:     End Day Interval 1:       How many cost sharing tiers do you offer?     Coinsurance % Interval 1:     End Day Interval 1:       What is your lowest cost tier?     Coinsurance % Interval 2:     Begin Day Interval 2:       Tier 1     Coinsurance % Interval 3:     Begin Day Interval 3:	are?	Indicate the coinsurance percentage and day interval(s) for the Medicare- covered stay (e.g., 1 to 30; 31 to 90);	
How many cost sharing tiers do you offer? Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: What is your lowest cost tier? Ciriser 1 Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:			
Coinsurance % Interval 2:     Begin Day Interval 2:     End Day Interval 2:       What is your lowest cost tier?     Coinsurance % Interval 2:     End Day Interval 2:       C Tier 1     Coinsurance % Interval 3:     Begin Day Interval 3:       C Tier 2     Begin Day Interval 3:     End Day Interval 3:		Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
What is your lowest cost tier?       O Tier 1       C Tier 2         Coinsurance % Interval 3:         Begin Day Interval 3:   End Day Interval 3:	How many cost sharing tiers do you offer?		
What is your lowest cost tier?     Image: Consurance % Interval 3:     End Day Interval 3:       C Tier 2     End Day Interval 3:     End Day Interval 3:		Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
C Tier 2 Consultance 4 Interval 3: Degin Day Interval 3: End Day Interval 3:	What is your lowest cost tier?		
O Tier 2		Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
C Tier 3			
	O Tier 3		

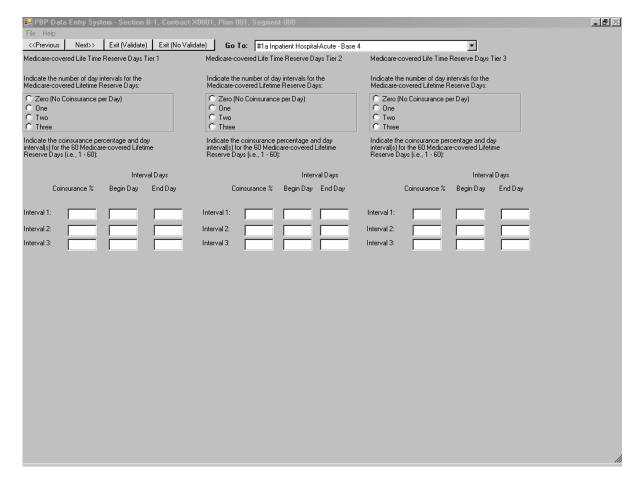
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## Section B - 1A - Inpatient Hospital-Acute – Base 3 Screen

📴 PBP Data Entry System - Section B-1, Contract X0001, Plan 001, File Help	Segment 000	_ 8 >
	#1a Inpatient Hospital-Acute - Base 3	
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.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
C Yes C No	C Yes C No	
Indicate Coinsurance percentage for the Medicare-covered stay:	Indicate Coinsurance percentage for the Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Coinsurance per Day) C One C Two C Three	C Zero (No Coinsurance per Day) C One C Two C Three	
Indicate the coinsurance percentage and day interval(s) for the Medicare- covered stay (e.g., 1 to 30; 31 to 90);	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 1: Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3	

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



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

Fu Associates, Ltd.

📴 PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000	_ <del>8</del> ×
Kervious         Next>>         Exit (Validate)         Exit (No Validate)         Go To:         #1a Inpatient Hospital-Acute - Base 5	
Indicate the number of day intervals for Additional Days:	
C Zero (No Coinsurance per Day) C One C Two	
C Three	
Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999);	
Coinsurance % Interval 1: Begin Day Interval 1:	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
	//

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

🛃 PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000	_ 8 ×
File     Help       < <previous< td="">     Next&gt;&gt;     Exit (Validate)     Exit (No Validate)     Go To:     #1a Inpatient Hospital-Acute - Base 6</previous<>	
<pre>&lt;<previous next="">&gt; Exit (Validate) Exit (No Validate) Go To: #1 a Inpatient Hospital-Acute - Base 6</previous></pre>	
© Yes	
C 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)     O One	
C Two	
O 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: End Day Interval 1:	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
Indicate Coinsurance percentage for Upgrades:	

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

Fu Associates, Ltd.

PBP Data Entry System - Section B-1, Contract X0001	1, Plan 001, Segment 000	_ 8 >
File Help > Exit (Validate) Exit (No Validate)	Go To: #1a Inpatient Hospital-Acute - Base 7	
If you do not have a service-specific deductible for this benefit but offer a plan-specific, then enter the plan deductible in Section D.	Medicare-covered Copayment Cost Sharing for Tier 1:	
Is there an enrollee Deductible?	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
C Yes C No	C Yes C No	
Indicate Deductible Amount for Tier 1:	Indicate Copayment amount for the Medicare-covered stay:	
	Indicate the number of day intervals for the Medicare-covered stay:	
Indicate Deductible Amount for Tier 2:	C Zero (No Copayment per Day) C One	
Indicate Deductible Amount for Tier 3:	C Two C Three	
	Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 30): For more information on cost share limitations please view the variable help.	
Is there an enrollee Copayment?	Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
O No		
	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	

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

🖶 PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000 Fle Help	_
celle relip	
Medicare-covered Copayment Cost Sharing for Tier 2: Medicare-covered Copayment Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.) all services provided to the enrollee in the inpatient facility.)	
C Yes C No C Yes	
Indicate Copayment amount for the Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Copayment per Day)         C One           C One         C Two	
C Two	
C Three Indicate the copayment amount and day interval(s) for the Medicare-covered stay	
Indicate the copayment amount and day interval(s) for the Medicare- covered stay (e.g., 1 to 30; 31 to 30); For more information on cost share limitations please imitations please view the variable help.	
Copayment Amt Interval 1: End Day Interval 1: End Day Interval 1: Copayment Amt Interval 1: End 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:	
Construction of the second secon	
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	

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

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🔛 PBP Data Entry File Helo	System - Section	n B-1, Contract	X0001, Plan (	)01, Segment (	100						_ 8 ×
< <previous nex<="" th=""><th>t&gt;&gt; Exit (Validat</th><th>e) Exit (NoVal</th><th>idate) Go</th><th>To: #1a Inpati</th><th>ent Hospital-A</th><th>cute - Base 9</th><th></th><th></th><th><b>-</b></th><th></th><th></th></previous>	t>> Exit (Validat	e) Exit (NoVal	idate) Go	To: #1a Inpati	ent Hospital-A	cute - Base 9			<b>-</b>		
Medicare-covered Life	Time Reserve Days	: Tier 1		vered Life Time R			Medicare-cov	ered Life Time Res	erve Days Tie	r3	
Indicate the number of covered Lifetime Rese	day intervals for the ve Days:	Medicare-	Indicate the covered Life	number of day inte time Reserve Day	ervals for the N s:	Medicare-	Indicate the n covered Lifetir	umber of day interv me Reserve Days:	als for the Me	dicare-	
C Zero (No Copayme C One C Two C Three	nt per Day)		C Zero (No C One C Two C Two C Three	) Copayment per [	)ay)		C Zero (No C One C Two C Three	Copayment per Daj	y)		
Indicate the copaymer 60 Medicare-covered I	t amount and day in ifetime Reserve Day	terval(s) for the ys (i.e., 1 - 60):	Indicate the 60 Medicare	copayment amour -covered Lifetime	nt and day inte Reserve Days	erval(s) for the s (i.e., 1 - 60):	Indicate the c 60 Medicare c	opayment amount a overed Lifetime Re	and day interv eserve Days (i.	al(s) for the .e., 1 - 60):	
	Inter	val Days			Interva	l Days			Interva	l Days	
Copay Am	ount Begin Day	End Day		Copay Amount	Begin Day	End Day		Copay Amount	Begin Day	End Day	
Interval 1:			Interval 1:				Interval 1:				
Interval 2:			Interval 2:				Interval 2:				
Interval 3:			Interval 3:				Interval 3:				
											1.

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

📰 PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000	_ 8 ×
Go To:       #1a Inpatient Hospital-Acute - Base 10	
Indicate the number of day intervals for Additional Days:	
C Zero (No Copayment per Day) O One C Two O Three	
Indicate the copayment amount and day interval(s) for Additional Days (enter '999' if unlimited days are offered; e.g., 91 to 999):	
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
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## Section B – 1B - Inpatient Hospital Psychiatric – Base 11 Screen

🔛 PBP Data Entry System - Section B-1, Contract X0001, Plan 001,	Segment 000	X
File Help		
	#1a Inpatient Hospital-Acute - Base 11	
Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?	Indicate Copayment amount for Upgrades per stay:	
O Yes		
O No	Indicate Copayment amount for Upgrades per day:	
Indicate Copayment amount for the Non-Medicare-covered stay:		
	Enrollee must receive Authorization from one or more of the following:	
	Enrollee must receive Authorization from one or more or the following:	
Indicate the number of day intervals for the Non-Medicare-covered stay:	Primary Care Physician (Internist/Family Practice, General Practice)	
C Zero (No Copayment per Day) C One	Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review	
O Two	Organization Medical Director/Ordization Management/Ordization Neview     Other, describe	
O Three		
Indicate the copayment amount and day interval(s) for the Non-Medicare- covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999):		
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:		
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:		
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:		
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Fu Associates,	Ltd.
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Section B – 1B - Inpatient Hospital Psychiatric – Base 12 Screen

📰 PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000 File Help	_ <del>_</del> _ <del>/</del> ×
Continue Trappione Continue (Next) >> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 12	
Is a referral required for Inpatient Hospital - Acute Services? Inpatient Hospital - Acute Notes	
O Yes         Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
Notes (Optional):	
Y I I I I I I I I I I I I I I I I I I I	
	1.

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

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🔛 PBP Data Entry System - Section B-1, Contract X0001, I	Plan 001, Segment 000	
File Help		_
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #1a Inpatient Hospital-Acute (B Only) - Base 1 Is there a service-specific Maximum Plan Benefit Coverage amount?	<b>_</b>
CLICK FOR DESCRIPTION OF BENEFIT	O Yes	
Do you offer Inpatient Hospital - Acute Services as a benefit?	C No	
C Yes C No	Indicate Maximum Plan Benefit Coverage amount:	
Select type of benefit for Inpatient Hospital - Acute Services:		
C Mandatory	Select Maximum Plan Benefit Coverage periodicity:	
C Optional		
Does this benefit have unlimited days?	C Every two years	
C Yes	C Every year C Every six months	
O No, indicate number	C Every three months C Every Benefit Period	
Indicate number of days per period:	O Every Stay	
	O Other, Describe	
Select the days periodicity:		
C Every three years	7	
C Every two years C Every year		
C Every six months		
C Every three months C Every Benefit Period		
C Every Stay		
O Other, Describe		
		li li

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

Page 13 of 215

BPBP Data Entry System - Section B-1, Contract X0001, File Help	Plan 001,	l, Segment 000	_ & ×
Kite         Next>>         Exit (Validate)         Exit (No Validate)           Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?         Exit (No Validate)         Exit (No Validate)	Go To:	#1a Inpatient Hospital-Acute (B Only) - Base 2 Indicate the number of day intervals for the stay:	
Yes     No     Indicate the Maximum Enrollee Out-of-Pocket Cost amount:		O Zero (No Coinsurance per Day) O One O Two O Three	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:		Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):	
C Every three years C Every two years C Every year		Coinsurance % Interval 1: Begin Day Interval 1:	
C Every six months C Every three months C Every Benefit Period C Every Stay		Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
C Other, Describe Is there an enrollee Coinsurance? C Yes			
No Indicate Coinsurance percentage per stay:			

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

Fu Associates, Ltd.

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🔡 PBP Data Entry System - Section B-1, Contract X0001, I	<sup>9</sup> lan 00 <u>1,</u>	Segment 000	
File Help			
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To:	#1a Inpatient Hospital-Acute (B Only) - Base 3	•
Is there an enrollee Deductible?		Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):	
C Yes C No		Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
		Copayment Anit Interval 1. Begin Day Interval 1. End Day Interval 1.	
Indicate Deductible Amount:		· · · · · · · · · · · · · · · · · · ·	
		Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
Is there an enrollee Copayment?			
O Yes	7	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
C No			
Indicate Copayment amount per stay:			
		rollee must receive Authorization from one or more of the following: None	
		Primary Care Physician (Internist/Family Practice, General Practice)	
Indicate the number of day intervals for the stay:		Physician Specialist	
C Zero (No Copayment per Day) C One		Organization Medical Director/Utilization Management/Utilization Review Other, describe	
O Two		a referral required for Inpatient Hospital - Acute Services?	
C Three		a referrai required for inpatient Hospital - Acute Services? Yes	Г
		No	
			/

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

Fu Associates, Ltd.

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	stem - Section B·	1, Contract X0001, I	Plan 001,	Segment 000	_8>
File Help < <previous next="">&gt;</previous>	Exit (Validate)	Exit (No Validate)	Go To:	#1a Inpatient Hospital-Acute (B Only) - Base 4	1
Inpatient Hospital - Acute I				_	
		nika kanadi indala ana		. Do not repeat information captured in data entry.	
	ai information to des	cribe benefit in this servi	ice category	. Do not repeat information captured in data entry.	
Notes (Optional):					
				-	

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 16 of 215

📴 PBP Data Entry System - Section B-1, Contract X0001, Plan 001	, Segment 000	_ 8 )
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To:</previous>	#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?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
C Yes	O Yes O No	
C No		
Select enhanced benefit: Additional Days	Select the Maximum Enrollee Out-of-Pocket Cost type:	
Non-Medicare-covered Stay	Covered under Inpatient Hospital Services Category 1a     Plan-specified amount per period	
	<ul> <li>Plan-specified amount per period</li> </ul>	
Select type of benefit for Additional Days:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
C Mandatory C Optional		
	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
Is this benefit unlimited for Additional Days?	C Every three years	
C Yes	C Every two years	
O No, indicate number	C Every year C Every six months	
Indicate number of Additional Days per benefit period:	C Every six months	
	C Every Benefit Period	
	C Every Stay	
Select type of benefit for Non-Medicare-covered stay:	O Other, Describe	
C Mandatory		
C Optional		

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

Fu Associates, Ltd.

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ion B-1, Contract X0001, Plan 001, Segment 000
date) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 2
C Zero (No Coinsurance per Day) C Dre T wo T wo T hree Indicate the coinsurance percentage and day interval(s) for the Medicare- covered stay (e.g., 1 to 30; 31 to 90): Coinsurance % Interval 1: End Day Interval 1: Coinsurance % Interval 2: End Day Interval 2: End D

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 18 of 215

🔛 PBP Data Entry System - Section B-1, Contract X0001, Plan 001	, Segment 000	_1
File Help < <pre> </pre> Kit (No Validate) (Next) Kit (No Validate) (Next) Kit (No Validate) (Next)	#1b Inpatient Hospital Psychiatric - Base 3	
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	Do you charge the Medicare-defined cost shares? (These are the total	
charges for all services provided to the enrollee in the inpatient facility.)	charges for all services provided to the enrollee in the inpatient facility.)	
C Yes C No	C No	
Indicate Coinsurance percentage for the Medicare-covered stay:	Indicate Coinsurance percentage for the Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Coinsurance per Day)	Indicate the number of day intervals for the Medicare-covered stay: Zero (No Coinsurance per Day)	
O One	C One	
C Two C Three	O Two O Three	
Indicate the coinsurance percentage and day interval(s) for the Medicare-	Indicate the coinsurance percentage and day interval(s) for the Medicare-	
covered stay (e.g., 1 to 30; 31 to 90):	covered stay (e.g., 1 to 30; 31 to 90):	
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 19 of 215

E PBP Data El	ntry Syste	em - Section I	8-1, Contract XC	1001, Plan 0	)1, Segmei	nt 000						_8×
	Next>>	Exit (Validate)	Exit (No Valida	te) Go T	o: #1bln	patient Hospita	l Psychiatric - I	Base 4		•		
Medicare-covered	l Life Time F	Reserve Days T	ier 1	Medicare-co	, vered Life Ti	me Reserve Da	ays Tier 2	Medicare-	covered Life Time I	Reserve Days 1	Tier 3	
Indicate the numb Medicare-covered	er of day in Lifetime Re	tervals for the eserve Days:		Indicate the Medicare-co	number of d	ay intervals for ne Reserve Day	the /s:	Indicate th Medicare-	ie number of day in covered Lifetime R	itervals for the eserve Days:		
C Zero (No Coin C One C Two C Three	isurance pe	r Day)		C Zero (N C One C Two C Three	o Coinsuranc	e per Day)		C Zero ( C One C Two C Three	No Coinsurance p	er Day)		
Indicate the coinst interval(s) for the 6 Reserve Days (i.e.	60 Medicare	entage and day covered Lifetin	y ne	Indicate the interval(s) for Reserve Day	the 60 Med	percentage an icare-covered l )):	id day Lifetime	interval(s) I	e coinsurance per ior the 60 Medicar ays (i.e., 1 - 60):	centage and da a-covered Lifeti	ay me	
		Interva	l Days			Interv	val Days			Interva	l Days	
Coinsura	ance %	Begin Day	End Day	Coi	nsurance %	Begin Day	End Day		Coinsurance %	Begin Day	End Day	
Interval 1:				Interval 1:				Interval 1:				
Interval 2:				Interval 2:				Interval 2:				
Interval 3:				Interval 3:				Interval 3:				
												//

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 20 of 215

🔛 PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000	_ 8 ×
File Help	
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 5</previous>	
Indicate the number of day intervals for Additional Days:	
C Zero (No Coinsurance per Day)	
C One C Two	
C Three	
Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):	
Coinsurance % Interval 1: End Day Interval 1:	
Coinsurance % Interval 2: End Day Interval 2: End Day Interval 2:	
Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3:	
	1.

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 21 of 215

error Berling	01, Segment 000		_ 8 ×
	o: #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?		_	
C Yes			
O No			
Indicate Coinsurance percentage for the Non-Medicare-covered stay:			
Indicate the number of day intervals for the Non-Medicare-covered stay:			
<ul> <li>Zero (No Coinsurance per Day)</li> <li>One</li> </ul>			
C Two C Three			
Indicate the coinsurance percentage and day interval(s) for the Non- Medicare-covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999);			
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:			
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:			
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:			

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

Fu Associates, Ltd.	

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📴 PBP Data Entry System - Section B-1, Contract X0001, I	Plan 001, Segment 000	_ 8 ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	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.	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.)	
Is there an enrollee Deductible?	C Yes C No	
C Yes C No		
	Indicate Copayment amount for the Medicare-covered stay:	
Indicate Deductible Amount for Tier 1:	Indicate the number of day intervals for the Medicare-covered stay:	
	O Zero (No Copayment per Day)	
Indicate Deductible Amount for Tier 2:	C One C Two	
	O Three	
Indicate Deductible Amount for Tier 3:	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:	
Is there an enrollee Copayment? C Yes	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
O No	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
	Copayineni Anii Intervaris. Begin Day Intervaris. End Day Intervaris.	

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 23 of 215

歸 PBP Data Entry System - Section B-1, Contract X0001, Plan 001,	Segment 000	Ð
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To:</previous>	#1b Inpatient Hospital Psychiatric - Base 8	
Medicare-covered Copayment Cost Sharing for Tier 2:	Medicare-covered Copayment Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
	C Yes C No	
Indicate Copayment amount for the Medicare-covered stay:	Indicate Copayment amount for the Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	C Zero (No Copayment per Day)	
C Zero (No Copayment per Day)	O One	
C One C Two	O Two	
C Three	C Three	
Indicate the copayment amount and day interval(s) for the Medicare- covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.	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: End Day Interval 1: End Day Interval 1:	
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2: End Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 3: End Day Interval 3: End Day Interval 3:	

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

Fu Associates, Ltd.

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vledicare-c	overed Life Time	Reserve Days 1	Tier 1	Medicare-co	overed Life Time R	eserve Days 1	Tier 2	Medicare-cove	ered Life Time Res	erve Days Tie	r3
idicate the overed Lif	enumber of day in etime Reserve Da	itervals for the h ays:	Medicare-	Indicate the covered Life	number of day inte stime Reserve Day	ervals for the N is:	Medicare-	Indicate the nu covered Lifetin	umber of day interv ne Reserve Days:	als for the Me	dicare-
C Zero (N C One C Two C Three	lo Copayment pe	Day)		C Zero (N C One C Two C Three	o Copayment per [	)ay)		C Zero (No 0 C One C Two C Three	Copayment per Day	y)	
idicate the 0 Medicar	e copayment amo e-covered Lifetim	unt and day inte e Reserve Day:	erval(s) for the s (i.e., 1 · 60):	Indicate the 60 Medicare	copayment amour e-covered Lifetime	nt and day inte Reserve Days	erval(s) for the s (i.e., 1 - 60):	Indicate the co 60 Medicare-c	opayment amount a overed Lifetime Re	and day interv eserve Days (i.	al(s) for the .e., 1 - 60):
		Interv	al Days			Interva	l Days			Interva	l Days
	Copay Amount	Begin Day	End Day		Copay Amount	Begin Day	End Day		Copay Amount	Begin Day	End Day
nterval 1:				Interval 1:				Interval 1:			
nterval 2:				Interval 2:				Interval 2:			
nterval 3:				Interval 3:				Interval 3:			

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

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CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 25 of 215

🔜 PBP Data Entry System - Section B-1, Contract X0001, Plan (	001, Segment 000
File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go</previous<>	To: #1b Inpatient Hospital Psychiatric - Base 10
Indicate the number of day intervals for Additional Days:	
C Zero (No Copayment per Day)	
C One C Two	
C Three	
Indicate the copayment amount and day interval(s) for Additional Days (ente "999" if unlimited days are offered; e.g., 91 to 999);	a
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1	:
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2	h.
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3	k

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

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🔡 PBP Data Entry System - Section B-1, Contract X0001, Plan 001	, Segment 000	_ 8 >
File Help		
	#1b Inpatient Hospital Psychiatric - Base 11	
Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?	Enrollee must receive Authorization from one or more of the following:	
O Yes O No	Primary Care Physician (Internist/Family Practice, General Practice)	
U No	Physician Specialist	
Indicate Copayment amount for the Non-Medicare-covered stay:	Organization Medical Director/Utilization Management/Utilization Review     Other, describe	
Indicate the number of day intervals for the Non-Medicare-covered stay:	Is a referral required for Inpatient Psychiatric Hospital Services?	
C Zero (No Copayment per Day)	C Yes C No	
O One		
O Two		
C Three		
Indicate the copayment amount and day interval(s) for the Non-Medicare- covered stay (enter "399" if unlimited days are offered; e.g.; 1 to 999):		
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:		
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:		
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:		

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

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	Entry Sys	tem - Section I	I-1, Contract X0001,	Plan 001,	Segment 000					_ 8
File Help		Lesaures	Lesaures 1						1	
< <previous< td=""><td>Next&gt;&gt;</td><td>Exit (Validate)</td><td>Exit (No Validate)</td><td>Go To:</td><td>#1b Inpatient H</td><td>ospital Psychiatric</td><td>- Base 12</td><td>•</td><td>J</td><td></td></previous<>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient H	ospital Psychiatric	- Base 12	•	J	
npatient Psychi	iatric Hospit	al Notes								
lote may includ	de additiona	al information to de	scribe benefit in this ser	vice category	y. Do not repeat ir	nformation capture	d in data entry.			
lotes (Optional)	):							A	1	
								-	1	
									1	
								<u> </u>	1	

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 28 of 215

File ede     cdPrevious But (Valdade)        cutckTop ESCRIPTION OF BENET        Do you offer (registert Psychiatic Hospial Services as a benefit?         Vere        Select type of benefit for (registert Psychiatic Hospial Services)               Select type of benefit for (registert Psychiatic Hospial Services)               Select type of benefit for (registert Psychiatic Hospial Services)                  Select type of benefit for (registert Psychiatic Hospial Services)                           Select type of benefit for (registert Psychiatic Hospial Services) <th>🔜 PBP Data Entry System - Section B-1, Contract X0001, P</th> <th>lan 001, Segment 000</th> <th>_ B ×</th>	🔜 PBP Data Entry System - Section B-1, Contract X0001, P	lan 001, Segment 000	_ B ×
Do you offer Inpatient Psychiatric Hospital Services as a benefit?  Yes No Select type of benefit for Inpatient Psychiatric Hospital Services:  Mandatory Does this benefit have unlimited days?  Yes No, indicate number Select the days per period: Select	< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Is there a service-specific Maximum Plan Benefit Coverage amount?	×
C Every year C Every six months C Every three months C Every Benefit Period C Every Stay	Do you offer Inpatient Psychiatric Hospital Services as a benefit?  Yes No Select type of benefit for Inpatient Psychiatric Hospital Services:  Mandatory Dotional Does this benefit have unlimited days?  Yes No, indicate number Indicate number of days per period: Select the days periodicity:	<ul> <li>Yes</li> <li>No</li> </ul> Select the Maximum Plan Benefit Coverage type: <ul> <li>Covered under Inpatient Hospital Services Category 1a</li> <li>Plan-specified amount per period</li> </ul> Indicate Maximum Plan Benefit Coverage amount: <ul> <li>Select Maximum Plan Benefit Coverage periodicity:</li> <li>Select Maximum Plan Benefit Coverage periodicity:</li> <li>Every three years</li> <li>Every two years</li> <li>Every two years</li> <li>Every two pensis</li> <li>Every three months</li> <li>Every three months</li> <li>Every Benefit Period</li> </ul>	
	C Every two years C Every year C Every six months C Every three months C Every Benefit Period C Every Stay		

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

Fu Associates, Ltd.

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🔡 PBP Data Entry System - Section B-1, Contract X0001, Plan C	01, Segment 000	B×
File Help < <pre>Previous Next&gt;&gt; Exit (Validate) Exit (No Validate) Go</pre>		
< <pre>Vervious Next&gt;&gt; Exit (Validate) Exit (No Validate) Fis there a service-specific Maximum Enrollee Out-of-Pocket Cost?</pre>	To: #1b Inpatient Hospital Psychiatric (B Only) - Base 2	
O Yes		
C No		
Select the Maximum Enrollee Out-of-Pocket Cost type:		
C Covered under the Inpatient Hospital Services Category 1a C Plan-specified amount per period		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:		
C Every three years C Every two years		
C Every year		
O Every six months O Every three months		
C Every Benefit Period		
C Every Stay C Other, Describe		
	-	

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

Fu Associates, Ltd.

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📴 PBP Data Entry System - Section B-1, Contract X0001,	, Plan 001, Segment 000				_ 8 ×
File Help < <pre> &gt; Exit (Validate) Exit (No Validate) Is there an enrollee Coinsurance? </pre> C Yes	Go To: #1b Inpatient Indicate the coinsurance p (enter ''999'' if unlimited da			×	
C No Indicate Coinsurance percentage per stay:	Coinsurance % Interval 1:				
Indicate the number of day intervals for the stay:					
C Zero (No Coinsurance per Day) C One C Two C Three	Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:		

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-1, Contract X0001,	Plan 001, Segment 000	_ B ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Is there an enrollee Deductible?</previous>	Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 4	
O Yes	Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999);	
O No	Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
Indicate Deductible Amount:		
	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
Is there an enrollee Copayment?		
C Yes C No	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	
Indicate Copayment amount per stay:	Enrollee must receive Authorization from one or more of the following:	
	None	
Indicate the number of day intervals for the stay:	Primary Care Physician (Internist/Family Practice, General Practice)     Physician Specialist	
C Zero (No Copayment per Day)	Organization Medical Director/Utilization Management/Utilization Review	
C One C Two	C Other, describe	
O Three	Is a referral required for Inpatient Psychiatric Hospital Services?	
	© Yes	
	C No	
		11

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

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💀 PBP Data Entry System - Section	B-1, Contract X0001, Plan 0	D1, Segment 000		_ B ×
File Help <pre>&lt;<previous next="">&gt; Exit (Validate</previous></pre>	e) Exit (NoValidate) <b>Go</b> 1	o: #1b Inpatient Hospital Psychiatric (B Only) - Base 5	<b>_</b>	
Inpatient Psychiatric Hospital Notes		<ul> <li>Territorial and the spicial systematic (promy) - pase 3</li> </ul>		
		<b>.</b>		
	describe benefit in this service cate	gory. Do not repeat information captured in data entry.		
Notes (Optional):			<u> </u>	
			-	

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

Fu Associates, Ltd.

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RPBP Data Entry System - Section B-2, Contract X0001, Plan 001, S ile Help	egment UUU	-					
	#2 SNF - Base 1						
CLICK FOR DESCRIPTION OF BENEFIT	Do you allow less than 3 day inpatient hospital stay prior to SNF admission?						
oes the plan provide Skilled Nursing Facility Services as a supplemental enefit under Part C?	C Yes O No						
) Yes ) No	Indicate the Number of Hospital Days Required Prior to SNF Admission						
elect enhanced benefits: Additional days beyond Medicare-covered	(0-2): C Zero						
Non-Medicare-covered stay	C One C Two						
Select type of benefit for Additional Days beyond Medicare-covered:	Maximum Plan Benefit Coverage is not applicable for this Service						
C Mandatory C Optional	Category.						
s this benefit unlimited for Additional Days?							
C Yes C No, indicate number							
Select type of benefit for the Non-Medicare-covered stay:							
O Optional							

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

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DDD Data Entry Custom Contine D. 2. Contract V0001	Disp. 001 Cogmont 000				
BPBP Data Entry System - Section B-2, Contract X0001, F File Help	rian 001, Segment 000				_8
<pre></pre> <pre></pre> <pre></pre> <pre></pre> <pre>// Previous   Next&gt;&gt;   Exit (Validate)   Exit (No Validate)   </pre>	Go To: #2 SNF - Base 2				
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the number of day	intervals for the Medicare.	covered stair	<b>•</b>	
			covered stay.		
O Yes O No	C Zero (No Coinsurance p	ber Dayj			
	O Two				
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	C Three				
	Indicate the coinsurance p	ercentage and day interv-	al(s) for Medicare-		
	covered stay (e.g.; 1 to 20	; 21 to 100):			
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:		
C Every three years			Enu Day Interval 1.		
C Every two years C Every year					
C Every six months	Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:		
C Every three months					
C Every Stay		·			
O Other, Describe	Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:		
Is there an enrollee Coinsurance?					
C Yes					
O No					
Do you charge the Medicare-defined cost shares? (These are the					
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)					
O Yes					
O No					
Indicate Coinsurance percentage for the Medicare-covered stay:					

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

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<mark>: PBP Data I</mark> File Help	Entry Syste	em - Section B-2	2, Contrac	ct X0001, Pla	n 001,	, Segment O	00					_ <del>8</del> ×
< <previous< th=""><th>Next&gt;&gt;</th><th>Exit (Validate)</th><th>Exit (No V</th><th>/alidate) 6</th><th>o To:</th><th>#2 SNF - B</th><th>ase 3</th><th></th><th></th><th>-</th><th></th><th></th></previous<>	Next>>	Exit (Validate)	Exit (No V	/alidate) 6	o To:	#2 SNF - B	ase 3			-		
Indicate the num	ber of day in	ntervals for Addition	hal Days:									
C Zero (No Co C One C Two C Three	insurance pe	er Day)										
Indicate the co (enter "999" if t	insurance pe unlimited day	ercentage and day is are offered; e.g.,	, 101 to 999	for Additional Da 9):	hs							
Coinsurance %	Interval 1:	Begin Day Interv	val 1: Ei	ind Day Interval	:							
Coinsurance %	Interval 2:	Begin Day Interv	val 2: Ei	nd Day Interval	2:							
Coinsurance %	Interval 3:	Begin Day Interv	val 3: Ei	ind Day Interval	3:							

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 36 of 215

BPBP Data Entry Syste File Help	em - Section B-2, Contr	act X0001, Plan 001, 9	Gegment 000	
< <previous next="">&gt;</previous>	Exit (Validate) Exit (No	Validate) Go To:	#2 SNF - Base 4	1
Is the Coinsurance structure I Coinsurance structure for the	for the Non-Medicare-cove Medicare-covered stay?	red stay the same as the	Is there an enrollee Deductible?	
O Yes O No			C Yes C No	
Indicate Coinsurance percer	ntage for the Non-Medicare	e-covered stay:	Indicate Deductible Amount:	
Indicate the number of day i		are-covered stay:		
C Zero (No Coinsurance p C One	per Day)			
C Two C Three				
Indicate the coinsurance p covered stay (enter ''999''	ercentage and day interval if unlimited days are offered	(s) for the Non-Medicare- l: e.g., 1 to 999):		
Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:		
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:		
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:		

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 37 of 215

BPBP Data Entry System - Section B-2, Contract X0001, Plan 001,	Segment 000	_ 8 ×
File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go To:</previous<>	#2 SNF - Base 5	
Is there an enrollee Copayment?	Indicate the number of day intervals for Additional Days:	
C Yes C No	C Zero (No Copayment per Day) C One C Two	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	O Three	
C Yes C No	Indicate the copayment amount and day interval(s) for Additional Days (enter ''999'' if unlimited days are offered; e.g. , 101 to 999);	
Indicate Copayment amount for Medicare-covered stay:	Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Copayment per Day)	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
C One C Two C Three	Copayment Amt Interval 3: End Day Interval 3:	
Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): For more information on cost share limitations please view the variable help.		
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:		
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:		
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:		

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

Fu Associates, Ltd.	CY 2014 PBP – Section B
	12/6/2012
	CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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		1-1
BPBP Data Entry System - Section B-2, Contract X0001, Plan 00	1, Segment 000	_ B ×
File Help		
	: #2 SNF - Base 6	
Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?	Enrollee must receive Authorization from one or more of the following:	
O Yes	Primary Care Physician (Internist/Family Practice, General Practice)	
O No	Physician Specialist	
Indicate Copayment amount for Non-Medicare-covered stay:	Organization Medical Director/Utilization Management/Utilization Review	
malcate copayment amount for Normealcare covered stay.	C Other, describe	
	Is a referral required for SNF Services?	
Indicate the number of day intervals for the Non-Medicare-covered stay:	C Yes	
O Zero (No Copayment per Day)	O No	
C One		
C Two		
C Three		
Indicate the copayment amount and day interval(s) for the Non-Medicare- covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999):		
covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999);		
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:		
,,		
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:		
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:		
		//
		11

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

Fu Associates, Ltd.	CY 2014 PBP – Section B
	12/6/2012
	CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To: #2 SNF - Base 7</previous>	🔛 PBP Data Entry System - Section B-2, Contract X0001, F	lan 001, Segment 000	_ 8 ×
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes (Optional):	File Help <td>Go To: #2 CNE Base 7</td> <td></td>	Go To: #2 CNE Base 7	
Votes (Optional):	SNF Notes		
Votes (Optional):	Note may include additional information to describe benefit in this servi	e estedoru. Do not repest information captured in data entru	
		ie categoly. Do not repeat information captured in data entry.	
	Notes (Optional):		
	1		

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

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🔡 PBP Data Entry System - Section B-2, Contract X0001,	, Plan 001, Segment 000	_ 8 ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #2 SNF (B Only) - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is a hospital stay required before admission to a SNF?	
Do you offer SNF Care as a benefit?	C Yes C No	
C Yes C No	Indicate number of days required for hospital stay:	
Select type of benefit for SNF Care:		
C Mandatory C Optional	Is there a service-specific Maximum Plan Benefit Coverage amount?	
Does this benefit have unlimited days?	C Yes	
C Yes C No, indicate number	C No	
Indicate number of days per period:	Indicate Maximum Plan Benefit Coverage amount:	
Select the days periodicity:	Select Maximum Plan Benefit Coverage periodicity: © Every three years	
C Every three years C Every two years	C Every two years	
C Every year C Every six months	© Every year © Every six months	
C Every three months	C Every three months	
C Every Stay C Other, Describe	C Every Stay C Other, Describe	
		/
		11

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

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🔛 PBP Data Entry System - Section B-2, Contract X0001,	Plan 001, Segment 000	_ B ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)           Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</previous>	Go To: #2 SNF (B Only) - Base 2 Indicate the number of day intervals for the stay:	<b>_</b>
O Yes	Zero (No Coinsurance per Day)	
C No	C One	
Indicate amount for Maximum Enrollee Out-of-Pocket Cost:	C Two	
	C Three	
	Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g.; 1 to 999);	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:		
O Every three years	Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
C Every two years C Every year		
C Every six months	Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
C Every three months		
C Every Stay C Other, Describe		
Is there an enrollee Coinsurance?	Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
C Yes		
O No		
Indicate Coinsurance percentage:		

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

Fu Associates, Ltd.

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🛃 PBP Data Entry System - Section B-2, Contract X0001, I	Plan 001, Segment 000		_ 8 ×
File       Help         < <previous< td="">       Next&gt;&gt;       Exit (Validate)       Exit (No Validate)         Is there an enrollee Deductible?         O       Yes</previous<>	Go To: #2 SNF (B Only) - Base 3 Indicate the copayment amount and day interval(s) fo if unlimited days are offered; e.g., 1 to 999);	▼ or the stay (enter "999"	
O No Indicate Deductible Amount:	Copayment Amt Interval 1: Begin Day Interval 1: Copayment Amt Interval 2: Begin Day Interval 2:	End Day Interval 1:	
Is there an enrollee Copayment?	Copayment Amt Interval 3: Begin Day Interval 3:	End Day Interval 3:	
Indicate Copayment amount per Stay:			
Indicate the number of day intervals for the stay: C Zero (No Copayment per Day) C One C Two			
C Three			

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

Fu Associates, Ltd.

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📰 PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000	_ 8 >
File         Help           <<         Frevious         Next>>         Exit (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?	
C Yes C 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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-3, Contract X0001, Plan 001,	Segment 000
File Help	
	#3 Cardiac and Pulmonary Rehabilitation Services - Base 1
CLICK FOR DESCRIPTION OF BENEFIT	Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	Services?
	O Yes O No, indicate number
O No	Indicate number of visits for Additional Intensive Cardiac Rehabilitation
Select enhanced benefit: Additional Cardiac Rehabilitation Services	Services:
Additional Intensive Cardiac Rehabilitation Services	Select the Additional Intensive Cardiac Rehabilitation Services
Additional Pulmonary Rehabilitation Services	periodicity:
Select type of benefit for Additional Cardiac Rehabilitation Services:	C Every three years C Every two years
C Optional	O Every year
Is this benefit unlimited for Additional Cardiac Rehabilitation Services?	C Every six months
C Yes C No, indicate number	O Other, Describe
Indicate number of visits for Additional Cardiac Rehabilitation Services:	Select type of benefit for Additional Pulmonary Rehabilitation Services:
	Mandatory     Optional
Select the Additional Cardiac Rehabilitation Services periodicity:	Is this benefit unlimited for Additional Pulmonary Rehabilitation Services?
C Every three years	C Yes
C Every two years C Every year	O No, indicate number
O Every six months	Indicate number of visits for Additional Pulmonary Rehabilitation Services:
C Every three months C Other, Describe	
Select type of benefit for Additional Intensive Cardiac Rehabilitation Services:	Select the Additional Pulmonary Rehabilitation Services periodicity:
C Mandatory	C Every three years C Every two years
C Optional	C Every year
	C Every six months C Every three months
	C Other, Describe

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

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-3, Contract X0001, F File Help	Plan 001, Segment 000			_ B ×
<pre></pre> < <pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate)</pre>	Go To: #3 Cardiac and Pulmonary Rehabilitation Ser	vices - Base 3	-	
Is there an enrollee Deductible?	,	Minimum Copayment	Maximum Copayment	
C Yes		Copayment	Copayment	
C No	Indicate Copayment amount for Medicare-covered Cardiac Rehabilitation Services:			
Indicate Deductible Amount:	la facto Caracteria anno 16 Mañares anno d			
	Indicate Copayment amount for Medicare-covered Intensive Cardiac Rehabilitation Services:			
Is there an enrollee Copayment?	Indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services:			
C Yes	Pulmonary Rehabilitation Services:			
C No	Indicate Copayment amount for Additional Cardiac			
Select which Cardiac and Pulmonary Rehabilitation Services have a	Rehabilitation Services:		I	
Copayment (Select all that apply): Medicare-covered Cardiac Rehabilitation Services	Indicate Copayment amount for Additional Intensive Cardiac Rehabilitation Services:			
Medicale-covered Cardiac Fenabilitation Services			,	
Medicare-covered Pulmonary Rehabilitation Services	Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:			
Additional Cardiac Rehabilitation Services     Additional Intensive Cardiac Rehabilitation Services				
Additional Pulmonary Rehabilitation Services				
				1.

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

Fu Associates, Ltd.

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🔡 PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segment 000	_ B ×
File         Help           <	•
Controllee 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):	
1	
	li l

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

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🔡 PBP Data Entry System - Section B-4, Contract X0001, I	Plan 001, Segment 000
Eile Help	
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	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? C Yes C No	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Every three years C Every two years C Every year	
C Every six months C Every three months C Other, Describe	

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

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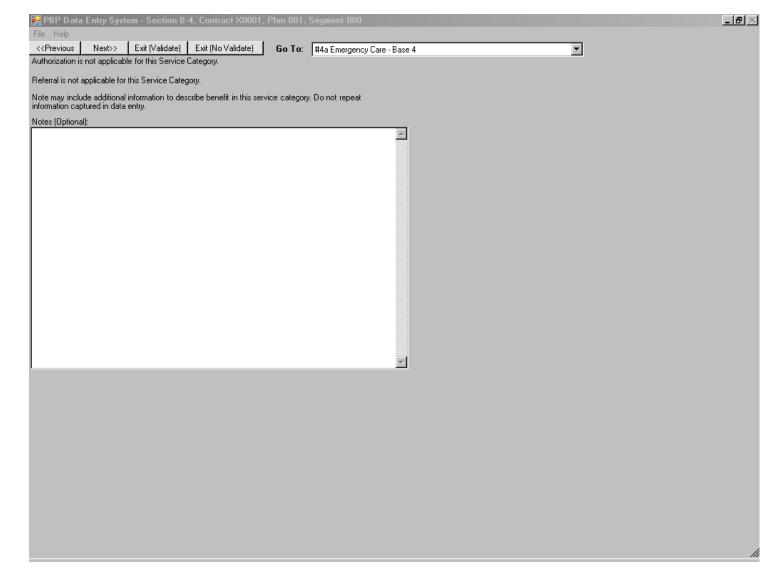
BP Data Entry System - Section B-4, Contract X0001, Help		
Previous Next>> Exit (Validate) Exit (No Validate)	Go To: #4a Emergency Care - Base 2	
ere an enrollee Coinsurance?	Is there an enrollee Deductible?	
/es	© Yes	
No	C No	
ndicate Minimum Coinsurance percentage for Medicare-covered enefits:	Indicate Deductible Amount:	
enenics.		
dicate Maximum Coinsurance percentage for Medicare-covered		
enefits:		
the Coinsurance for Medicare-covered Benefits waived if dmitted to hospital?		
) Yes		
No No		
elect either Days or Hours within which admission must occur for		
aiver:		
) Days ) Hours		
nter number of Days or Hours:		

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

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🔜 PBP Data Entry System - Section B-4, Contract X0001,	Plan 001, Segment 000	_ B ×
<u>F</u> ile <u>H</u> elp		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #4a Emergency Care - Base 3	
Is there an enrollee Copayment?	Does ER cost sharing count towards any plan-level deductibles?	
C Yes	C Yes	
O No		
Indicate Minimum Copayment amount for Medicare-covered Benefits: Indicate Maximum Copayment amount for Medicare-covered Benefits:	Indicate the plan-level deductibles where ER cost sharing counts: In-Network only Qut-of-Network only Combined (In-Network and Qut-of-Network)	
Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?		
C Yes C No		
Select either Days or Hours within which admission must occur for waiver:		
C Days C Hours		

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



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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-4, Contract X0001, I	Plan 001, Segment 000		_ B ×
File Help			
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #4b Urgently Needed Care - Bas	e 1 💌	
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Select Maximum Enrollee Out-of-Pocket	C Yes C No	
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	Select Maximum Enrollee Dut-of-Pocket Cost periodicity: C Every two years E Very two years E Very year E Very year D Every six months D Uther, Describe 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 – 4B – Urgently Needed Care – Base 2 Screen

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🔡 PBP Data Entry System - Section B-4, Contra	act X0001, Plan 001, Segment 000		<u>_ 8 ×</u>
File Help			
	Validate) Go To: #4b Urgently Needed Care - Base 2	•	
Is there an enrollee Deductible?	Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?		
O Yes O No	C Yes		
	C No		
Indicate Deductible Amount:	Select either Days or Hours within which admission must occur for waiver:		
	O Days		
Is there an enrollee Copayment?	C Hours		
C Yes	Enter number of Days or Hours:		
C No			
Indicate Minimum Copayment amount for Medicare -covered Benefits:			
Indicate Maximum Copayment amount for Medicare-covered Benefits:			

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

Fu Associates, Ltd.

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🛃 PBP Data Entry Sy	stem - Section B-	4, Contract X0001, I	<sup>9</sup> lan 001, Seg	ment 000		_ 8 ×
File Help	1					
< <previous next="">&gt; Authorization is not applic</previous>		Exit (No Validate)	Go To:  #4	b Urgently Needed Care - Base 3	<b>T</b>	
Referral is not applicable f						
Note may include addition information captured in da	iai information to dest ta entry.	cribe benerit in this servi	ce category. Do	not repeat		
If you have entered a rang	ge of cost sharing, yo	u must describe the reas	on for this range	a.		
Natas (Oatianal)						
Notes (Optional):				A		
				_		
				Y		

Section B – 4C – Worldwide Coverage – Base 1

Fu Associates, Ltd.

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CLICK FOR DESCRIPTION OF BENEFIT	lidate) Go To: #4c Worldwide Coverage - Bas	Is there a service-specific Maximum Enrollee
	Is there a Maximum Plan Benefit Coverage amount for Worldwide Coverage?	Out-of-Pocket Cost?
Does the plan provide Emergency Care Services as a supplemental benefit under Part C?	C Yes C No	C Yes C No
© Yes © No	Indicate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Select enhanced benefit:		
Worldwide Coverage	Select the Maximum Plan Benefit	Select Maximum Enrollee Out-of-Pocket Cost periodicity:
Select type of benefit for Worldwide Coverage:	Coverage periodicity:	C Every three years
Mandatory	C Every three years C Every two years	C Every two years
O Optional	<ul> <li>Every year</li> </ul>	C Every year C Every six months
	C Every six months C Every three months	C Every three months
	C Other, Describe	C Other, Describe

Section B – 4C – Worldwide Coverage – Base 2

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🔜 PBP Data Entry System - Section B-4, Co	ntract X0001, Plan 001, Segment 000	
<u>File</u> <u>H</u> elp		
< <previous next="">&gt; Exit (Validate) Exit (</previous>		
Is there an enrollee Copayment?	Is there an enrollee Coinsurance?	
O Yes O No	C Yes C No	
10 NU		
Indicate Copayment amount for Worldwide Coverage:	Indicate Coinsurance percentage for Worldwide Coverage:	
	Is there an enrollee Deductible?	
	O Yes O No	
	Indicate Deductible Amount:	

Section B – 4C – Worldwide Coverage – Base 3

Fu Associates, Ltd.

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🔚 PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000	- 8 ×
File Help	
< <previous nexb=""> Exit (Validate) Exit (No Validate) Go To: ##4c Worldwide Coverage - Base 3</previous>	<b>-</b>
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.	
Notes (Optional):	
-	

Section B – 5 – Partial Hospitalization – Base 1 Screen

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-5, Contract X0001.	, Plan 001,	Segment 000	_ 8 ×
File Help < <pre>// Comparison of the second seco</pre>	Go To:	#5 Partial Hospitalization - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	4010.	Is there an enrollee Coinsurance?	
Enhanced Benefits are not applicable for this Service Category.		C Yes	
Maximum Plan Benefit Coverage is not applicable for this Service			
Category.		Indicate Coinsurance percentage for Medicare-covered Benefits:	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?			
O Yes O No		Is there an enrollee Deductible?	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:		O Yes O No	
		Indicate Deductible Amount:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:			
C Every three years			
C Every two years C Every year			
C Every six months C Every three months			
O Other, Describe			

Section B – 5 – Partial Hospitalization – Base 2 Screen

🔜 PBP Data Entry System - Section B-5, Contract X0001, Plan 001	, Segment 000	_ B ×
File Help		
	#5 Partial Hospitalization - Base 2	<b>_</b>
Is there an enrollee Copayment?	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
C Yes C No		
	Notes (Optional):	×
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		
Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review		
C Other, describe		
Is a referral required for Partial Hospitalization?		
O Yes		
O No		
		-
		//

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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-6, Contra	ct X0001, Plan 001, Segment 000		_8_
File Help			
< <previous next="">&gt; Exit (Validate) Exit (No</previous>		es - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?	
Enhanced Benefits are not applicable for this Service Category.	C Yes C No	C Yes C No	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	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 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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-6, Contract X0001, Plan 001,	Segment 000	_ D ×
File Help		
	#6 Home Health Services - Base 2	
Is there an enrollee Deductible?		
C Yes C No		
<u>-</u>		
Indicate Deductible Amount:		
Is there an enrollee Copayment?		
O Yes		
C 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

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Certexious       Next>       Ext (Valdale)	BPBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000		_ <del>8</del> ×
Enclose una freceive Authorization finon one or more of the following: Nore Phrag Cae Physician (Internit/Fanity Practice, General Practice) Program atom Media Deterdry/Utilization Management/Utilization Review Differ, describe a referral required for Home Health Services? Yes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Note (Optional): Internity Carterian Carter	File Help   <	<b></b>	
Ves No Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Note: (Optional):	Enrollee must receive Authorization from one or more of the following:  None  Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist		
C No Vote may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Votes (Optional):	Is a referral required for Home Health Services?		
Notes (Optional)	C Yes C No		
	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
	Notes (Optional):		
		<b>T</b>	

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

Fu Associates, Ltd.

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🔡 PBP Data Entry System - Section B-6, Contract X0001, Plan O	01, Segment 000 📃 🖪 🔀
File Help   <	
< <previous< th="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go T           CLICK FOR DESCRIPTION OF BENEFIT        </previous<>	o: #6 Home Health Services - MMP Services Base 1 Select Maximum Enrollee Out-of-Pocket Cost periodicity:
Does this plan provide non-Medicare Home Health Services?	C Every three years
C Yes C No	C Every two years C Every year C Every six months
Select Non-Medicare Home Health Services:	C Every three months C Other, Describe
Additional nours of care     Personal Care Services	Is there an enrollee Coinsurance?
Other 1     Other 2	C Yes C No
Enter name of Other 1 Service:	Select which Non-Medicare Home Health Services have a Coinsurance (se that apply):
Enter name of Other 2 Service:	Additional hours of care Personal Care Services
	Other 1     Other 2
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate coinsurance Minimum Maximum percentage for one or Coinsurance Coinsurance more of the following services:
C No	Additional hours of care
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Personal Care Service
	Other 1
	Other 2

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

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	CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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## PBP 2014 Data Entry System Screens

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File Help	1		
< <previous next="">&gt;</previous>	Exit (Validate)	Exit (No Validate) Go To:	#6 Home Health Services - MMP Services Base 2
is there an enrollee Copayn	nent?		Enrollee must receive Authorization from one or more of the following:
C Yes			
© No			Primary Care Physician (Internist/Family Practice, General Practice)
	e Home Health Servi	ices have a Copayment (select all	
that apply): Additional hours of care			Dther, describe
Personal Care Services			Is a referral required for Services?
Other 1			
Other 2			O Yes O No
Indicate copayment percentage for one or more of the following services:	Minimum Copayment	Maximum Copayment	
Additional hours of care			
Personal Care Service			
Other 1			
Other 2			
•			

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

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< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #7a Primary Care Physician Services - Base 1	<b>•</b>
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
aximum Plan Benefit Coverage is not applicable for this ervice Category.	C Yes C No	
there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
) Yes ) No	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
ndicate Maximum Enrollee Out-of-Pocket Cost amount:	' Is there an enrollee Deductible?	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	C Yes C No	
C Every two years C Every year C Every six months	Indicate Deductible Amount:	
C Every three months C Other, Describe	Is there an enrollee Copayment?	
	C 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

Fu Associates, Ltd.

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File Help	
< <pre>evicus Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To: #7a Primary Care Physician Services - Base 2</pre>	
Authorization 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):	<u> </u>
	-
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Section B – 7B – Chiropractic Services – Base 1 Screen

Fu Associates, Ltd.

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File       Heb       Exit (Validate)       Exit (IN Validate)       Exit (I		, Contract X0001, Plan 001, Segment 000		_ 8 ×
CLICK FOR DESCRIPTION OF BENEFIT       Select Routine Care periodicity.       Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?         Does the plan provide Chiropractic Services as a supplemental benefit under Part C?       E very three years       Yes         Ores the plan provide Chiropractic Services as a supplemental benefit under Part C?       E very three years       Yes         Yes       Describe       Indicate Maximum Enrollee Out-of-Pocket Cost amount         No       Describe       Indicate Maximum Plan Benefit Coverage amount?         Select type of benefit for Routine Care:       Yes       Select Maximum Plan Benefit Coverage amount?         Mandatory       Indicate Maximum Plan Benefit Coverage amount.       Every three years         Yes       Select Maximum Plan Benefit Coverage periodicity.       Every three years         Yes       No       Every three years         No, indicate number       Select Maximum Plan Benefit Coverage periodicity.       Every three years         Indicate number of visits for Routine Care:       Every three years       Every three months         No, indicate number of visits for Routine Care:       Every three years       Every three months         Indicate number of visits for Routine Care:       Every three years       Every three months         Every three months       Every three months       Dither, Describe <td>File Help</td> <td>-</td> <td></td> <td></td>	File Help	-		
Descrive of the		Exit [No Validate] Go To: #7b Chiropractic Se	_	
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?       Every two years       Yes         Yes       Every three months       Indicate Maximum Enrollee Out-of-Pocket Cost amount:         No       Indicate Maximum Plan Benefit         Select type of benefit for Routine Care:       Yes         Mandatory       Indicate Maximum Plan Benefit Coverage amount?         Mandatory       Indicate Maximum Plan Benefit Coverage amount:         Yes       Select Maximum Plan Benefit Coverage amount:         Yes       No         No       Select Maximum Plan Benefit Coverage amount:         Yes       No         Optional       Indicate Maximum Plan Benefit Coverage periodicity:         Is this benefit unlimited for Routine Care?       Every three years         Yes       Select Maximum Plan Benefit Coverage periodicity:         No, indicate number       Every three years         Every three years       Every three years         Every three years       Every three years         Every year       Every three months         Dutter, Describe       Other, Describe	CLICK FOR DESCRIPTION OF BENEFIT		Is there a service-specific Maximum Enrollee Out-of- ∃ Pocket Cost?	
Select enhanced benefit:       Is there a service-specific Maximum Plan Benefit         Routine Care       Yes         Select type of benefit for Routine Care:       Yes         Mandatory       Indicate Maximum Plan Benefit Coverage amount:         Is this benefit unlimited for Routine Care?       Indicate Maximum Plan Benefit Coverage amount:         Yes       Select Maximum Plan Benefit Coverage amount:         Is this benefit unlimited for Routine Care?       Select Maximum Plan Benefit Coverage periodicity:         Yes       Select Maximum Plan Benefit Coverage periodicity:         No, indicate number       Select Maximum Plan Benefit Coverage periodicity:         Every three years       Every three years         Every three years       Other, Describe	C Yes	C Every two years C Every year C Every six months C Every three months	C No	
Select type of benefit for Routine Care: <sup>o</sup> Yes <sup>o</sup> periodicity:          Mandatory        Indicate Maximum Plan Benefit Coverage amount: <sup>o</sup> Every three years          Is this benefit unlimited for Routine Care? <sup>o</sup> Select Maximum Plan Benefit Coverage periodicity: <sup>o</sup> Every six months          Ves           Select Maximum Plan Benefit Coverage periodicity: <sup>o</sup> Every six months          Ves           Select Maximum Plan Benefit Coverage periodicity: <sup>o</sup> Every three months          Indicate number of visits for Routine Care:           Select Maximum Plan Benefit Coverage periodicity:           Other, Describe          Indicate number of visits for Routine Care:           Select Maximum Plan Benefit Coverage periodicity:           Other, Describe          Indicate number of visits for Routine Care:           Every three years           Other, Describe          Very six months           Every three months           Other, Describe		Is there a service-specific Maximum Plan Benefit	· · · · · · · · · · · · · · · · · · ·	
Mandatory       Indicate Maximum Plan Benefit Coverage amount:       Every two years         Is this benefit unlimited for Routine Care?       Every six months         Yes       Select Maximum Plan Benefit Coverage periodicity:       Every three months         Indicate number       Every three years       Other, Describe         Indicate number of visits for Routine Care:       Every three years       Other, Describe         Every two years       Every three years       Other, Describe	Select type of benefit for Routine Care:		periodicity:	1
Is this benefit unlimited for Routine Care?  Select Maximum Plan Benefit Coverage periodicity:  Select Maximum Plan Benefit Benefi		Indicate Maximum Plan Benefit Coverage amount:	C Every two years	
Indicate number     C Every three years       Indicate number of visits for Routine Care:     C Every two years       C Every two years     C Every two years       C Every two years     C Every two years       C Every three months     C Every three months		1	C Every six months C Every three months	
Indicate number of visits for Routine Care: C Every two years C Every year C Every six months C Every three months			C Other, Describe	
		C Every two years C Every year C Every six months C Every three months		

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

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<mark>: PBP Data</mark> File Help	Entry Syst	em - Section B·	7, Contract X0001,	Plan 001,	Segment 000			<u>-8×</u>
< <pre></pre>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#7b Chiropractic Services - Base 2	•		
Is there an en	rollee Coinsur	ance?						
C Yes C No								
that apply):	covered Chir	Services have a C opractic Services	Coinsurance (Select all					
Indicate Minir covered Ben	num Coinsura efits:	ince percentage p	er visit for Medicare-					
Indicate Max covered Ben	mum Coinsur efits:	ance percentage	per visit for Medicare-					
Indicate the M Care:	1inimum Coin:	surance percenta <u>o</u>	ge per visit for Routine					
Indicate the N Routine Care:	taximum Coin	isurance percenta;	ge per visit for					

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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-7, Contract X0001, P	lan 001, Segment 000	_ 8 ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #7b Chiropractic Services - Base 3	
Is there an enrollee Deductible?	Indicate Minimum Copayment amount per visit for Routine Care:	
C Yes C No		
Indicate Deductible Amount:	Indicate Maximum Copayment amount per visit for Routine Care:	
Is there an enrollee Copayment?	Enrollee must receive Authorization from one or more of the following:	
O Yes	Primary Care Physician (Internist/Family Practice, General Practice)	
C No	Physician Specialist	
Select which Chiropractic Services have a Copayment (Select all that apply):	Organization Medical Director/Utilization Management/Utilization Review Other, describe	
Medicare-covered Chiropractic Services	Is a referral required for Chiropractic Services?	
Routine Care		
Indicate Minimum Copayment amount for Medicare-covered Benefits:		
	,	
Indicate Maximum Copayment amount for Medicare-covered Benefits		

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

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	ntry System	n - Section B-	7, Contract X0001, I	Plan 001,	Segment 000	_ 8
File Help						_
< <previous chiropractic="" servi<="" td=""><td>Next&gt;&gt;</td><td>Exit (Validate)</td><td>Exit (No Validate)</td><td>Go To:</td><td>#7b Chiropractic Services - Base 4</td><td></td></previous>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#7b Chiropractic Services - Base 4	
Uniropractic Servi	ices inotes					
Note may include	e additional in	formation to des	cribe benefit in this serv	ice categor	y. Do not repeat information captured in data entry.	
Notes (Optional):						
						<u> </u>
						V

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

Fu Associates, Ltd.

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PBP Data Entry System - Section B-7           File         Help           << <previous< td="">         Next&gt;&gt;</previous<>	, Contract X0001, Plan 001, Segment 000 Exit (No Validate) Go To: #7c Occupational The	rapu Services - Base 1	_ <del>_</del> 8_×
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	
Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category.	Every three years     Every two years     Every year     Every six months     Every three months	C Yes C No Indicate Deductible Amount:	
Do you apply the Medicare coverage limit?	O Other, Describe      Is there an enrollee Coinsurance?	Is there an enrollee Copayment? C Yes C No	
O Yes O No	O Yes		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No     Indicate Coinsurance percentage per visit for     Medicare-covered Benefits:	Indicate Copayment amount per visit for Medicare- covered Benefits:	
C Yes C No			
Cost amount:			

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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000		_ B ×
File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go To:         #7c Occupational Therapy Services - Base 2</previous<>		
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?		
C Yes C 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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-7, Contract X0001, P	'lan 001,	Segment 000
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To:	#7c Occupational Therapy Services - MMP Services - Base 1
CLICK FOR DESCRIPTION OF BENEFIT		Is there an enrollee Coinsurance?
		C Yes
Does this plan provide non-Medicare Occupational Therapy Services?		C No
C Yes		Indicate Coinsurance Percentage:
O No		
Enter name of Non-Medicare Occupational Therapy		
Service:		Is there an enrollee Copayment?
Is there a service-specific Maximum Plan		C Yes C No
Benefit Cost amount?		NO NO
O Yes		Indicate Copayment Amount:
O No		
Indicate Maximum Plan Benefit Cost amount		• • • • • • • • • • • • • • • • • • •
		Enrollee must receive Authorization from one or more of the following:
		Primary Care Physician (Internist/Family Practice, General Practice)
Select Maximum Plan Benefit Cost		Physician Specialist
periodicity:		Organization Medical Director/Utilization Management/Utilization Review
C Every three years		Other, describe
C Every two years C Every year		Is a reterral required for Services?
C Every six months		C Yes C No
C Every three months		NO NO
C Other, Describe		

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

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	CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING	

PBP Data Entry System - Section B-7, File Help	Contract X0001, Plan 001, Segment 000		×
	Exit (No Validate) <b>Go To:</b> #7d Physician Speciali	st Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	
Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category.	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	No     Indicate Deductible Amount:     Is there an enrollee Copayment?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?		
O Yes O No	C No	C No	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	

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

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File         Help           << <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go To:         #7d Physician Specialist Services - Base 2</previous<>	•	
Increase in the second secon		
Is a referral required for Physician Specialist Services?		
O Yes O No		
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes (Optional):	×	
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Section B – 7E – Mental Health Specialty Services – Base 1 Screen

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Free Help <   <	
CLICK FOR DESCRIPTION OF BENEFIT	
Enhanced Benefits are not applicable for this Service Category.	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
C Yes C No	
Indicate Maximum Enrollee_Out-of-Pocket Cost amount:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Every three years C Every two years	
C Every year C Every six months	
C Every three months C Other, Describe	
	//

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

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🔛 PBP Data Entry System - Section B-7, Contract X0001, I	Plan 001, Segment 000	_ 8 ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #7e Mental Health Specialty Services - Base 2	<b>v</b>
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
O Yes	O Yes	
C No	O No	
		hi

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

Fu Associates, Ltd.

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File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go To:         #7e Mental Health Specialty Services - Base 3</previous<>		
In the metric of the following:  None  Primary Care Physician (Internist/Family Practice, General Practice)  Primary Care Physician (Internist/Family Practice, General Practice)  Primary Care Physician (Internist/Family Practice, General Practice)  Organization Medical Director/Utilization Management/Utilization Review  Other, describe		
Is a referral required for Mental Health Specialty Services - Non-Physician?		
O Yes O No		
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
Notes (Optional):		
nores (optionia).	Ā	
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Section B – 7F – Podiatry Services – Base 1 Screen

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-7, Co	ntract X0001, Plan 001, Segment 000		_ B ×
File Help			
< <previous next="">&gt; Exit (Validate) Exit</previous>	(No Validate) Go To: #7f Podiatry Services - Base		
CLICK FOR DESCRIPTION OF BENEFIT	Select the Routine Footcare periodicity: C Every three years	Is there a service-specific Maximum Enrollee Out- of-Pocket Cost?	
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	C Every two years C Every year	O Yes O No	
C Yes C No	C Every six months C Every three months C Other. Describe	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select enhanced benefits:	Is there a service-specific Maximum Plan Benefit Coverage amount?		
Select type of benefit for Routine Footcare:	O Yes O No	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Mandatory C Optional	Indicate Maximum Plan Benefit Coverage amount:	C Every three years C Every two years	
Is this benefit unlimited for Routine Footcare?		C Every year C Every six months	
C Yes C No	Select Maximum Plan Benefit Coverage periodicity:	<ul> <li>Every three months</li> <li>O Other, Describe</li> </ul>	
Indicate number of Routine Footcare visits:	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe		
			li li

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

Fu Associates, Ltd.

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🔡 PBP Data Entry System - Section B-7, Contract X0001, Plan 001	, Segment 000	_ 8 >
File Help < <pre> </pre> Kit (No Validate) Kit (No Validate) Go To:	#7f Podiatry Services - Base 2	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
		1
O No	C No	
Select which Podiatry Services have a Coinsurance (Select all that apply):  Medicare-covered Podiatry Services  Routine Footcare	Select which Podiatry Services have a Copayment (Select all that apply): Medicare-covered Podiatry Services Routine Footcare	
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Minimum Coinsurance percentage for Routine Footcare:	Indicate Minimum Copayment amount per visit for Routine Footcare:	
Indicate Maximum Coinsurance percentage for Routine Footcare:	Indicate Maximum Copayment amount per visit for Routine Footcare:	
Is there an enrollee Deductible?		
O Yes		
O No		
Indicate Deductible Amount:		

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

Fu Associates, Ltd.	
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🔡 PBP Data Entry System - Section B-7, Contract X0001,	, Plan 001, Segment 000		_ 8 ×
File Help < <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #7f Podiatry Services - Base 3	•	
Contentions	r ce)		
Is a referral required for Podiatrist Services?			
C Yes C No			
Note may include additional information to describe benefit in this ser	rvice category. Do not repeat information captured in data en	tru	
Notes (Optional):	vice category. Do not repeat information captured in data en	чу.	

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-7, Con File Help	tract X0001, Plan 001, Segment 000		_8 <u>×</u>
	lo Validate) Go To: #7g Other Health Care Pr	ofessional - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	1
Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of- Pocket Cost? C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost	C Every three years C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe Is there an enrollee Coinsurance? C Yes C No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	C Yes No Indicate Deductible Amount: Is there an enrollee Copayment? C Yes C No Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
			<i>"</i>

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

Fu Associates, Ltd.

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🔡 PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000	_ <del>_</del> 8 ×
File     Help       < <previous< td="">     Next&gt;&gt;       Exit (Validate)     Exit (No Validate)       Go To:     #7g Other Health Care Professional - Base 2</previous<>	
<	
Is a referral required for Other Health Care Professional Services?	
C Yes C No	
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
Notes (Optional):	
	li.

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

Fu Associates, Ltd.

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🖳 PBP Data Entry System - Section B-7, Co	ntract X0001, Plan 001,	Segment 000		_8>
File Help < <previous next="">&gt; Exit (Validate) Exit (</previous>	(No Validate) Go To:	#7h Psychiatric Services - Base 1	<b>_</b>	
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-F	Pocket Cost?			
O Yes O No				
Indicate Maximum Enrollee Out-of-Pocket Cost amo				
	ant.			
Select the Maximum Enrollee Out-of-Pocket Cost p	oriodicitur			
C Every three years	enouicity.			
C Every two years C Every year				
C Every six months C Every three months				
C Other, Describe				

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

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🔗 PBP Data Entry System - Section B-7, Contract X0001, Plan 0	001, Segment 000	_
ile Help < <previous next="">&gt; Exit (Validate) Exit (No Validate) <b>Go</b>ʻ</previous>	To: #7h Psychiatric Services - Base 2	
there an enrollee Coinsurance?	Is there an enrollee Copayment?	
) Yes	© Yes	
No	C No	
elect which Psychiatric Services have a Coinsurance (Select all that apply): Medicare-covered Individual Sessions	Medicare-covered Individual Sessions	
Medicare-covered Group Sessions	Medicare-covered Group Sessions Indicate minimum Copayment amount for Medicare-covered	
Indicate minimum Coinsurance percentage for Medicare-covered Individual Sessions:	Indicate minimum Copayment amount for Medicate-covered Individual Sessions:	
Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:	Indicate maximum Copayment amount for Medicare-covered Individual Sessions:	
Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:	Indicate minimum Copayment amount for Medicare-covered Group Sessions:	
Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:	Indicate maximum Copayment amount for Medicare-covered Group Sessions:	
s there an enrollee Deductible?		
U Yes O No		
Indicate Deductible Amount:		

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

Fu Associates, Ltd.

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🐖 PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000 File Help		- <u>8 ×</u>
rive Heip < <pre>Previous Next&gt;&gt; Exit (Validate) Exit (Validate) Go To: #7h Psychiatric Services - Base 3</pre>	<b>_</b>	
Enrollee must receive Authorization from one or more of the following:	_	
Is a referral required for Psychiatric Services?		
O Yes O 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 – 7I – Physical Therapy and Speech Language Pathology Services – Base 1 Screen

Fu Associates, Ltd.

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PBP Data Entry System - Section B- File Help	7, Contract X0001, Plan 001, Segment 000	
< <previous next="">&gt; Exit (Validate)</previous>	Exit (No Validate) Go To: #7iPT and SP Services	- Base 1
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?
Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category.	C 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.	No     Indicate Deductible Amount:     Is there an enrollee Copayment?     Yes
Is there a service-specific Maximum Enrollee Dut-of-Pocket Cost?	Is there an enrollee Coinsurance?	No     Indicate Copayment amount per visit for Medicare- covered Benefits:
Out-of-Pocket Cost?  Yes No Indicate Maximum Enrollee Out-of-Pocket Co- amount:	Indicate Coinsurance percentage per visit for Medicare-covered Benefits:	

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

Fu Associates, Ltd.	CY 2014 PBP – Section B
	12/6/2012
	CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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File Help	Entry Syst	em - Section B-	7, Contract X0001,	Plan 001,	, Segment 000			_8
< <previous< td=""><td>Next&gt;&gt;</td><td>Exit (Validate)</td><td>Exit (No Validate)</td><td>Go To:</td><td>#7i PT and SP Services - Base 2</td><td></td><td>•</td><td></td></previous<>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#7i PT and SP Services - Base 2		•	
Enrollee must re None Primary Care Physician Sp	eceive Autho e Physician ( pecialist n Medical Dir	rization from one o Internist/Family Pr	or more of the following: actice, General Practic anagement/Utilization F	e)			_	
		sical Therapy and	Speech-Language Pat	noloav Servi	vices?			
C Yes								
O No								
Note may includ	de additional	information to des	cribe benefit in this ser	vice categor	ry. Do not repeat information captured	in data entry.		
Notes (Optional	n.							
Notes (Optional	lj.			_			<b>A</b>	
							7	

Section B – 7I – Physical Therapy and Speech Language Pathology Services – MMP Services – Base 1 Screen

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 89 of 215

	D To: #7i PT and ST - MMP Services - Base 1 Is there an enrollee Coinsurance?	
oes this plan provide non-Medicare Physical and/or Speech herapy services?	C Yes C No	
O Yes O No	Select which Non-Medicare Home Health Services have a Coinsurance (select all that apply):	
Select non-Medicare Physical and/or Speech Therapy Services Other 1 Other 2	C Other 2	
nter name of Other 1 Service:	Indicate coinsurance Minimum Maximum percentage for one or Coinsurance Coinsurance more of the following services:	
nter name of Other 2 Service:	Other 1	
there a service-specific Maximum Plan enefit Cost amount? ) Yes	Select Maximum Plan Benefit Cost periodicity:	
ndicate Maximum Plan Benefit Cost amount	C Every three years C Every two years C Every year	
	C Every six months C Every three months C Other, Describe	

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

Fu Associates, Ltd.	CY 2014 PBP – Section B	Page 90 of 215
	12/6/2012	
CMS SENSIT	IVE INFORMATION - REQUIRES SPECIAL HAN	NDLING

## PBP 2014 Data Entry System Screens

	a Entry Sys	stem - Section B	-7, Contract X000	)1, Plan 001,	Segment 000		_ B X
File Help < <previous< th=""><th>Next&gt;&gt;</th><th>Exit (Validate)</th><th>Exit (No Validate)</th><th>Go To:</th><th>#7iPT and ST - MMP S</th><th>Gervices - Base 2</th><th><b>•</b></th></previous<>	Next>>	Exit (Validate)	Exit (No Validate)	Go To:	#7iPT and ST - MMP S	Gervices - Base 2	<b>•</b>
have a Copayr D Other 1 D Other 2	Non-Medicar ment (select	e Home Health Se all that apply):	vices	Enrollee must r None Primary Car Physician S Organization Other, desc Is a referral req	eceive Authorization from e Physician (Internist/Fam pecialist n Medical Director/Utilizati	one or more of the following: nily Practice, General Practice) ion Management/Utilization Revi	ew
Indicate copay percentage for more of the fol services: Other 1	r one or	Minimum Copayment	Maximum Copayment	C No			
Other 2							

Fu Associates, Ltd.

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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	_ 8 ×
File       Help         < <previous< td="">       Next&gt;&gt;       Exit (Validate)       Exit (No Validate)       Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 1</previous<>	
Enhanced Benefits are not applicable for this Service Category.	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
O Yes	
O No	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Every three years C Every two years	
C Every year C Every six months	
C Every three months	
C Other, Describe	
	//

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 92 of 215

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	
	#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?	Indicate Maximum Coinsurance percentage for Medicare-covered Lab Services
C Yes C No	

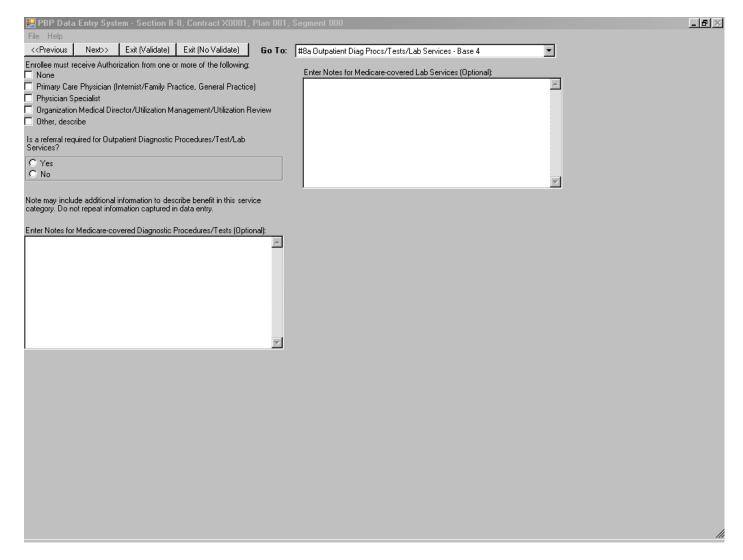
Section B – 8A – Outpatient Diagnostic Procedures/Tests/Lab Services – Base 3 Screen

🔛 PBP Data Entry System - Section B-8, Contract X0001, Plan (	101, Segment 000	_ B ×
File Help		
	To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 3	
Is there an enrollee Deductible?	Indicate whether a separate physician/professional service cost share applies:	
C Yes C No	C Sometimes, describe C No	
	U No	
Indicate Deductible Amount:		
	Is there an enrollee Coinsurance for a separate physician/professional service?	
Is there an enrollee Copayment?	C Yes C No	
© Yes		
O No	Indicate Minimum Coinsurance percentage for a separate physician/professional service:	
Select which Outpatient Diag Procs/Tests/Lab Services have a		
Copayment (Select all that apply):	Indicate Maximum Coinsurance percentage for a separate	
Medicare-covered Diagnostic Procedures/Tests     Medicare-covered Lab Services	physician/professional service:	
Indicate Minimum Copayment amount for Medicare-covered Diagnostic	Is there an enrollee Copayment for a separate physician/professional service?	
Procedures/Tests:		
	O No	
Indicate Maximum Copayment amount for Medicare-covered Diagnostic	Indicate Minimum Copayment amount for a separate physician/professional service:	
Procedures/Tests:	service.	
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	Indicate Maximum Copayment amount for a separate physician/professional service:	
Indicate Maximum Copayment amount for Medicare-covered Lab		
Services:		
		li.

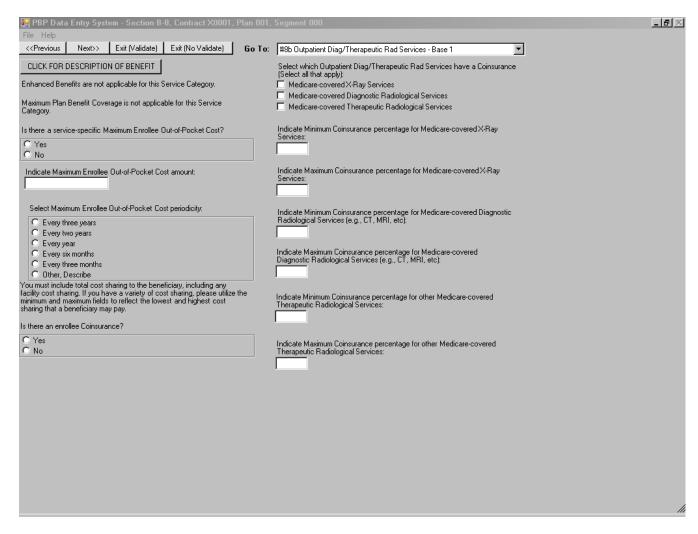
Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 94 of 215

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

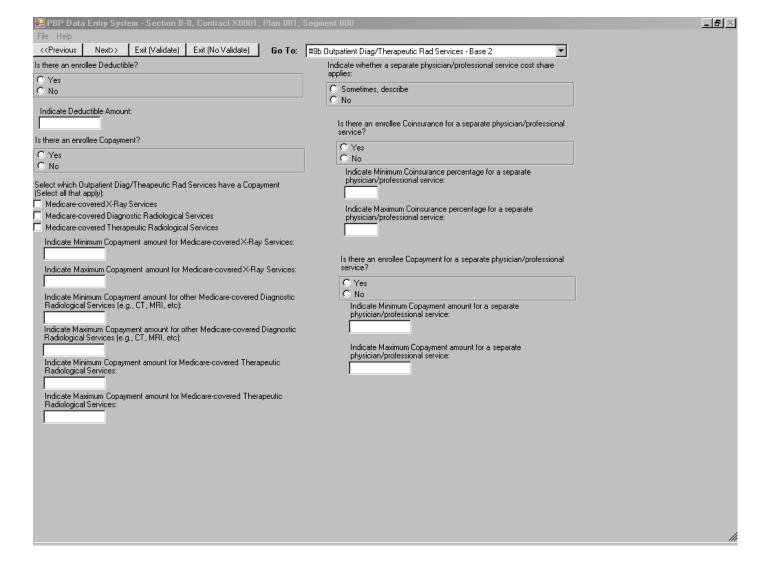


Section B – 8B – Outpatient Diagnostic/Therapeutic Radiological Services – Base 1 Screen



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



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

Fu Associates, Ltd.

🔜 PBP Data Entry System - Section B-8, Contract X0001, Plan 001, S	Segment 000	_ <del>8</del> ×
File Help > 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:	Parter Notes for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.) (Optional):	
Primary Care Physician (Internist/Family Practice, General Practice)		
Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review		
🗖 Other, describe		
Is a referral required for Dutpatient Diagnostic/Therapeutic Radiological, and X- Ray Services?		
C Yes C No		
Outpatient Diagnostic and Therapeutic Radiological Services Notes	<b>•</b>	
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 Therapeutic Radiological Services (Optional):	
Enter Notes for Medicare-covered X-Ray Services (Optional):		
×	<b>•</b>	

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

🚆 PBP Data Entry System - Section B-9, Contract X0001, Plan 001,	Segment 000	<u>_8×</u>
	#9a Outpatient Hospital Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	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	
Enhanced Benefits are not applicable for this Service Category.	and maximum helds to reflect the lowest and highest cost sharing that a beneficiary may pay.	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Is there an enrollee Coinsurance?	-
	C Yes C No	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
O Yes O No	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:		
C Every three years		
O Every two years O Every year		
O Every six months		
Every three months     O Other, Describe		

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 99 of 215

< <previous< td="">       Next&gt;&gt;       Exit (Validate)       Exit (No Validate)       Go To: #9a Outpatient Hospital Services - Base 2         Is there an enrollee Deductible?       Enrollee must receive Authorization from one or more of the following:         Yes       None         No       Primary Care Physician (Internist/Family Practice, General Practic         Indicate Deductible Amount:       Organization Medical Director/Utilization Management/Utilization         Organization Medical Director/Utilization Management/Utilization       Other, describe</previous<>	📰 PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segme	ent 000
It there an envolve Deductible?  Yes No Indicate Deductible Amount:  Yes No Is there an envolve Copsyment?  Yes Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment amount per visit for Medicate covered Benefits:  Indicate Minimum Copsyment Amount per visit for Minimum Copsyment Am	File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go To: #3a 0</previous<>	Dutpatient Hospital Services - Base 2
No       Indicate Minimum Copayment amount per visit for Medicare-covered Benefit:	Is there an enrollee Deductible?  C Yes  No Indicate Deductible Amount: Is there an enrollee Copayment?	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
Indicate Minimum Copayment amount per visit for Medicare covered Benefits:		
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:		
	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	

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

Fu Associates, Ltd.

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🖶 PBP Data Entry System - Sectio	n B-9, Contract X0001, I	<sup>9</sup> lan 001, Segment O	00			_ 8
File Help < <previous next="">&gt; Exit (Valida</previous>	te) Exit (No Validate)	с. т. <u>Ша а н</u>				
Outpatient Hospital Services Notes		60 10:  #9a Uutpa	tient Hospital Services - Base 3	3	•	
Note may include additional information to	o describe benefit in this serv	ice category. Do not rep	peat information captured in da	ita entry.		
Notes (Optional):						
					Ŧ	

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 101 of 215

🔜 PBP Data Entry System - Section B-9, Contract X0001, Plan 001, S	Segment 000	_B×
File Help		
< <pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To:</pre>	#9b ASC Services - Base 1	•
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category.	You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Is there an enrollee Coinsurance?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	C Yes C No	
C Yes C No	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
Select the Maximum Enrollee Out-of-Pocket Cost type:	benents.	
C Covered under Outpatient Hospital Services Category 9a C Plan-specified amount per period		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:		
C Every three years C Every two years C Every year C Every six months		
C Every three months C Other, Describe		

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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-9, Contract X0001,	Plan 001, Segment 000	
File Help		1
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #9b ASC Services - Base 2	1
Is there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:	
C No	Primary Care Physician (Internist/Family Practice, General Practice)	
L	Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review	
Indicate Deductible Amount:	Other, describe	
	la a seferal cominal for Assistant Cominal Control Comina O	
Is there an enrollee Copayment?	Is a referral required for Ambulatory Surgical Center Services? O Yes	
O Yes	O No	
C No		_
Indicate Minimum Copayment amount per visit for Medicare-covere	1	
Benefits:		
Indicate Maximum Copayment amount per visit for Medicare-covere Benefits:	d	
		/

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

Fu Associates, Ltd.

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🛃 PBP Data Entry Sys	stem - Section B	9, Contract X0001, I	<sup>9</sup> lan 001,	Segment 000		
File Help < <previous next="">&gt;</previous>	Exit (Validate)	Exit (No Validate)	C T			7
ASC Services Notes	Exit (Validate)	Exit (No Validate)	60 10:	#9b ASC Services - Base 3		]
Note may include addition	al information to de:	scribe benefit in this serv	ice category	<ol> <li>Do not repeat information captured in data entry.</li> </ol>		
Notes (Optional):						_
					<u> </u>	A

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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B- File Help	9, Contract X0001, Plan 001	, Segment 000		_ 8
<pre>&gt; Exit (Validate)   </pre>	Exit (No Validate) Go To:	#9c Outpatient Substance Abuse - Base 1	<b>•</b>	
CLICK FOR DESCRIPTION OF BENEFIT				
Enhanced Benefits are not applicable for this S	Service Category.			
Maximum Plan Benefit Coverage is not applica	able for this Service Category.			
Is there a service-specific Maximum Enrollee C				
O Yes	TUPOPPOCKET COST?			
O No				
Select the Maximum Enrollee Out-of-Pocket C				
C Covered under Outpatient Hospital Servic C Plan-specified amount per period	ces Category 9a			
Indicate Maximum Enrollee Out-of-Pocket C	ost amount:			
Select Maximum Enrollee Out-of-Pocket Co	ost periodicity:			
C Every three years C Every two years				
C Every year				
C Every six months C Every three months				
O Other, Describe				

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-9, Contract X0001, Plan 001,	Segment 000	_ B ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To:</previous>	#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	Is there an enrollee Deductible?	
minimum and maximum fields to reflect the lowest and highest cost	O Yes	
sharing that a beneficiary may pay.	C No	
Is there an enrollee Coinsurance?	Indicate Deductible Amount:	
O Yes		
O No	Is there an enrollee Copayment?	
Select which Outpatient Substance Abuse Services have a Coinsurance (Select all that apply):	C Yes C No	
Medicare-covered Individual Sessions		
Medicare-covered Group Sessions	Select which Outpatient Substance Abuse Services have a Copayment (Select all that apply):	
Indicate minimum Coinsurance percentage for Medicare-covered Individual Sessions:	Medicare-covered Individual Sessions	
	Medicare-covered Group Sessions	
Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:	Indicate minimum Copayment amount for Medicare-covered Individual Sessions	
Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:	Indicate maximum Copayment amount for Medicare-covered Individual Sessions:	
I Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:	Indicate minimum Copayment amount for Medicare-covered Group Sessions:	
	Indicate maximum Copayment amount for Medicare-covered Group Sessions:	
		//
		11.

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-9, Contract X0001, F	lan 001, Segment 000	_ B ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #9c Outpatient Substance Abuse - Base 3	
Enrollee must receive Authorization from one or more of the following:	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
Primary Care Physician (Internist/Family Practice, General Practice Physician Specialist	Notes (optional).	
Provident Specialist           Organization Medical Director/Utilization Management/Utilization Rel	eview A	
C Other, describe		
Is a referral required for Outpatient Substance Abuse Services?		
C Yes		
O No		
	<b>x</b>	
	,	

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

Fu Associates, Ltd.

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🔛 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	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
If blood is given as a part of an inpatient hospital stay, the cost sharing for the blood should be included in the inpatient hospital cost sharing. Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	C Every three years C Every two years C Every year C Every six months C Every three months	
C Yes	C Other, Describe Is there an enrollee Coinsurance?	
O No Select enhanced benefit:	is there an enrollee Coinsurance?	
Three (3) pint deductible waived	O Yes O No	
Select type of benefit for Three (3) Pint Deductible Waived:	Indicate Coinsurance percentage per unit for Medicare-covered Benefits:	
O Mandatory		
O Optional		
Maximum Plan Benefit Coverage is not applicable for this Service Category.		
Maximum Harrberteik eeverage is net applicable for this service eategory.		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
C Yes		
O No		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
		1

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

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🔡 PBP Data Entry System - Section B-9, Contract X0001, Plan 001,	Segment 000	_6	×
File Help			
< <pre>&lt;<pre>eviceus Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To: Is there an enrollee Deductible?</pre></pre>	#9d Outpatient Blood Services - Base 2	×	
C Yes	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	•	
C No			
Lafact. Dad attle Amount	Notes (Optional):	<u> </u>	
Indicate Deductible Amount:			
Is there an enrollee Copayment?			
C Yes			
O 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)     Provide the Practice Practice			
Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review			
C Other, describe			
Is a referral required for Outpatient Blood Services?			
C Yes			
O No			
		<b>*</b>	
			//

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

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

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🔐 PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000	
File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go To:         #10a Ambulance Services · Base 2</previous<>	
Enrollee must receive Authorization for non-emergency Medicare services from one or more of the following: <ul> <li>None</li> <li>Primary Care Physician (Internist/Family Practice, General Practice)</li> <li>Physician Specialist</li> <li>Organization Medical Director/Utilization Management/Utilization Review</li> <li>Other, describe</li> </ul>	
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes (Optional):	<u> </u>
	<b>*</b>

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 111 of 215

🔛 PBP Data Entry System - Section B-10, Con File Help	tract X0001, Plan 001, Segment 000		_ B ×
< <previous next="">&gt; Exit (Validate) Exit (N</previous>	o Validate) Go To: #10b Transportation Servi	ces - Base 1 💌	
CLICK FOR DESCRIPTION OF BENEFIT	Select Type of Transportation for Plan-approved Location:	Indicate number of trips for Any Location:	
Does the plan provide Transportation Services as a supplemental benefit under Part C? C Yes C No	C One-way C Round Trip C Days C Other, describe	Select Any Location Trips periodicity:	
Select enhanced benefit: C Plan-approved Location C Any Location	Indicate number of days for Plan-approved Location:	C Every two years Every year Every six months Every three months Other, Describe	
Select type of benefit for Plan-approved Location: C Mandatory C Optional Is this benefit unlimited for number of trips for Plan- approved Location? C Yes	Select Mode of Transportation for Plan-approved Location: Taxi Bus/Subway Van Medical Transport Other, describe	Select Type of Transportation for Any Location: C Dne-way C Round Trip C Days C Other, describe Indicate number of days for Any Location:	
C No Indicate number of trips for Plan-approved Location: Select Plan-approved Location Trips periodicity: C Every three years C Every two years C Every two years	Select type of benefit for Any Location: C Mandatory D Dptional Is this benefit unlimited for number of trips for Any Location? C Yes No	Select Mode of Transportation for Any Location: Taxi Bus/Subway Van Medical Transport	
C Every two years C Every year C Every six months C Every three months C Other, Describe		C Other, describe	

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

Page 112 of 215

< <previous< td="">       Nexb&gt;       Exit (Validate)       Exit (No Validate)       Go To:       #10b Transportation Services - Base 2         Is there a service-specific Maximum Plan Benefit Coverage amount?       Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?       Is there a nerrollee Coinsurance?</previous<>	🔛 PBP Data Entry System - Section B-10, Cor	ntract X0001, Plan 001, Segment 000		_ 8 ×
Is there a service-specific Maximum Plan Benefit Coverage amount? Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Is there an enrollee Coinsurance? O Yes O Yes	File Help			
O Yes O Yes			Is there an enrollee Coinsurance?	
	C Yes	C Yes C No	O No	
Indicate Maximum Plan Benefit Coverage amount: Indicate Maximum Enrollee Out-of-Pocket Cost amount:			Indicate Coinsurance percentage:	
Select Maximum Plan Benefit Coverage periodicity: E-very three years E-very three years E-very three months D-ther, Describe C-ther,	C Every three years C Every two years C Every year C Every six months C Every three months	Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every year C Every six months C Every three months	C Yes C No	

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 113 of 215

🚂 PBP Data Entry System - Section B-10, Contract X0001, Plan 0	11, Segment 000	_8×
File Help	-	
	#10b Transportation Services - Base 3	•
Is there an enrollee Copayment?	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
C Yes C No	Notes (Optional):	
Indicate Copayment amount per trip:		A
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?		
O Yes		
C No	1	
		<b>y</b>
		1

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

Page 114 of 215

PBP Data Entry System - Section B-11, Co	ontract X0001, Plan 001, Segment 000		
iile Help < <previous next=""  ="">&gt;   Exit (Validate)   Exit (N</previous>			
< <previous next="">&gt; Exit (Validate) Exit (N</previous>	No Validate) Go To: #11a DME - Base 1	V	
CLICK FOR DESCRIPTION OF BENEFIT			
nhanced Benefits are not applicable for this ervice Category.	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	
	C Every three years	O Yes	
aximum Plan Benefit Coverage is not applicable r this Service Category.	C Every two years C Every year	O No	
This Service Category.	C Every six months	Indicate Deductible Amount:	
there a service-specific Maximum Enrollee Out-of- ocket Cost?	C Every three months		
Yes	Other, Describe Is there an enrollee Coinsurance?		
ves No		Is there an enrollee Copayment?	
ndicate Maximum Enrollee Out-of-Pocket Cost	C Yes C No	O Yes	
ndicate Maximum Enrollee Uut-of-Pocket Lost mount:		C No	
	Indicate Minimum Coinsurance percentage for Medicare -covered Benefits:	Indicate Minimum Consument amount per	
		Indicate Minimum Copayment amount per item for Medicare-covered Benefits:	
	Indicate Maximum Coinsurance percentage for Medicare		
	-covered Benefits:	Indicate Maximum Copayment amount per	
		item for Medicare-covered Benefits:	

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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-11, Contract X0001, Plan 001,	Segment 000	_ @ ×
File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go To:</previous<>	#11a DME - Base 2	<b>T</b>
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
C Yes C No	Notes (Optional):	A
Enrollee must receive Authorization from one or more of the following:  None  Primary Care Physician (Internist/Family Practice, General Practice)  Physician Specialist		
<ul> <li>Organization Medical Director/Utilization Management/Utilization Review</li> <li>Other, describe</li> </ul>		
Referral is not applicable for this Service Category.		
		<b>•</b>
		li

Section B – 11A – Durable Medical Equipment – MMP Services - Base 1 Screen

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 116 of 215

🔡 PBP Data Entry System - Section B-11, Contract X0001, Plan 001	, Segment 000	_ 8 ×
File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go To:</previous<>	#11a DME - MMP Services - Base 1	
	#11a DME - MMP Services - Base 1         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) (set that apply):         Durable Medical Equipment for use outside the home         Other 1         Other 2	elect all
Out-of-Pocket Cost?  Yes No	Indicate coinsurance Minimum Maximum percentage for one or Coinsurance Coinsurance more of the following services:	8
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Durable Medical Equipment for use	
	Other 1	
	Other 2	

Section B – 11A – Durable Medical Equipment – MMP Services - Base 2 Screen

Fu Associates, Ltd.	CY 2014 PBP – Section B	Page 117 of 215
	12/6/2012	
	CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING	

	stem - Section B	11, Contract X0001	, Plan 001	, Segment 000
File Help < <previous next="">&gt;</previous>	Exit (Validate)	Exit (No Validate)	Go To:	#11a DME - MMP Services - Base 2
Is there an enrollee Copay			40 10.	
C Yes				Enrollee must receive Authorization from one or more of the following:
C No				Primary Care Physician (Internist/Family Practice, General Practice)
				🥅 Physician Specialist
Select which Non-Medicar (select all that apply):	re Durable Medical I	Equipment(s) have a Co	payment	Organization Medical Director/Utilization Management/Utilization Review
Durable Medical Equip	ment for use outside	the home		🔲 Other, describe
C Other 1				Is a referral required for Services?
				C Yes
Indicate copayment percentage for one or more of the following services:	Minimum Copayment	Maximum Copayment		C No
Durable Medical Equipment for use outside the home				
Other 1				
Other 2				
•				

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

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	12/6/2012	
CMS S	SENSITIVE INFORMATION - REQUIRES SPECIAL HAN	DLING

🔜 PBP Data Entry System - Section B-11, Contract X0001, Plan 001	, Segment 000	_ B ×
File Help		
	#11b Prosthetics/Medical Supplies - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT		
Enhanced Benefits are not applicable for this Service Category.	C Yes C No	
Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply): Medicare-covered Prosthetic Devices	
© Yes	Medicare-covered Medical Supplies	
O No		
Select Maximum Enrollee Out-of-Pocket Cost type:	Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	
C Covered under DME Category 11a C Plan-specified amount per period		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	
C Every three years		
C Every two years C Every year		
C Every six months	Indicate Maximum Coinsurance percentage for Medicare-covered Medical	
O Every three months	Supplies:	
C Other, Describe		
		li li

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

Fu Associates, Ltd.

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📴 PBP Data Entry System - Section B-11, Contract X0001, Plan 001,	Segment 000	_ B ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To:</previous>	#11b Prosthetics/Medical Supplies - Base 2	
Is there an enrollee Deductible?	Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	
C Yes	Flosheuc Devices.	
O No		
Indicate Deductible Amount:	Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:	
Is there an enrollee Copayment?	Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:	
Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply): Medicare-covered Prosthetic Devices Medicare-covered Medical Supplies	Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	

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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segmen	nt 000 💶 🖪 🗵
File Help	
	osthetics/Medical Supplies - Base 3
	ote may include additional information to describe benefit in this service ategory. Do not repeat information captured in data entry.
Primary Care Physician (Internist/Family Practice, General Practice)     Physician Specialist	otes (Optional):
Crganization Medical Director/Utilization Management/Utilization Review	*
C Other, describe	
Referral is not applicable for this Service Category.	
	<b>v</b>
-	_

Section B – 11B – Prosthetics/Medical Supplies – MMP Services - Base 1 Screen

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-11, Contract	X0001, Plan 001	, Segment 000	_ 8 ×
File Help			
< <previous next="">&gt; Exit (Validate) Exit (No Valid</previous>	ate) Go To:	#11b Prosthetics/Medical Supplies - MMP Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT		Is there an enrollee Coinsurance?	
		C Yes	
Does this plan provide non-Medicare Prosthetics/Medical Sup	plies?	O No	
C Yes		Indicate Coinsurance Percentage:	
O No			
E transformer (New Markey Cardina			
Enter name of Non-Medicare Service:		la thana an annalla a Caranna an 10	
		Is there an enrollee Copayment?	
Is there a service-specific Maximum Plan		C Yes C No	
Benefit Coverage amount?		e no	
O Yes		Indicate Copayment Amount:	
O No			
Indicate Maximum Plan Benefit Coverage			
amount:		Enrollee must receive Authorization from one or more of the follo	owing:
		None Primary Care Physician (Internist/Family Practice, General P	(raction)
		Physician Specialist	racticej
Select Maximum Plan Benefit Coverage		Organization Medical Director/Utilization Management/Utilization	ation Review
periodicity:		Other, describe	
C Every three years			
C Every two years C Every year		Is a referral required for Services?	
C Every six months		C Yes C No	
C Every three months		O No	
O Other, Describe			
			1

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

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🔛 PBP Data Entry System - Section B-11, Contract X0001, Plan 0	01, Segment 000	_ B ×
File Help		
< <pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To</pre>	#11c Diabetic Supplies and Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select which Diabetic Supplies and Services have a Coinsurance (Select all that apply):	
Enhanced Benefits are not applicable for this Service Category.	Medicare-covered Diabetic Supplies	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Medicare-covered Diabetic Therapeutic Shoes or Inserts	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Supplies:	
C Yes		
O No		
Select Maximum Enrollee Out-of-Pocket Cost type:	Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Supplies:	
C Covered under DME Category 11a C Plan-specified amount per period		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	I Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	
Every three years		
C Every two years	Is there an enrollee Deductible?	
O Every year	C Yes	
C Every six months C Every three months	C No	
O Other, Describe		
Is there an enrollee Coinsurance?	Indicate Deductible Amount:	
C Yes		
C No		

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

Fu Associates, Ltd.

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BPBP Data Entry System - Section B-11, Contract X0001,	Plan 001, Segment 000	_ 8 )
File Help < <pre> </pre> Kit (Validate) Exit (No Validate)	Go To: #11c Diabetic Supplies and Services - Base 2	
Is there an enrollee Copayment?	Do you limit Diabetic Supplies and Services to those from specified manufacturers?	
© Yes	C Yes	
O No	C No	
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	Enrollee must receive Authorization from one or more of the following:	
Medicare-covered Diabetes Supplies	Primary Care Physician (Internist/Family Practice, General Practice)	
Medicare-covered Diabetic Therapeutic Shoes or Inserts	Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review	
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	Organization Medical Director/Utilization Management/Utilization Neview     Other, describe	
	Referral is not applicable for this Service Category.	
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
	Notes (Optional):	
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:		

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

Fu Associates, Ltd.

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CePrevious       Nexto>       Exit (Validate)       Exit (No Validate)       Go To:       #12 End Stage Rend Disease - Base 1       Image: Comparison of the comp	🔜 PBP Data Entry Sy File Help	stem - Section B-1	2, Contract X0001, Plan 00 <sup>-</sup>	1, Segment 000			<u>_ 8</u>
Extert of DECent in Nore of DENETITY       periodicity:       Indicate Maximum Plan Benefit Coverage is not applicable for this Service-Specific Maximum Enrollee Out-of-Pocket Cost?       Indicate Maximum Enrollee Out-of-Pocket Cost and highest cost sharing that a beneficiary may pay.       Indicate Maximum Enrollee Out-of-Pocket Cost and highest cost sharing that a beneficiary may pay.       Indicate Maximum Enrollee Out-of-Pocket Cost and highest cost sharing that a beneficiary may pay.       Indicate Maximum Enrollee Out-of-Pocket Cost and highest cost sharing that a beneficiary may pay.       Indicate Maximum Enrollee Out-of-Pocket Cost and highest cost sharing that a beneficiary may pay.       Indicate Maximum Consurance percentage for Medicare-covered Benefits:       Indicate Maximum Copayment amount per session for Medicare-covered Benefits:         Indicate Maximum Consurance percentage for Medicare-covered Benefits:       Indicate Maximum Consurance percentage for Medicare-covered Benefits:	< <previous next="">&gt;</previous>	Exit (Validate)	Exit (No Validate) Go To:	#12 End-Stage Renal	Disease - Base 1	-	
Enhanced Benefits are not applicable for this Service Category.       C Every two years Every year       No         Maximum Plan Benefit Coverage is not applicable for this Service Category.       C Every years       Indicate Deductible Amount:         Is there a service-specific Maximum Enrollee Out- of-Pocket Cost?       O ther, Describe       Is there an enrollee Copayment?         Yes       You must include total cost sharing to the beneficiary, including any facility cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.       Indicate Maximum Copayment amount per session for Medicare-covered Benefits:         Yes       No         Indicate Maximum Enrollee Out-of-Pocket Cost amount:       Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:         Indicate Maximum Coinsurance percentage for       Indicate Maximum Coinsurance percentage for	CLICK FOR DESCRIPT	ION OF BENEFIT	Select Maximum Enrollee O periodicity:	ut-of-Pocket Cost			
Ores       Defendedary, including any facility cost sharing, if you have a variety of cost sharing, please ultize the innimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.       Indicate Maximum Enrollee Out-of-Pocket Cost and highest cost sharing that a beneficiary may pay.         Indicate Maximum Enrollee Out-of-Pocket Cost amount:       Is there an enrollee Coinsurance?       Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:         Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:       Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Service Category. Maximum Plan Benefit Co applicable for this Service Is there a service-specific	verage is not Category.	C Every two years Every year Every six months Every three months Other, Describe You must include total cost	sharing to the	No     Indicate Deductible Amount:		
Indicate Maximum Enrollee Out-of-Pocket Cost amount: Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Indicate Maximum Coinsurance percentage for	C Yes		have a variety of cost sharir minimum and maximum field	ng, please utilize the s to reflect the lowest	C Yes C No		
	Indicate Maximum Enroll	ee Out-of-Pocket Cost	and highest cost sharing the ls there an enrollee Coinsure C Yes No Indicate Minimum Coinsu Medicare-covered Benef Indicate Maximum Coinsu Indicate Maximum Coinsu	ance? rance percentage for rance percentage for rance percentage for	session for Medicare-covered Benefits:		

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 125 of 215

RPBP Data Entry System - Section B-12, Contract X0001, Plan 001, Segment 000		_82
<pre>&lt;<pre>resp </pre> </pre> Kit (Validate) Exit (No Validate) Go To: #12 End-Stage Renal Disease - Base 2	<b>_</b>	
nrollee 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		
s a referral required for End-Stage Renal Disease services?		
O Yes O No		
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
lotes (Optional):		
	<u>^</u>	
	-	

Section B – 13A – Acupuncture and Other Alternative Therapies – Base 1 Screen

Fu Associates, Ltd.

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BPBP Data Entry System - Section B-13, Col File Help	ntract X0001, Plan 001, Segment 000		6
	o Validate) <b>Go To</b> : #13a Acupuncture a	nd Other Alternative Therapies - Base 1	
CLICK FOR DESCRIPTION OF BENE	Indicate limit for Number of Treatments:	Is there a service-specific Maximum Enrollee Out-of- Pocket Cost?	
Does the plan provide Acupuncture and Other Alternative Therapies Services as a supplemental benefit under Part C?	Indicate Number of Treatments periodicity:	Yes     No     Indicate Maximum Enrollee Out-of-Pocket Cost	
C Yes C No	C Every two years C Every year C Every six months	amount:	
Select enhanced benefit:           Number of Treatments	C Every three months C Other, Describe	Indicate Maximum Enrollee Out-of-Pocket Cost	
Select type of benefit for Number of Treatments:	Is there a service-specific Maximum Plan Bene Coverage amount?	C Every three years C Every two years	
Is this benefit unlimited for Number of Treatments?	No     Indicate Maximum Plan Benefit Coverage     amount:	C Every year C Every six months C Every three months	
C Yes C No		O Other, Describe	
	Indicate Maximum Plan Benefit Coverage periodicity: C Every three years		
	C Every two years C Every year C Every six months C Every three months		
	C Other, Describe		

Section B – 13A – Acupuncture and Other Alternative Therapies – Base 2 Screen

Fu Associates, Ltd.

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BPD ata Entry System - Section B-13, Cont	ract X0001, Plan 001, Segment 000	_ 8 ×
File Help		
	Validate) Go To: #13a Acupuncture and Other Alternative Therapies - Base 2	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes	© Yes	
○ No	O No	
Indicate Coinsurance percentage:	Indicate Copayment amount per treatment:	
Is there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:	
© Yes	None None	
O No	Primary Care Physician (Internist/Family Practice, General Practice)	
	Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review	
Indicate Deductible Amount:		
	Is a referral required for Acupuncture and Other Alternative Therapies Services?	
	C Yes	
	C No	

Section B – 13A – Acupuncture and Other Alternative Therapies – Base 3 Screen

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 128 of 215

BPBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000		_ 8 ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To: #13a Acupuncture and Other Alternative Therapies - Base 3 Acupuncture and Other Alternative Therapies Notes</previous>	<b>•</b>	
ote may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
otes (Optional):		
a see (alkansed).	A	
	<b>T</b>	
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Section B – 13B – OTC Items and Services – Base 1 Screen

Fu Associates, Ltd.

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## PBP 2014 Data Entry System Screens

BB PBP Data Entry System - Section B-13, Contract X0001, File Help	Plan 001, Segment 000	_ <b>F</b> ×
<pre>&lt;<previous next="">&gt; Exit (Validate) Exit (No Validate)</previous></pre>	Go To: #13b OTC Items and Services - Base 1	×
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
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.	C Yes C 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?	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Yes C No	C Every three years C Every two years	
Select type of benefit for OTC items and services:	C Every year C Every six months	
C Mandatory C Optional	C Every three months C Every month	
Is there a service-specific Maximum Plan Benefit Coverage amount?		
Indicate Maximum Plan Benefit Coverage amount: Indicate Maximum Plan Benefit Coverage periodicity: © Every three years © Every two years © Every year © Every year © Every six months © Every three months © Every month		

Section B – 13B – OTC Items and Services – Base 2 Screen

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 130 of 215

🔛 PBP Data Entry System - Section B-13, Contra	nct X0001, Plan 001, Segment 000	_ <del>8</del> ×
File Help < <previous next="">&gt; Exit (Validate) Exit (No V</previous>	alidate) Go To: #13b OTC Items and Services - Base 2	
Is there an enrollee Coinsurance?	Does this cover all of the CMS OTC list?	
C Yes C No	C Yes C No	
Indicate Coinsurance percentage:	Authorization is not applicable for this service category.	
Is there an enrollee Deductible?	Referral is not applicable for this service category.	
O Yes O No		
Indicate Deductible Amount:		
Is there an enrollee Copayment?		
C No Indicate Copayment amount:		

Section B – 13B – OTC Items and Services – Base 3 Screen

Fu Associates, Ltd.

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歸 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000		_ B ×
File Help		
CPrevious         Next>>         Exit (Validate)         Exit (No Validate)         Go To:         #13b DTC Items and Services - Base 3           OTC Items and Services Notes                                #13b DTC Items and Services - Base 3	•	
UTE items and Services Notes		
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
Notes (Optional):	A	
	<b>*</b>	
		1

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

Fu Associates, Ltd.

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PBP Data Entry System - Section B-13, Contract X0001. File Help	Plan 001, Segment 000	_ B ×
<pre>&lt;<pre>ree Heip &lt;&lt;<pre>Previous Next&gt;&gt; Exit (Validate) Exit (No Validate)</pre></pre></pre>	Go To: #13c Meal Benefit - Base 1	<b>_</b>
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Does the plan provide a Meal Benefit as a supplemental benefit under Part C?	C Yes C No	
C Yes C No	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select type of benefit:	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Mandatory C Optional	C Every three years	
Is there a service-specific Maximum Plan Benefit Coverage amount?	C Every two years C Every year C Every six months	
O Yes O No	C Every six monitos	
Indicate Maximum Plan Benefit Coverage amount:		
Indicate Maximum Plan Benefit Coverage periodicity:		
C Every three years C Every two years		
Every year     Every six months		
C Every three months		
O Other, Describe		

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-13, Contract X0001	I, Plan 001, Segment 000	
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #13c Meal Benefit - Base 2	×
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes C No	O Yes O No	
Indicate Coinsurance percentage:	Indicate Copayment amount:	-
Is there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice)	
Indicate Deductible Amount:	Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review     Other, describe	
	Is a referral required for the Meal Benefit?	
	C No	

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

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🔛 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000	
<pre>&lt;<previous next="">&gt; Exit (Validate) Exit (No Validate) Go To: #13c Meal Benefit - Base 3</previous></pre>	×
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
Notes (Optional):	
	<u>^</u>
l	<b>Y</b>
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Section B – 13D – Other 1 – Base 1 Screen

Fu Associates, Ltd.

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🔡 PBP Data Entry System - Section B-13, Contract X0001,	Plan 001, Segment 000	_ 8 ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #13d Other 1 - Base 1	<b>•</b>
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Plan Benefit Coverage amount:	
Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional):' field you will lose all previously entered data.	Indicate Maximum Plan Benefit Coverage periodicity:	
You may edit the name of the service text partially without losing all previously entered data.	C Every three years C Every two years	
Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, transportation, medical devices etc).	C Every year C Every six months C Every three months	
Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13C.	Other, Describe  Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.	C Yes No	
Enter name of Service (Optional):	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select type of benefit:	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Mandatory C Optional	Every three years     Every two years	
	O Every year	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Every six months	
O Yes	C Every three months O Other, Describe	
O No		
		hi

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

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📰 PBP Data Entry System - Section B-13, Contract XD File Help	001, Plan 001, Segment 000	_ 6 ×
< <previous next="">&gt; Exit (Validate) Exit (No Validate</previous>	Go To: #13d Other 1 - Base 2	<b>v</b>
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
O Yes O No	O Yes O No	
Indicate Coinsurance percentage:	Indicate Copayment amount:	
Is there an enrollee Deductible? O Yes O No	Enrollee must receive Authorization from one or more of the following: <ul> <li>None</li> <li>Primary Care Physician (Internist/Family Practice, General Practice)</li> <li>Physician Specialist</li> <li>Organization Medical Director/Utilization Management/Utilization Review</li> </ul>	
Indicate Deductible Amount:	Other, describe     Is a referral required for Other Services?	
	O Yes O No	

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

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📴 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000	_ 8 ×
File Help	
> Exit (Validate) Exit (No Validate) Go To: #13d Other 1 - Base 3 Other Services Notes	
Uner Services Notes	
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
Nata (Ostissa)	
Notes (Optional):	<b>A</b>
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Section B – 13E – Other 2 – Base 1 Screen

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📴 PBP Data Entry System - Section B-13, Contract X0001,	, Plan 001, Segment 000	B×
File Help > Exit (Validate) Exit (No Validate)	Gio To: #13e Other 2 - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Plan Benefit Coverage amount:	
Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional)' 'field you will lose all previously entered data. You may edit the name of the service text partially without losing all previously entered data. Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, transportation, medical devices etc). Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-138. 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 periodicity:	

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

Fu Associates,	Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 139 of 215

🔡 PBP Data Entry System - Section B-13, Contract X(	0001, Plan 001, Segment 000		_ <del>8</del> ×
File Help <pre>&lt;<previous next="">&gt; Exit (Validate) Exit (No Validate)</previous></pre>	e) Go To: #13e Other 2 - Base 2	•	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?		
O Yes	O Yes	]	
O No	C No		
Indicate Coinsurance percentage:	Indicate Copayment amount:		
Is there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:		
O Yes	None     Primary Care Physician (Internist/Family Practice, General Practice)		
C No	Physician Specialist		
Indicate Deductible Amount:	Organization Medical Director/Utilization Management/Utilization Review     Other, describe		
	Is a referral required for Other Services?		
	O Yes	7	
	C No		
			//

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

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🚆 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000		_ 8 >
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Goo To: #13e Other 2 · Base 3 Other Services Notes</previous>	<b>_</b>	
Juliel Services Moles		
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
lotes (Optional):	<u></u>	
	_	
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12/6/2012

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

BPBP Data Entry System - Section B-13, Contract X0001,	Plan 001, Segment 000	_ <del>-</del> 7 ×
File Help > Exit (Validate) Exit (No Validate)	GoTo: #13/Other 3 - Base 1 ▼	
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Plan Benefit Coverage amount:	
Note: After completing your data entry in this category, if you delete ALL text in the "Enter name of Service (Optional):" field you will lose all previously entered data.	Indicate Maximum Plan Benefit Coverage periodicity:	
You may edit the name of the service text partially without losing all previously entered data.	C Every three years C Every two years C Every year	
Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, transportation,	C Every six months C Every six months	
medical devices etc).	O Other, Describe	
$Over\text{-the-Counter}\left(e.g.\right)$ adult diapers, band-aids, etc.) benefits should only be entered in B-13B.	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.	C No	
Enter name of Service (Optional):	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:	
Select type of benefit:	O Every three years	
C Mandatory	C Every two years C Every year	
C Optional	C Every six months	
Is there a service-specific Maximum Plan Benefit Coverage amount?	O Every three months	
C Yes	O Other, Describe	
O No		
		h

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

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📴 PBP Data Entry System - Section B-13, Contract XD File Help	001, Plan 001, Segment 000	<u> 8 ×</u>
< <previous next="">&gt; Exit (Validate) Exit (No Validate</previous>	) Go To: #13f Other 3 - Base 2	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes C No	C Yes C No	
Indicate Coinsurance percentage:	Indicate Copayment amount:	
Is there an enrollee Deductible? C Yes No Indicate Deductible Amount:	Enrollee must receive Authorization from one or more of the following: None Rimary 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? C Yes C No	
		11

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

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PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000		_ 8 >
e Help <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To: #13f Other 3 · Base 3</previous>	<b>•</b>	
her Services Notes		
ote may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
the Optimum		
ites (Optional):	*	
	~	

Section B – 13G – Dual Eligible SNPs with Highly Integrated Services – Base 1 Screen

Fu Associates, Ltd.

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🔡 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segn	ment 000	_ 8 >
File Help		
	pDual Eligible SNPs with Highly Integrated Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount?	
<ul> <li>Plans only fill out this section if they have re</li> <li>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.</li> </ul>	C Yes C No Indicate Maximum Plan Benefit Coverage amount:	
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.	Indicate Maximum Plan Benefit Coverage periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	
You may edit the name of the service text partially without losing all previously entered data.	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.	C Yes C No	
Enter name of Service (Optional):	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:	
Select type of benefit: C Mandatory C Optional	C Every three years C Every two years C Every year C Every six months	
	Every three months     O Other, Describe	
		/

Section B – 13G – Dual Eligible SNPs with Highly Integrated Services – Base 2 Screen

Fu Associates,	Ltd.
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BPBP Data Entry System - Section B-13, Contract X0	0001, Plan 001, Segment 000	<u>- 8 ×</u>
< <previous next="">&gt; Exit (Validate) Exit (No Validate</previous>	e) Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 2	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes C No	O Yes O No	
Indicate Minimum Coinsurance percentage:	Indicate Minimum Copayment amount:	
Indicate Maximum Coinsurance percentage:	Indicate Maximum Copayment amount:	
Is there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:	
C Yes C No	Frimary Care Physician (Internist/Family Practice, General Practice)	
	Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review	
Indicate Deductible Amount:	Otganization Medical Director/Otilization Management/Otilization Neview     Other, describe	
	Is a referral required for Other Services?	
	C Yes	
	O No	
		//

Section B – 13G – Dual Eligible SNPs with Highly Integrated Services – Base 3 Screen

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000		_ 8 >
File Help		
<pre>&lt;<pre>evious Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 3</pre></pre>	•	
Dual Eligible SNPs with Highly Integrated Services Notes		
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
Notes (Optional):	<u> </u>	
	-	

Section B – 13H – Additional Services – Base 1 Screen

Fu Associates, Ltd.

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🔡 PBP Data Entry System - Section B-13, Contract X0001, Plan 001,	, Segment 000		. 8 ×
File Help			
<pre>&lt;<previous next="">&gt; Exit (Validate) Exit (No Validate) Go To:</previous></pre>	#13h Additional Services - Base 1	•	
CLICK FOR DESCRIPTION OF BENEFIT	Enter name of Other 1 Service:		
Does the plan provide Additional Services?	Enter name of Other 2 Service:		
C Yes C No			
Select Additional Services (select all that apply):	<b>5</b>		
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women	Enter name of Other 3 Service:		
Freestanding Birth Center Services			
Respiratory Care Services Family Planning Services			
Family Planning Services Nursing Home Services Home and Community Based Services Personal Care 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			
			/

Section B – 13H – Additional Services – Base 2 Screen

Fu Associates, Ltd.

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💀 PBP Data Entry System - Section B-13, Contract X0001, Plan	001, Segment 000		_ 8 ×
File Help			
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go 1</previous>	o: #13h Additional Services - Base 2	V	
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 refelct the lowest and highest cost	Indicate Coinsurance for one or more of the following services.	Minimum Maximum Coinsurance Coinsurance	
sharing that a beneficiary may pay. Is there an enrollee Coinsurance?	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
C Yes C No	Tobacco Cessation Counseling for Pregnant Women		
Select which Additional Services have a Coinsurance (Select all that apply	Freestanding Birth Center Services		
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women	Respiratory Care Services		
Freestanding Birth Center Services Respiratory Care Services Family Planning Services	Family Planning Services		
Nursing Home Services Home and Community Based Services	Nursing Home Services		
Personal Care Services Self-Directed Personal Assistance Services Private Duty Nursing Services	Home and Community Based Services		
Case Management (Long Term Care) Institution for Mental Disease Services for Individuals 65 or Older	Personal Care Services		
Services in an Intermediate Care Facility for the Mentally Retarded Case Management	Self-Directed Personal Assistance Services		
Other 1 Other 2 Other 3	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		
			/

Section B – 13H – Additional Services – Base 3 Screen

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-13, Contract X0001, Plan	001	, Segment 000		
File Help < <previous next="">&gt; Exit (Validate) Exit (No Validate) Go</previous>	To:	#13h Additional Services - Base 3		•
Is there an enrollee Copayment?		, licate Copayment for one or more of the following vices.	Minimum Copayment	Maximum Copayment
C No Select which Additional Services have a Copayment (Select all that apply):	Ea Tre	ly and Periodic Screening, Diagnostic, and atment (EPSDT) Services		
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women	То	bacco Cessation Counseling for Pregnant Women		
Freestanding Birth Center Services Respiratory Care Services	Fre	estanding Birth Center Services		
Family Planning Services Nursing Home Services	Re	spiratory Care Services		
Home and Community Based Services Personal Care Services Self-Directed Personal Assistance Services	Fa	nily Planning Services		
Seri-Directed Personal Assistance Services Private Duty Nursing Services Case Management (Long Term Care)	Nu	rsing Home Services		
Institution for Mental Disease Services for Individuals 65 or Older Services in an Intermediate Care Facility for the Mentally Retarded Case Management	Ho	me and Community Based Services		
Other 1 Other 2	Pe	rsonal Care Services		
Other 3	Se	f-Directed Personal Assistance Services		
	Pri	vate Duty Nursing Services		
	Ca	se Management (Long Term Care)		
		titution for Mental Disease Services for Individuals or Older		
	Se Me	rvices in an Intermediate Care Facility for the ntally Retarded		
	Ca	se Management		
	Ot	ner 1		
	Ot	ner 2		
	Ot	ner 3		

Section B – 13H – Additional Services – Base 4 Screen

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🔡 PBP Data Entry System - Section B-13, Contract X0001	Plan 001, Segment 000	<u>_ 8 ×</u>
File Help <pre>&lt;<pre>revious</pre> Next&gt;&gt; Exit (Validate)</pre> Exit (No Validate)	Go To: #13h Additional Services - Base 4	7
Additional Services Notes	-	-
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
Notes (Optional):		
		li

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

Fu Associates, Ltd.

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🛃 PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 00	0 _8×
File Help	
< <pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate) Go To: #14a Medicar</pre>	e-covered Preventive Services
CLICK FOR DESCRIPTION OF BENEFIT	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
Medicare-covered Preventive Services Attestation	Notes (Optional):
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:	
Primary Care Physician (Internist/Family Practice, General Practice)	
Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review	
Is a referral required?	
O Yes	
C No	
	<u>×</u>

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-14, Contract X0001, Plan 001,	, Segment 000	_ 8 >
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To:</previous>	#14b Annual Physical Exam - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount?	
Enter Medicare-covered preventive services at \$0 cost sharing in PBP service category 14a.	C Yes C No	
You should only use these supplemental benefits for Annual Physical Exams not covered by Driginal Medicare. You may charge copays for these Annual Physical Exams. NDTE: 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?	Indicate Maximum Plan Benefit Coverage amount: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No	
© No	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select type of benefit for the Annual Physical Exam:		
C Mandatory C Optional		

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

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🖫 PBP Data Entry System - Section B-14, Contract X0001, Plan 00 File - Help	UT, Segment UUU	_ 5
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To:</previous>	o: #14b Annual Physical Exam - Base 2	
s there an enrollee Coinsurance?	Is there an enrollee Copayment?	
O Yes O No	C Yes C No	
Indicate Coinsurance percentage for each Annual Physical Exam:	Indicate Copayment amount for each Annual Physical Exam:	
s there an enrollee Deductible?		
O Yes O No		

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

Fu Associates, Ltd.

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File Help	ystem - Section B	14, Contract X0001	. Plan 001	l, Segment 000			_ 8 >
< <previous next=""></previous>	> Exit (Validate)	Exit (No Validate)	Go To:	#14b Annual Physical Exam - Base 3		•	
Enrollee must receive Au None Primary Care Physici Physician Specialist Organization Medical Other, describe	uthorization from one o an (Internist/Family Pr	or more of the following: actice, General Practice	)				
Is a referral required for	the Annual Physical E	xam?					
C Yes C No							
Note may include additi	onal information to de:	scribe benefit in this serv	vice categoi	ry. Do not repeat information captured in data	a entry.		
Notes:							
110(03.						-	
						7	

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

Fu Associates, Ltd.

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🚆 PBP Data Entry System - Section B-14, Contrac File Help < <previous next=""> Exit (Validate) Exit (No Val</previous>		n/Health Management Programs - Base 1	]
CLICK FOR DESCRIPTION OF BENEFIT oes the plan provide Supplemental Education/Health anagement Programs as a benefit under Part C?	Select type of benefit for Health Education:	Select type of benefit for Membership in Health Club/Fitness Classes: C Mandatory C Optional	
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 Nutritional Benefit: C Mandatory C Optional Select type of benefit for Additional Smoking and Tobacco Use Cessation: C Mandatory C Optional	Select type of benefit for Nursing Hotline: C Mandatory O Optional	

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

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Previous Next>> Exit (Validate) Exit (No	Validate) Go To: #14c Supplemental Education/Health Management Programs - Base 2 💌	
re a service-specific Maximum Plan Benefit rage amount for Supplemental Education/Health gement Programs?	Is there a service-specific Maximum Enrollee Out- of-Pocket Cost for Supplemental Education/Health Management Programs?	
Yes	O Yes	
lo cate Maximum Plan Benefit Coverage amount:	C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
ect the Maximum Plan Benefit Coverage iodicity:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
Every two years Every two years Every year	C Every three years C Every two years C Every two years	
Every six months Every three months Other, Describe	C Every six months C Every three months C Other. Describe	

Section B – 14C – Supplemental Education/Health Management Programs – Base 3 Screen

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📴 PBP Data Entry System - Section B-14, Contract X0001	I, Plan 001, Segment 000	_ B ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	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.	Indicate Coinsurance percentage for Nutritional Benefit:	
Is there an enrollee Coinsurance?	Indicate Coinsurance percentage for Additional Smoking and Tobacco Use Cessation:	
O Yes		
○ No		
Select which Supplemental Education/Health Management Programs have a Coinsurance (Select all that apply): Health Education Nutritional Benefit	Indicate Minimum Coinsurance percentage for Membership in Health Club/Fitness Classes:	
<ul> <li>Additional Smoking and Tobacco Use Cessation</li> <li>Membership in Health Club/Fitness classes</li> <li>Nursing Hotline</li> </ul>	Indicate Maximum Coinsurance percentage for Membership in Health Club/Fitness Classes:	
Indicate Minimum Coinsurance percentage for Health Education:	Indicate Coinsurance percentage for Nursing Hotline:	
Indicate Maximum Coinsurance percentage for Health Education:		

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 158 of 215

🔛 PBP Data Entry System - Section B-14, Contract X0001	l, Plan 001, Segment 000	_ B ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #14c Supplemental Education/Health Management Programs - Base 4	
Is there an enrollee Deductible?	Indicate Copayment amount for Health Education:	
O Yes O No		
Indicate Deductible Amount:	Indicate Copayment amount for Nutritional Benefit:	
Is there an enrollee Copayment?	Indicate Copayment amount for Additional Smoking and Tobacco Use	
C Yes	Cessation:	
C No		
Select which Supplemental Education/Health Management Programs have a Copayment (Select all that apply):	Indicate Minimum Copayment amount for Membership in Health Club/Fitness Classes:	
Programs have a Copayment (Select all that apply):		
Nutritional Benefit	Indiana Marinez Communitaria da Manhardia in Uralli, Child Chara	
Additional Smoking and Tobacco Use Cessation	Indicate Maximum Copayment amount for Membership in Health Club/Fitness Classes:	
Membership in Health Club/Fitness classes Nursing Hotline		
	Indicate Copayment amount for Nursing Hotline:	

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segm	ient 000
File Help	
<pre>&lt;<previous next="">&gt; Exit (Validate) Exit (No Validate) Go To: #14c S</previous></pre>	Supplemental Education/Health Management Programs - Base 5
Enrollee must receive Authorization from one or more of the following:	Supplemental Education/Health Management Programs Notes
Primary Care Physician (Internist/Family Practice, General Practice)     Physician Specialist	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
Organization Medical Director/Utilization Management/Utilization Review     Other, describe	Notes (Optional):
Is a referral required for Supplemental Education/Health Management Programs?	<u>×</u>
C Yes C No	
	×

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-14, Contract X0001, Plan 001,	Segment 000	_ 8
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To:</previous>	#14d - Kidney Disease Education Services Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category.	You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Is there an enrollee Coinsurance?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	O No	
O Yes O No	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:		
C Every three years C Every two years C Every year C Every six months C Every three months C Other. Describe		

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

Fu Associates, Ltd.

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PBP Data Entry System - Section B-14, Contract X0001,	Plan 001, Segment 000	
File Help	Go To: #14d - Kidney Disease Education Services Base 2	1
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 there an enrollee Copayment?	Is a referral required for Kidney Disease Education Services?	
C Yes C No	C Yes C No	
Indicate Minimum Copayment amount for Medicare-covered Benefits:		

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 162 of 215

	ry System - Section B-	14, Contract X0001,	, Plan 001,	Segment 000					_ 8
File Help < <previous ne<="" th=""><th>ext&gt;&gt; Exit (Validate)</th><th>E.S. 01-32-64-53-1</th><th>с т</th><th></th><th></th><th></th><th></th><th></th><th></th></previous>	ext>> Exit (Validate)	E.S. 01-32-64-53-1	с т						
	ext>> Exit (Validate) Ication Services Notes	Exit (No Validate)	60 10:	#14d - Kidney Dise	ase Education Service	es Base 3	•		
Note may include ac	dditional information to des	cribe benefit in this serv	vice category	. Do not repeat infor	mation captured in dat	ta entry.			
Notes (Optional):									
							<u> </u>		
							-		

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 163 of 215

🔜 PBP Data Entry System - Section B-14, Contract X0001, Plan 001	, Segment 000	<u>_ 8 ×</u>
File Help		
	#14e Diabetes Self-Management Training - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance? O Yes	
Enhanced Benefits are not applicable for this Service Category.	© No	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
C No	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Is there an enrollee Deductible?	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	C Yes C No	
Every three years     Every two years     Every year     Every year     Every six months     Every three months     Other, Describe	Indicate Deductible Amount:	
		1

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

Fu Associates, Ltd.

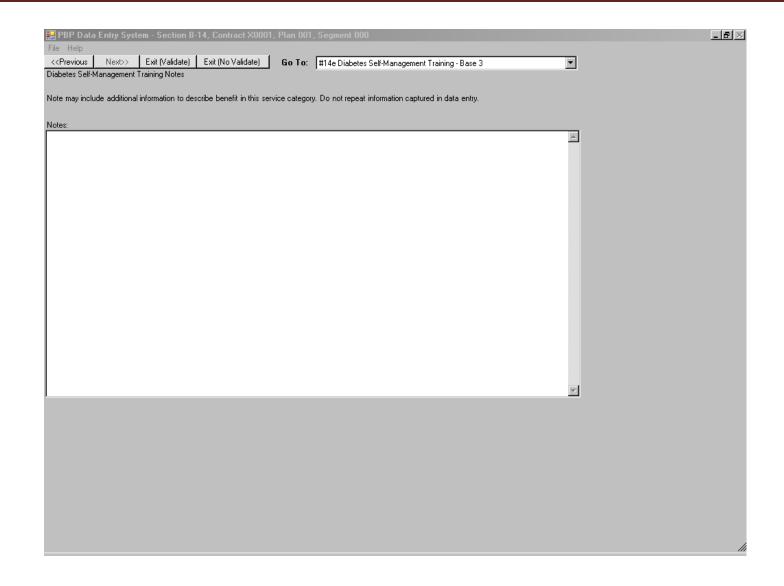
CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 164 of 215

File       Help         <       Kexto>       Exit (Validate)       Exit (No Validate)       Go To:       #114e Diabetes Self-Management Training - Base 2         Is there an enrollee Copayment?       Is there an enrollee Copayment for a separate physician/professional service?       Yes         No       Indicate Minimum Copayment amount for Medicare-covered Benefit:       Indicate Minimum Copayment amount for Medicare-covered Benefit:       Indicate Minimum Copayment amount for Medicare-covered Benefit:         Indicate Maximum       Expanse       Enrollee must receive Authorization from one or more of the following:         Indicate whether a separate physician/professional service cost share apples:       Enrollee must receive Authorization from one or more of the following:         Sometimes, describe       Primary Care Physician (Internist/Family Practice, General Practice)         Physician Specialist       Organization Medical Director/Utilization Management Training?         Yes       No         Indicate Minimum Coinsurance for a separate physician/professional service:       Self-Management Training?         Yes       No         Indicate Minimum Coinsurance procentage for a separate physician/professional service:       Self-Management Training?         Yes       No         Indicate Minimum Coinsurance percentage for a separate physician/professional service:       Yes         No       No
Is there an enrollee Copayment?  Is there an enrollee Copayment?  Yes No Indicate Minimum Copayment amount for Medicare-covered Benefits: Indicate Maximum Copayment amount for A separate physician/professional service: Indicate Maximum Copayment amount for Medicare-covered Benefits: Indicate Maximum Copayment amount for a separate physician/professional service: Indicate Maximum Copayment amount for a separate physician/professional service: Indicate Maximum Copayment amount for a separate physician/professional service: Indicate Minimum Consurance for a separate physician/professional service: Is a referral required for Diabetes Self-Management Training? Yes No Indicate Minimum Consurance percentage for a separate physician/professional service: Indicate Minimum Consurance percentage for a separate physician/professional service: Indicate Minimum Consurance percentage for a separate physician/professional service: Indicate Minimum Consurance percentage for a separate physician/professional service: Indicate Minimum Consurance percentage for a separate physician/professional service: Indicate Minimum Consurance percentage for a separate physician/professional service: Indicate Minim
Yes       No         Indicate Minimum Copayment amount for Medicare-covered Benefits:       Indicate Minimum Copayment amount for a separate physician/professional service:         Indicate Maximum Copayment amount for Medicare-covered Benefits:       Indicate Maximum Copayment amount for a separate physician/professional service:         Indicate Maximum Copayment amount for Medicare-covered Benefits:       Indicate Maximum Copayment amount for a separate physician/professional service:         Indicate Maximum Copayment amount for Medicare-covered Benefits:       Enrollee must receive Authorization from one or more of the following:         Indicate whether a separate physician/professional service cost share applies:       Enrollee must receive Authorization from one or more of the following:         Sometimes, describe       Primary Care Physician (Internist/Family Practice, General Practice)         No       Physician Specialist         Is there an enrollee Coinsurance for a separate physician/professional service?       Is a referral required for Diabetes Self-Management Training?         No       No         Indicate Minimum Coinsurance percentage for a separate physician/professional service:       No
No         Indicate Minimum Copayment amount for Medicare-covered Benefits:         Indicate Maximum Copayment amount for Medicare-covered Benefits:         Indicate Maximum Copayment amount for Medicare-covered Benefits:         Indicate Maximum Copayment amount for 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:         Struct         Is there an enrollee Coinsurance for a separate physician/professional service:         Indicate Minimum Coinsurance percentage for a separate physician/professional service:         Indicate Minimum Coinsurance percentage for a separate physician/professional service:
Indicate Minimum Copayment amount for Medicare-covered Benefits:       Indicate Minimum Copayment amount for a separate physician/professional service:         Indicate Maximum Copayment amount for Medicare-covered Benefits:       Indicate Maximum Copayment amount for a separate physician/professional service:         Indicate whether a separate physician/professional service cost share applies:       Enrollee must receive Authorization from one or more of the following:         None       Primary Care Physician (Internist/Family Practice, General Practice)         No       Prinsician Specialist         Is there an enrollee Coinsurance for a separate physician/professional service:       Is a referral required for Diabetes Self-Management Training?         No       No         Indicate Minimum Coinsurance percentage for a separate       No         Indicate Minimum Coinsurance percentage for a separate       No         No       No
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? Is there an enrollee Coinsurance for a separate physician/professional service? Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/professional service: Indicate Minimum Coinsurance percentage for a separate physician/p
applies:       None         Sometimes, describe       Primary Care Physician (Internist/Family Practice, General Practice)         No       Physician Specialist         Is there an enrollee Coinsurance for a separate physician/professional service?       Organization Medical Director/Utilization Management/Utilization Review         Yes       Is a referral required for Diabetes Self-Management Training?         Yes       No         Indicate Minimum Coinsurance percentage for a separate physician/professional service:       No
Solideatives, describe       Physician Specialist         No       Organization Medical Director/Utilization Management/Utilization Review         Is there an enrollee Coinsurance for a separate physician/professional service?       Other, describe         Yes       Is a referral required for Diabetes Self-Management Training?         No       Yes         Indicate Minimum Coinsurance percentage for a separate physician/professional service:       No
Is there an enrollee Coinsurance for a separate physician/professional service?       Organization Medical Director/Utilization Management/Utilization Review         O Yes       Other, describe         Indicate Minimum Coinsurance percentage for a separate physician/professional service:       Is a referral required for Diabetes Self-Management Training?         O Yes       No
Is there an enrollee Coinsurance for a separate physician/professional service?   Yes No Indicate Minimum Coinsurance percentage for a separate physician/professional service:  No
O No     O Yes       Indicate Minimum Coinsurance percentage for a separate physician/professional service:     O Yes
Indicate Minimum Coinsurance percentage for a separate physician/professional service:
physician/professional service:
Indicate Maximum Coinsurance percentage for a separate physician/professional service:

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

Fu Associates, Ltd.

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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-15, Contract X0001	, Plan 001, Segment 000		_ <del>8</del> ×
File Help > Exit (Validate) Exit (No Validate)	Go To: #15 Medicare Part B Rx Drugs - Base 1	•	
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?		
CEICK FOR DESCRIPTION OF BENEFIT	O Yes		
Is there a Maximum Enrollee Out-of-Pocket Cost?	O No		
C Yes C No	Select which Medicare Part B Rx Drugs have a Coinsurance (Select all that apply):		
U NO	Medicare Part B Chemotherapy Drugs		
	Other Medicare Part B Drugs		
Indicate Maximum Enrollee Out-of-Pocket Cost Amount:	Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:		
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate the Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:		
C Every three years C Every two years			
C Every year	Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:		
C Every six months C Every three months			
C Every month C Other, Describe	Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:		
			///

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

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🔡 PBP Data Entry System - Section B-15, Contract X0001	I, Plan 001, Segment 000	_ 8 ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #15 Medicare Part B Rx Drugs - Base 2	
Is there an enrollee Deductible?	Indiasta Minimum Consument Amount for	
C Yes	Indicate Minimum Copayment Amount for other Medicare Part B Drugs:	
C No		
Indicate Deductible Amount:		
	Indicate Maximum Copayment Amount for other Medicare Part B Drugs:	
Is there an enrollee Copayment?		
C Yes	Is Authorization Required?	
O No	O Yes	
Select which Medicare Part B Rx Drugs have a Copayment	C No	
(Select all that apply):		
Medicare Part B Chemotherapy Drugs		
Contract Con		
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy Drugs:		
Indicate Maximum Copayment Amount for		
Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy Drugs:		

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

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🔜 PBP Data Entry System - Section B-15, Contract X0001, Plan 001, Segment 000		_ 8 >
File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)         Go To: #15 Medicare Part B Rx Drugs - Notes (Optional)</previous<>	v	
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
Notes (Optional):		
	<u>~</u>	
	<b>T</b>	
,		

Section B – 15 – Home Infusion Bundled Services Screen

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 169 of 215

🔜 PBP Data Entry System - Section B-15, Contract X0001, Plan 00	1. Compart 000	_ 8 ×
File Help	r, segment 000	
	#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?	Does the plan pay for Part D drug home infusion services and supplies as a Medicaid benefit?	
O Yes	C Yes	
O No	C 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.	i	

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 170 of 215

🔛 PBP Data Entry System - Section B-16, Cor	ntract X0001, Plan 001, Segment 000		
File Help			
· · · · ·	o Validate) Go To: #16a Preventive Dental - E		
CLICK FOR DESCRIPTION OF BENEFIT	Select the Oral Exams periodicity:	Select type of benefit for Fluoride Treatment:	1
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C? C Yes C No	C Every three years Every two years Every year Every six months Every three months C Other, Describe	Mandatory     Dptional  Is this benefit unlimited for Fluoride Treatment?      Yes     No, indicate number	]
Select enhanced benefits:	Select type of benefit for Prophylaxis (Cleaning):		
<ul> <li>Gran Exams</li> <li>Prophylaxis (Cleaning)</li> <li>Fluoride Treatment</li> <li>Dental X-Rays</li> </ul>	C Mandatory O Dptional	Indicate number of visits for Fluoride Treatment:	
	Is this benefit unlimited for Prophylaxis (Cleaning)?	Select the Fluoride Treatment periodicity:	
Select type of benefit for Oral Exams: Mandatory Optional	C Yes C No, indicate number	C Every three years     Every two years     Every year	
Is this benefit unlimited for Oral Exams?	Indicate number of visits for Prophylaxis (Cleaning):	C Every six months C Every three months C Other, Describe	
O No, indicate number	Select the Prophylaxis (Cleaning) periodicity:	7	
Indicate number of visits for Oral Exams:	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe		
			1

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-16, Co	ntract X0001, Plan 001, Segment 000	_ B ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (N</previous>	o Validate) Go To: #16a Preventive Dental - Base 2	
Select type of benefit for Dental X-Rays:	Is there a service-specific Maximum Plan Benefit Coverage amount?	
C Mandatory	O Yes	
C Optional	O No	
Is this benefit unlimited for Dental X-Rays?	Does the Maximum Plan Renafit Coverage amount apply to In-	
C Yes	Does the Maximum Plan Benefit Coverage amount apply to In- network services only OR does it apply to both In-network and Out- of-network services?	
C No, indicate number		
Indicate number of visits for Dental X-Rays:	In-network services only     Both In-network and Out-of-network services	
	Indicate Maximum Plan Benefit Coverage amount:	
Select the Dental X-Rays periodicity:		
C Every three years	Select the Maximum Plan Benefit Coverage periodicity:	
C Every two years C Every year	© Every three years	
C Every six months	C Every two years	
C Every three months	O Every year	
O Other, Describe	Every six months     Every three months	
	🔿 Other, Describe	
		li.

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

Fu Associates, Ltd.

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PBP Data Entry System - Section B-16, Contract X0001 File Help	, Plan 001, Segment 000		. 8 ×
<pre></pre> <pre></pre> <pre></pre> <pre></pre> <pre>// Comparison of the second secon</pre>	Go To: #16a Preventive Dental - Base 3		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? © Yes © No	Is there a combination of services included in a single cost per Office Visit?	Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	<ul> <li>No</li> <li>Select which combination of services are included in a single cost per Office Visit:</li> <li>Oral Exams</li> </ul>	Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  C Every three years C Every two years C Every year C Every six months	<ul> <li>Prophylaxis (Cleaning)</li> <li>Fluoride Treatment</li> <li>Dental X-Rays</li> </ul>	Indicate Minimum Coinsurance percentage for Fluoride Treatment:	
C Every three months C Other, Describe	Indicate Coinsurance percentage for Office Visit:	Indicate Maximum Coinsurance percentage for Fluoride Treatment:	
Is there an enrollee Coinsurance? C Yes C No	Indicate Minimum Coinsurance percentage for Oral Exams:	Indicate Minimum Coinsurance percentage for Dental X-Rays:	
Select which Preventive Dental Services have a Coinsurance (Select all that apply):	Indicate Maximum Coinsurance percentage for Oral Exams:	Indicate Maximum Coinsurance percentage for Dental X-Rays:	
			//

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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-16, Contract X0001	1, Plan 001, Segment 000	_ B ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #16a Preventive Dental - Base 4	
Is there an enrollee Deductible?	Indicate Copayment amount for Office Visit:	
O Yes O No		
O NO		
Indicate Deductible Amount:	Indicate Minimum Copayment amount for Oral Exams:	
	Indicate Maximum Copayment amount for Oral Exams:	
Is there an enrollee Copayment?		
O Yes	Indicate Minimum Copayment amount for Prophylaxis (Cleaning):	
C No		
Select which Preventive Dental Services have a Copayment (Select all that apply):	, Indicate Maximum Copayment amount for Prophylaxis (Cleaning):	
Oral Exams		
Prophylaxis (Cleaning)		
Fluoride Treatment     Provide Reserved	Indicate Minimum Copayment amount for Fluoride Treatment:	
Dental X-Rays		
Is there a combination of services included in a single cost per Office Visit?	Indicate Maximum Copayment amount for Fluoride Treatment:	
C Yes		
O No	Indicate Minimum Copayment amount for Dental X-Rays:	
Select which combination of services are included in a single		
cost per Office Visit:	Indicate Maximum Copayment amount for Dental X-Rays:	
Cral Exams		
Prophylaxis (Cleaning)     Fluoride Treatment		
Dental X-Rays		

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 174 of 215

🔐 PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000	_ B ×
File       Help         < <previous< td="">       Next&gt;&gt;       Exit (Validate)       Exit (No Validate)       Go To:       #16a Preventive Dental - Base 5</previous<>	
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
Notes (Optional):	
	1

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

Fu Associates, Ltd.

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🔡 PBP Data Entry System - Section B-16, Contract X0001,	Plan 001, Segment 000		_ 8 ]
File Help <pre>&lt;<previous next="">&gt; Exit (Validate) Exit (No Validate)</previous></pre>	Go To: #16b Comprehensive Dental - Base	1	
CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Non-routine Services:	Select type of benefit for Diagnostic Services:	
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	<ul> <li>Mandatory</li> <li>Optional</li> </ul>	<ul> <li>Mandatory</li> <li>Optional</li> </ul>	
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Is this benefit unlimited for Non-routine Services?	Is this benefit unlimited for Diagnostic Services?	
C Yes C No	C Yes C No, indicate number	<ul> <li>Yes</li> <li>No, indicate number</li> </ul>	
Select enhanced benefits: Non-routine Services Diagnostic Services Restorative Services	Indicate number of visits for Non-routine Services:	Indicate number of visits for Diagnostic Services:	
<ul> <li>Endodontics/Periodontics/Extractions</li> <li>Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services</li> </ul>	Select the Non-routine Services periodicity:	Select the Diagnostic Services periodicity:	
	C Every three years Every two years Every year Every year Every six months	Every three years     Every two years     Every year     Every year     Every six months	
	C Every three months C Other, Describe	C Every three months C Other, Describe	
			,

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

Fu Associates, Ltd.

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File Help			
< <previous next="">&gt; Exit (Validate) Exit</previous>	t (No Validate) <b>Go To:</b> #16b Comprehensive D	Dental - Base 2	
Select type of benefit for Restorative Services:	Select type of benefit for Endodontics/Periodontics/Extractions:	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
O Optional	C Mandatory C Optional	O Mandatory O Optional	]
s this benefit unlimited for Restorative Services?	Is this benefit unlimited for Endodontics/Periodontics/Extractions?	ls this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	
No, indicate number Indicate number of visits for Restorative	C Yes C No, indicate number	O Yes O No, indicate number	]
Services:	Indicate number of visits for Endodontics/Peridontics/Extractions:	Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Select the Restorative Services periodicity:  Every three years Every two years Every six months Every three months Other, Describe	Select the Endodontics/Periodontics/Extractions periodicity: Every three years Every two years Every year Every six months Every three months Dther, Describe	Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity: © Every two years © Every year © Every six months © Every three months © Other, Describe	

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 177 of 215

👪 PBP Data Entry System - Section B-16, Contract X0001, Plan 001.	l, Segment 000	_ 8 ×
File Help		
	#16b Comprehensive Dental - Base 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
C Yes C No	C Yes C No	
Select the Maximum Plan Benefit Coverage type:	Select the Maximum Enrollee Out-of-Pocket Cost type:	
C Covered under Preventive Dental Category 16a C Plan-specified amount per period	C Covered under Preventive Dental Category 16a C Plan-specified amount per period	
Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
C In-network services only	C Every three years	
C Both In-network and Out-of-network services	O Every two years	
Indicate Maximum Plan Benefit Coverage amount:	C Every year C Every six months	
	C Every six months	
	O Other, Describe	
Select the Maximum Plan Benefit Coverage periodicity:		
C Every three years C Every two years C Every year		
C Every six months C Every three months C Other, Describe		
		///

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

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	C 1000	
BPBP Data Entry System - Section B-16, Contract X0001, Plan 001	, Segment UUU	_ 8 >
File Help		
	#16b Comprehensive Dental - Base 4	<b>•</b>
Is there an enrollee Coinsurance?	Indicate Minimum Coinsurance percentage for Restorative Services:	
C Yes		
O No		
Select which Comprehensive Dental Services have a Coinsurance (Select all	Indicate Maximum Coinsurance percentage for Restorative Services:	
that apply):		
Medicare-covered Benefits     Non-routine Services	Indicate Minimum Coinsurance percentage for	
Diagnostic Services	Endodontics/Periodontics/Extractions:	
Restorative Services		
Endodontics/Periodontics/Extractions		
🔲 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	Indicate Maximum Coinsurance percentage for	
Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	Endodontics/Periodontics/Extractions:	
Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:		
Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Minimum Coinsurance percentage for Non-routine Services:		
	Indicate Maximum Coinsurance percentage for Prosthodontics, Other	
	Oral/Maxillofacial Surgery, Other Services:	
Indicate Maximum Coinsurance percentage for Non-routine Services:		
	Is there an enrollee Deductible?	
Indicate Minimum Coinsurance percentage for Diagnostic Services:	C Yes	
	C No	
Indicate Maximum Coinsurance percentage for Diagnostic Services:	Indicate Deductible Amount:	
		· · · · · · · · · · · · · · · · · · ·

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 179 of 215

🔡 PBP Data Entry System - Section B-16, Contra	ct X0001, Plan 001, Segment 000	_ 8 ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Va</previous>	alidate) Go To: #16b Comprehensive Dental - Base 5	
Is there an enrollee Copayment? C Yes C No	Indicate Maximum Copayment amount for Diagnostic Services:	
Select which Comprehensive Dental Services have a Copayment (Select all that apply): Medicare-covered Benefits Non-routine Services Diagnostic Services	Indicate Minimum Copayment amount for Restorative Services:	
Restorative Services     Endodontics/Periodontics/Extractions     Prosthodontics, Other Oral/Maxillofacial     Surgery, Other Services	Indicate Maximum Copayment amount for Restorative Services:	
Indicate Minimum Copayment amount for Medicare- covered Benefits:	Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions:	
Indicate Maximum Copayment amount for Medicare- covered Benefits:	Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions:	
Indicate Minimum Copayment amount for Non-routine Services:	Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Maximum Copayment amount for Non-routine Services:	Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Minimum Copayment amount for Diagnostic Services:		

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-16, Co	ontract X0001, Plan 001,	Segment 000		
File Help < <pre>&gt; Exit (Validate) Exit (</pre>	No Validate) Go To:			
Enrollee must receive Authorization from one or more None Primary Care Physician (Internist/Family Practice, Physician Specialist Organization Medical Director/Utilization Manage	e of the following: , General Practice)	#16b Comprehensive Dental - Base 6	×	
Cther, describe				
Is a referral required for Comprehensive Dental Servic	ces?			
C Yes C No				
Note may include additional information to describe t	penefit in this service category	. Do not repeat information captured in data entru		
	benefic in this service category	. Do nocrepeat information captured in data entry		
Notes (Optional):			A	
			<b>Y</b>	

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

Fu Associates, Ltd.

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💀 PBP Data Entry System - Section B-17, Contr File Help	act X0001, Plan 001, Segment 000		_ 8
< <previous next="">&gt; Exit (Validate) Exit (No V</previous>	/alidate) Go To: #17a Eye Exams - Base 1		
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of- Pocket Cost?	
Does the plan provide Eye Exams as a supplemental benefit under Part C?	C Yes C No	C Yes C No	
O Yes O No	Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select enhanced benefit: Routine Eye Exams	C In-network services only		
Select type of benefit for Routine Eye Exams:	C Both In-network and Out-of-network services	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Mandatory C Optional	Indicate Maximum Plan Benefit Coverage amount:	C Every three years C Every two years	
Is this benefit unlimited for Routine Eye Exams?		C Every year C Every six months	
C Yes	Select the Maximum Plan Benefit Coverage periodicity:	C Every three months	
O No, indicate number	C Every three years C Every two years	C Other, Describe	
Indicate number of exams for Routine Eye Exams:	O Every year		
	C Every six months C Every three months		
Select the Routine Eye Exams periodicity:	O Other, Describe		
C Every three years C Every two years			
C Every year			
C Every six months C Every three months			
C Other, Describe			

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

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🔛 PBP Data Entry System - Section B-17, Contract X0001,	Plan 001, Segment 000	_ B ×
File Help > Exit (Validate) Exit (No Validate)	Go To: #17a Eye Exams - Base 2	<b></b>
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
O Yes O No	O Yes O No	
Select which Eye Exams have a Coinsurance (Select all that apply) <ul> <li>Medicare-covered Benefits</li> <li>Routine Eye Exams</li> </ul>	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?		
C Yes C No		
Indicate Deductible Amount:		

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

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CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 183 of 215

🖁 PBP Data Entry System - Section B-17, Contract X0001, Plan 00	1, Segment 000	_
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go To:</previous>	#17a Eye Exams - Base 3	▼
ndicate whether a separate physician/professional service cost share applies:	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
O Sometimes, describe	Notes (Optional):	
O No		
ls there an enrollee Coinsurance for a separate physician/professional service?		
O Yes		
O No		
Indicate Minimum Coinsurance percentage for a separate physician/professional service:		
I Indicate Maximum Coinsurance percentage for a separate physician/professional service:		
s there an enrollee Copayment for a separate physician/professional		
is there an enrollee Copayment for a separate physician/professional service?		
O Yes		
O No		
Indicate Minimum Copayment amount for a separate physician/professional		
service:		
Indicate Maximum Copayment amount for a separate physician/professional service:		
		<b>v</b>

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

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🔛 PBP Data Entry System - Section B-17, Contr	ract X0001, Plan 001, Segment 000		_ 8
File Help <pre></pre> <pre></pre> <pre></pre> <pre></pre> <pre></pre> <pre>File Help <pre></pre> <pre></pre> <pre>Exit (Validate)</pre> <pre>Exit (No<sup>1</sup>)</pre> </pre>	Validate) Go To: #17b Eye Wear - Base 1	<b>T</b>	
CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Contact Lenses:	Select type of benefit for Eye Glasses (Lenses and Frames):	
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	C Mandatory C Optional	C Mandatory C Optional	
Does the plan provide Eye Wear as a supplemental benefit under Part C?	Is this benefit unlimited for Contact Lenses?	Is this benefit unlimited for Eye Glasses (Lenses and Frames)?	
C Yes C No Select enhanced benefits:	Indicate quantity (number of pairs) for Contact Lenses:	No, indicate number Indicate quantity for Eye Glasses (Lenses and Frames):	
<ul> <li>Eye Glasses (Lenses and Frames)</li> <li>Eye Glass Lenses</li> <li>Eye Glass Frames</li> </ul>	Select Contact Lenses periodicity:	Select Eye Glasses (Lenses and Frames) periodicity:	
Upgrades	C Every three years C Every two years C Every year C Every six months	Every three years     Every two years     Every year     Every year     Every six months	
	C Every three months C Other, Describe	C Every three months C Other, Describe	

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

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-17, Contract X	0001, Plan 001, Segment 000
File Help	
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	
Select type of benefit for Eye Glass Lenses:	Select type of benefit for Eye Glass Frames:
C Mandatory C Optional	C Mandatory C Optional
Is this benefit unlimited for Eye Glass Lenses?	Is this benefit unlimited for Eye Glass Frames?
C Yes C No, indicate number	C Yes C No, indicate number
Indicate quantity (number of pairs) for Eye Glass Lenses:	Indicate quantity for Eye Glass Frames:
Select Eye Glass Lenses periodicity:	Select Eye Glass Frames periodicity:
C Every three years C Every two years	C Every three years C Every two years
O Every year	C Every wear
O Every six months	C Every six months
C Every three months C Other, Describe	C Every three months C Other, Describe
	Select type of benefit for Upgrades:
	O Mandatory
	C Optional

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

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 187 of 215

🔛 PBP Data Entry System - Section B-17, Contract X0001,	, Plan 001, Segment 000	_ B ×
File Help <pre>&lt;<previous next="">&gt; Exit (Validate) Exit (No Validate)</previous></pre>	Go To: #17b Eye Wear · Base 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No	Indicate Coinsurance percentage for Medicare-covered Benefits:	
Select the Maximum Enrollee Out-of-Pocket Cost type:	Indicate Coinsurance percentage for Contact Lenses:	
C Covered under Eye Exams Category 17a     Plan-specified amount per period	Indicate Coinsurance percentage for Eye Glasses (Lenses and Frames):	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Coinsurance percentage for Eye Glass Lenses:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years	Indicate Coinsurance percentage for Eye Glass Frames:	
C Every year C Every six months C Every three months C Other, Describe	Indicate Coinsurance percentage for Upgrades:	
Is there an enrollee Coinsurance?		
C Yes C 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		

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

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🔛 PBP Data Entry System - Section B-17, Contract X0001,	, Plan 001, Segment 000	
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #17b Eye Wear - Base 5	
Is there an enrollee Deductible?	Indicate Copayment amount for Eye Glasses (Lenses and Frames):	
C Yes C No		
Indicate Deductible Amount:	Indicate Copayment amount for Eye Glass Lenses:	
Is there an enrollee Copayment?	Indicate Copayment amount for Eye Glass Frames:	
O Yes		
O No	la fa la Commentaria et la Universita	
Select which Eye Wear Benefits have a Copayment (Select all that apply):	Indicate Copayment amount for Upgrades:	
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:		
		li li

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

Fu Associates, Ltd.

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🛃 PBP Data Entry S	ystem - 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	Enic (+ dilddco)	Enix (ito Yaliado)	40 10.	THUD FAE mean - Dase o	<u> </u>	
Note may include additio	nal information to de:	scribe benefit in this serv	rice category	<ul> <li>Do not repeat information captured in data entry.</li> </ul>		
Notes (Optional):						1
					<u></u>	
					<b>Y</b>	

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

Fu Associates, Ltd.

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🚂 PBP Data Entry System - Section B-18, Contract X00	01, Plan 001, Segment 000	<u>_8×</u>
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #18a Hearing Exams - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select Routine Hearing Exams periodicity:	
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Select type of benefit for Fitting/Evaluation for Hearing Aid:	
O Yes O No	C Mandatory C Optional	
Select enhanced benefits: Routine Hearing Exams Fitting/Evaluation for Hearing Aid	Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	
Select type of benefit for Routine Hearing Exams:	C Yes C No, indicate number	
C Mandatory C Optional	Indicate number for Fitting/Evaluation for Hearing Aid:	
Is this benefit unlimited for Routine Hearing Exams?		
C Yes C No, indicate number Indicate number for Routine Hearing Exams:	Select Fitting/Evaluation for Hearing Aid periodicity: C Every three years C Every two years	
	C Every year C Every six months C Every three months C Other, Describe	
		1

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

Fu	Associates,	Ltd.
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🔜 PBP Data Entry System - Section B-18, Cor	ntract X0001, Plan 001, Segment 000		- 8 ×
File Help			
< <previous next="">&gt; Exit (Validate) Exit (N</previous>	loValidate) GoTo: #18a Hearing Exams	Base 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	
C Yes C No	C Yes C No		
Does the Maximum Plan Benefit Coverage amount apply to In-network services only DR does it apply to both In-network and Dut-of-network services?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	
C In-network services only C Both In-network and Out-of-network services	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Minimum Coinsurance percentage for	
Indicate Maximum Plan Benefit Coverage amount:	C Every three years C Every two years	Routine Hearing Exams:	
Select the Maximum Plan Benefit Coverage periodicity:	C Every year C Every six months C Every three months C Other, Describe	Indicate Maximum Coinsurance percentage for Routine Hearing Exams:	
C Every three years C Every two years C Every year	Is there an enrollee Coinsurance?	Indicate Minimum Coinsurance percentage for	
C Every six months C Every three months	C No Select which Hearing Exam Benefits have a	Fitting/Evaluation for Hearing Aid:	
C Other, Describe	Coinsurance (Select all that apply):  Medicare-covered Benefits  Routine Hearing Exams	Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:	
O Yes O No	Fitting/Evaluation for Hearing Aid		
Indicate Deductible Amount:			
			1.

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

Fu	Associates,	Ltd.
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🔡 PBP Data Entry System - Section B-18, Contract X0001	, Plan 001, Segment 000	
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #18a Hearing Exams - Base 3	
Is there an enrollee Copayment?	Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	
O Yes		
O No		
Select which Hearing Exam Benefits have a Copayment(Select all that apply): Medicare-covered Benefits	Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	
Routine Hearing Exams		
Fitting/Evaluation for Hearing Aid	Enrollee must receive Authorization from one or more of the following:	
Indicate Minimum Copayment amount for Medicare-covered	None	
Benefits:	Primary Care Physician (Internist/Family Practice, General Practice)	
	Physician Specialist     Organization Medical Director/Utilization Management/Utilization Review	
In the Marine Community of Marine and	Other, describe	
Indicate Maximum Copayment amount for Medicare-covered Benefits:		
	Is a referral required for Hearing Exams?	
	O Yes	
Indicate Minimum Copayment amount for Routine Hearing Exams:	C No	
Indicate Maximum Copayment amount for Routine Hearing Exams		

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

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BPBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000		_ 8
le Help <previous next="">&gt; Exit (Validate) Exit (No Validate) <b>Go To:</b> #18a Hearing Exams - Base 4</previous>		
aring Exams Notes	<b>X</b>	
te may include additional information to describe benefit in this service category. Do not repeat information captured in	n data entry.	
tes (Optional):		
	A	
	<b>v</b>	

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

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-18, Co File Help	ontract X0001, Plan 001, Segment 000		<u>_ 8 ×</u>
< <previous next=""  ="">&gt;   Exit (Validate)   Exit (f</previous>	No Validate) Go To: #18b Hearing A	ds - Base 1 💌	
CLICK FOR DESCRIPTION OF BENEFIT	Select Hearing Aids (all types) periodicity:	Select Hearing Aids - Inner Ear periodicity:	
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	C Every three years C Every two years	C Every three years C Every two years	
supplemental benefit under Part C? C Yes C No	C Every year C Every six months C Every three months	C Every year C Every six months C Every three months	
Select enhanced benefits:	C Other, Describe	C Other, Describe	
Felect ennanced benefits: Hearing Aids (all types) Hearing Aids - Inner Ear	Select type of benefit for Hearing Aids - Inner Ear:	Select type of benefit for Hearing Aids - Outer Ear:	
Hearing Aids - Outer Ear	C Mandatory	C Optional	
Hearing Aids - Over the Ear Select type of benefit for Hearing Aids (all types):	C Optional	Is this benefit unlimited for Hearing Aids - Outer Ear?	
C Mandatory	Is this benefit unlimited for Hearing Aids - Inner Ear?	C Yes C No, indicate number	
O Optional	O Yes O No, indicate number	Indicate quantity for Hearing Aids - Outer Ear:	
Is this benefit unlimited for Hearing Aids (all types)?	Indicate quantity for Hearing Aids - Inner Ear:		
O Yes O No, indicate number		Select Hearing Aids - Outer Ear periodicity:	
Indicate quantity for Hearing Aids (all types):	J	O Every two years	
Indicate quantity for Hearing Alds (all types):		C Every year C Every six months	
		C Every three months	
		C Other, Describe	

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

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PBP Data Entry System - Section B-18, Contract           File         Help           < <previous< td="">         Next&gt;           Exit (Validate)         Exit (No Validate)</previous<>		
Select type of benefit for Hearing Aids - Over the Ear:	Select the Maximum Plan Benefit Coverage type:	
C Mandatory C Optional	C Covered under Hearing Exams Category - 18a C Plan-specified amount per period	
Is this benefit unlimited for Hearing Aids - Over the Ear? C Yes C No, indicate number	Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?	
Indicate quantity for Hearing Aids - Over the Ear:	C In-network services only C Both In-network and Out-of-network services	
	Indicate Maximum Plan Benefit Coverage amount:	
Select Hearing Aids - Over the Ear periodicity:	Indicate Maximum Plan Benefit Coverage periodicity:	
C Every two years Every year Every six months Every three months O Other, Describe	Every three years     Every two years     Every year     Every year     Every six months     Every three months     Other, Describe	
amount? O Yes O No		
		//

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

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🔜 PBP Data Entry System - Section B-18, Contract X File Help	0001, Plan 001, Segment 000	×
<pre></pre> <pre></pre> <pre></pre> <pre></pre> <pre>// Pie Heip </pre> <pre></pre> <pre>// Comparison of the test of test of</pre>	e) Go To: #18b Hearing Aids - Base 3	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Coinsurance percentage for Hearing Aids (all types):	
No     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: C Every three years C Every year C Every year C Every six months C Every three months C Other, Describe	Indicate Coinsurance percentage for Hearing Aids - Over the Ear:	
Is there an enrollee Coinsurance?		
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		
		<i>h</i>

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

Fu Associates, Ltd.

CY 2014 PBP – Section B 12/6/2012 CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING Page 197 of 215

🖶 PBP Data Entry System - Section B-18, Contract X0001,	, Plan 001, Segment 000	×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #18b Hearing Aids - Base 4	
Is there an enrollee Copayment?	Indicate Copayment amount per Hearing Aid - Outer Ear:	
Select which Hearing Aids Benefits have a Copayment (Select all that apply):	Indicate Copayment amount per two Hearing Aids - Outer Ear:	
🗖 Hearing Aid - Inner Ear		
Hearing Aid - Outer Ear		
Hearing Aids - Over the Ear	Indicate Copayment amount per Hearing Aid - Over the Ear:	
Indicate Minimum Copayment amount per Hearing Aid (all types):		
	Indicate Copayment amount per two Hearing Aids - Over the Ear:	
Indicate Maximum Copayment amount per Hearing Aid (all types):		
The second secon	Is there an enrollee Deductible?	
	C Yes	
Indicate Copayment amount per Hearing Aid - Inner Ear:	C No	
	Indicate Deductible Amount:	
Indicate Copayment amount per two Hearing Aids - Inner Ear:		
		///

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

Fu Associates, Ltd.

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🖁 PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000		_ 8 ×
File Help > Exit (Validate) Exit (No Validate) Go To: #18b Hearing Aids - Base 5	<b>_</b>	
nrollee 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		
s a referral required for Hearing Aids?		
C Yes C No		
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		
Notes (Optional):		
	<u> </u>	
	<b>T</b>	

Section B – 20 – Outpatient Drugs – Base 1 Screen

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📴 PBP Data Entry System - Section B-20, Co	ontract X0001, Plan 001, Segment 00(		_ 8 ×
File Help			
< <previous next="">&gt; Exit (Validate) Exit (</previous>	No Validate) Go To: #20 Outpatien	t Drugs - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a Maximum Plan Benefit Coverage amount for drugs?	Indicate Max Plan Benefit Coverage amount annually for drugs:	
Does the plan provide Outpatient Drugs as a supplemental benefit under Part C?	O Yes O No	Indicate Max Plan Benefit Coverage amount semi-annually for	
C Yes C No	Indicate type of Maximum Plan Benefit Coverage:	drugs:	
Select type of benefit:	<ul> <li>All drug groups covered by plan</li> <li>Combination of drug groups</li> </ul>	Indicate Max Plan Benefit Coverage amount quarterly for drugs:	
Mandatory     Optional	Individual drug groups		
Indicate the number of drug groupings that are offered:	Is the Maximum Plan Benefit Coverage net of the enrollee copay?	Indicate Max Plan Benefit Coverage amount monthly for drugs:	
	C Yes C No	Indicate Max Plan Benefit Coverage amount for Other for drugs:	
O 3 O 4	Indicate Maximum Plan Benefit Coverage periodicity for drugs:		
0 5	Annually Semi-annually		
	C Quarterly		
	Monthly Other, describe		

Section B – 20 – Outpatient Drugs – Base 2 Screen

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歸 PBP Data Entry System - Section B-20, Contract X0001, Plan 001,	, Segment 000	8 ×
File Help		
	#20 Outpatient Drugs - Base 2	
Can any unused amounts be carried forward to the next period within the contract period?	Indicate Max Plan Benefit Coverage amount annually for combination of drug groups:	
C Yes		
O No		
Select what combination of drug groups are included in the Maximum Plan	Indicate Max Plan Benefit Coverage amount semi-annually for combination of drug groups:	
Benefit:		
Group 2		
Group 3	Indicate Max Plan Benefit Coverage amount quarterly for combination of	
🗖 Group 4	drug groups:	
🗖 Group 5		
Indicate Maximum Plan Benefit Coverage periodicity for combination of drug	Indicate Max Plan Benefit Coverage amount monthly for combination of	
groups:	drug groups:	
Annually     Semi-annually		
Monthly	Indicate Max Plan Benefit Coverage amount for Other for combination of drug groups:	
🗖 Other, describe		
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Section B – 20 – Outpatient Drugs – Base 3 Screen

Fu Associates, Ltd.

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🔜 PBP Data Entry System - Section B-20, Contract X0001, Plan (	001, Segment 000	_ B ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate) Go T</previous>	o: #20 Outpatient Drugs - Base 3	•
Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
O Yes		
O No	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived: Group 1 Group 2	C Every year C Every six months C Every three months	
Group 3	Is there an enrollee Coinsurance for Medicare-covered Benefits?	
Group 4	O Yes	
🗖 Group 5	C No	
Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available?	Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply): Medicare Part B Chemotherapy Drugs	_
O Yes	Conter Medicare Part B Drugs	
O No	Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:	
Is there a Maximum Enrollee Out-of-Pocket Cost?		
O Yes		
C No Select what combination of drug groups applies for Maximum Enrollee	Indicate Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:	
Out-of-Pocket Cost:		
Group 1	la facto Minimum China anno 1997 (norther Martines Devic	
Group 2	Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	
Group 3 Group 4		
Group 5		
Medicare Covered Benefits	Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:	
		//

Section B – 20 – Outpatient Drugs – Base 4 Screen

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🔡 PBP Data Entry System - Section B-20, Contract X0001,	Plan 00	1, Segment 000
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To:	#20 Outpatient Drugs - Base 4
Is there an enrollee Deductible?		Indicate Minimum Copayment amount for Medicare Part B Chemotherapy Drugs:
C No		
Select what combination of drug groups applies for Deductible: Group 1 Group 2 Group 3 Group 4		Indicate Maximum Copayment amount for Medicare Part B Chemotherapy Drugs:
Group 5     Medicare Covered Benefits		Indicate Minimum Copayment for other Medicare Part B Drugs:
Indicate Deductible amount:		Indicate Maximum Copayment for other Medicare Part B Drugs:
Is there an enrollee Copayment for Medicare-covered Benefits?		Enrollee must receive Authorization for drugs from one or more of the
C Yes C No		following:
Select which Medicare-covered Outpatient Drugs have a Copaymen		🗖 None 🗖 Primary Care Physician (Internist/Family Practice, General Practice)
(Select all that apply):		Physician Specialist/Dentist
Medicare Part B Chemotherapy Drugs     Other Medicare Part B Drugs	J	Grganization Medical Director/Utilization Management/Utilization     Review
	J	C Other, describe

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

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	ystem - Section B·	20, Contract X0001	, Plan 001, Se	egment 000				
ile Help < <previous next="">&gt;</previous>	Exit (Validate)	Exit (No Validate)	C . T		N			
utpatient Drugs Notes	> Exit (Validate)	Exit (No Validate)	<b>GOTO:</b> [#2	20 Outpatient Drugs	<ul> <li>Notes (Uptional)</li> </ul>		•	
te may include additio	nal information to des	cribe benefit in this ser	vice category. D	o not repeat informa	tion captured in data	entry.		
es (Optional):								
							<u>^</u>	
							~	

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

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📴 PBP Data Entry System - Section B-20, Contract X0001.	, Plan 001, Segment 000	_ <b>8</b> ×
File Help		
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #20 Outpatient Drugs - Group 1 - Base 1	
Select a label for Group 1:	Indicate Maximum Plan Benefit Coverage annual amount for Group 1:	
Select the drug type(s) covered for Group 1: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:	
Is there a Maximum Plan Benefit Coverage amount for Group 1?	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:	
C Yes C No	Indicate Maximum Plan Benefit Coverage monthly amount for	
Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:	Group 1:	
☐ Semi-annually ☐ Quarterly ☐ Monthly	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:	
Per Prescription     Other, describe		
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:	
		li li

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

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👪 PBP Data Entry System - Section B-20, Contract X0001,	Plan 001, Segment 000		_ 8
File Help			
< <pre>&lt;</pre> < <pre>revious Next&gt;&gt; Exit (Validate) Exit (No Validate) Select from where Group 1 Drugs can be acquired: Designated Retail Pharmacy HM0-0wned Pharmacy Mail Order Other, describe</pre>	Go To: #20 Outpatient Drugs - Group 1 - Bas	e2 💌	
Is there an enrollee Coinsurance for Group 1?	Is there an enrollee Copayment for Group 1?		
C Yes C No	C Yes C No		
Indicate Coinsurance percentage for Group 1 Designated Retail Pharmacy:	Indicate Copayment amount for Group 1 Designated Retail Pharmacy:	Up to a day supply covered for Group 1 Designated Retail Pharmacy:	
Indicate Coinsurance percentage for Group 1 HMO-Owned Pharmacy:	Indicate Copayment amount for Group 1 HMO- Owned Pharmacy:	Up to a day supply covered for Group 1 HMO-Owned Pharmacy:	
Indicate Coinsurance percentage for Group 1 Mail Order:	Indicate Copayment amount for Group 1 Mail Order:	Up to a day supply covered for Group 1 Mail Order:	
Indicate Coinsurance percentage for Group 1 Other:	Indicate Copayment amount for Group 1 Other:	Up to a day supply covered for Group 1 Other:	

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

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🔛 PBP Data Entry System - Section B-20, Contract X000 File Help	1, Plan 001, Segment 000	_ B ×
< <previous next="">&gt; Exit (Validate) Exit (No Validate)</previous>	Go To: #20 Outpatient Drugs - Group 2 - Base 1	
Select a label for Group 2: Select the drug type(s) covered for Group 2: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage annual amount for Group 2: Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:	
Is there a Maximum Plan Benefit Coverage amount for Group 2? C Yes C No	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:	
Indicate Maximum Plan Benefit Coverage for Group 2 periodicity: Annually Semi-annually Quarterly Monthly	Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:	
<ul> <li>Per Prescription</li> <li>Other, describe</li> </ul>	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

Fu Associates, Ltd.

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Designated Retail Pharmacy         HMD-Owned Pharmacy         Mail Order         Other, describe         Is there an enrollee Coinsurance for Group 2?         Yes         No         Indicate Coinsurance precentage for Group 2 for         Indicate Coinsurance percentage for Group 2 for         Indicate Co	< <previous next="">&gt; Exit (Validate) Exit (No</previous>	Validate) Go To: #20 Outpatient Drugs - Grou	up 2 - Base 2	
Mail Order         Dther, describe         Is there an enrollee Coinsurance for Group 2?         Yes         No         Indicate Coinsurance percentage for Group 2 for         Indicate Coinsurance percentage for Group 2				
Dther, describe         Is there an enrollee Coinsurance for Group 2?         Yes         No         Indicate Coinsurance percentage for Group 2 for         Indica	-			
Is there an enrollee Coinsurance for Group 2?       Is there an enrollee Copayment for Group 2?         Yes       Yes         No       No         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2       Up to a day supply covered for Group 2         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 HMO-       Up to a day supply covered for Group 2         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 HMO-       Up to a day supply covered for Group 2         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 HMO-       Up to a day supply covered for Group 2         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Mail       Up to a day supply covered for Group 2         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Mail       Up to a day supply covered for Group 2         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Other:       Up to a day supply covered for Group 2         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Other:       Up to a day supply covered for Group 2				
Yes       No         Indicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy:       Up to a				
No       No         Indicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy:       Indicate Copayment amount for Group 2 Designated Retail Pharmacy:       Up to a				
Designated Retail Pharmacy:       Designated Retail Pharmacy:       Designated Retail Pharmacy:         Indicate Coinsurance percentage for Group 2 for HMD-Dwned Pharmacy:       Indicate Copayment amount for Group 2 HMD- Dwned Pharmacy:       Up to aday supply covered for Group 2 HMD-Dwned Pharmacy:         Indicate Coinsurance percentage for Group 2 for Mail Order:       Indicate Copayment amount for Group 2 Mail Order:       Up to aday supply covered for Group 2 Mail Order:         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Mail Order:       Up to aday supply covered for Group 2 Mail Order:         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Dther:       Up to a day supply covered for Group 2		O No		
Indicate Coinsurance percentage for Group 2 for HMD-Owned Pharmacy:       Indicate Copayment amount for Group 2 HMO- Owned Pharmacy:       Up to aday supply covered for Group 2 HMD-Owned Pharmacy:         Indicate Coinsurance percentage for Group 2 for Mail Order:       Indicate Copayment amount for Group 2 Mail Order:       Up to aday supply covered for Group 2 Mail Order:         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Mail Order:       Up to aday supply covered for Group 2         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Other:       Up to a day supply covered for Group 2	Indicate Coinsurance percentage for Group 2 for	Indicate Copayment amount for Group 2 Designated Betail Pharmacur	Up to a day supply covered for Group 2 Designated Betail Pharmacur	
HM0-Dwned Pharmacy:       Owned Pharmacy:       HM0-Dwned Pharmacy:         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Mail       Up to a day supply covered for Group 2         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Mail       Up to a day supply covered for Group 2         Indicate Coinsurance percentage for Group 2 for       Indicate Copayment amount for Group 2 Other:       Up to a day supply covered for Group 2				
Mail Order:     Mail Order:       Indicate Coinsurance percentage for Group 2 for     Indicate Copayment amount for Group 2 Other:     Up to a day supply covered for Group 2	Indicate Coinsurance percentage for Group 2 for HMO-Owned Pharmacy:	Indicate Copayment amount for Group 2 HMO- Owned Pharmacy:	Up to a day supply covered for Group 2 HMO-Owned Pharmacy:	
Mail Order:     Mail Order:       Indicate Coinsurance percentage for Group 2 for     Indicate Copayment amount for Group 2 Other:     Up to a day supply covered for Group 2				
	Indicate Coinsurance percentage for Group 2 for Mail Order:		Up to a day supply covered for Group 2 Mail Order:	
	Indicate Coinsurance percentage for Group 2 for	Indicate Copayment amount for Group 2 Other:	Up to a day supply covered for Group 2	
				li.

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

Fu Associates, Ltd.	
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🖶 PBP Data Entry System - Section B-20, Contract X00 File Help	01, Plan 001, Segment 000	_ <del>-</del> - <del>-</del> ×
Contraction of the second s	Go To: #20 Outpatient Drugs - Group 3 - Base 1 Indicate Maximum Plan Benefit Coverage annual amount for Group 3:	
Select the drug type(s) covered for Group 3: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 3:	
Is there a Maximum Plan Benefit Coverage amount for Group 3? C Yes C No	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3:	
Indicate Maximum Plan Benefit Coverage Group 3 periodicity: Annually Semi-annually Quarterly	Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:	
☐ Monthly ☐ Per Prescription ☐ Other, describe	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 3:	
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 3:	
		11

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

Fu Associates, Ltd.

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< <pre></pre>	Bo To: #20 Outpatient Drugs - Group 3 -	- Base 2	
Select from where Group 3 Drugs can be acquired:			
HMO-Owned Pharmacy			
Mail Order			
🗖 Other, describe			
Is there an enrollee Coinsurance for Group 3?	Is there an enrollee Copayment for Group 3?		
C Yes C No	O Yes O No		
Indicate Coinsurance percentage for Group 3 Designated Retail Pharmacy:	Indicate Copayment amount for Group 3 Designated Retail Pharmacy:	Up to a day supply covered for Group 3 Designated Retail Pharmacy:	
Indicate Coinsurance percentage for Group 3 HMO-Owned Pharmacy:	Indicate Copayment amount for Group 3 HMO- Owned Pharmacy:	Up to a day supply covered for Group 3 HMO-Owned Pharmacy:	
Indicate Coinsurance percentage for Group 3 Mail Order:	Indicate Copayment amount for Group 3 Mail	Up to a day supply covered for Group	
	Order:	3 Mail Order:	
Indicate Coinsurance percentage for Group 3 Other:	Indicate Copayment amount for Group 3 Other:	Up to a day supply covered for Group	
		3 Other:	
			li li

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

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🔛 PBP Data Entry System - Section B-20, Contract X000	01, Plan 001, Segment 000	_ B ×
File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)</previous<>		
Select a label for Group 4:	Go To: #20 Outpatient Drugs - Group 4 - Base 1 Indicate Maximum Plan Benefit Coverage annual amount for Group 4:	
Select the drug type(s) covered for Group 4: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 4:	
Is there a Maximum Plan Benefit Coverage amount for Group 4? C. Yes C. No	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4:	
Indicate Maximum Plan Benefit Coverage Group 4: Annually Semi-annually Quarterly Monthly	Indicate Maximum Plan Benefit Coverage monthly amount for Group 4:	
Per Prescription     Other, describe	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 4:	
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 4:	
		//

Section B – 20 – Outpatient Drugs-Group 4 – Base 2 Screen

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Select from where Group 4 Drugs can be acquired: Designated Retail Pharmacy HMO-Owned Pharmacy Mail Order Other, describe		_	
Is there an enrollee Coinsurance for Group 4?	Is there an enrollee Copayment for Group 4?		
C Yes C No	C Yes C No		
Indicate Coinsurance percentage for Group 4 Designated Retail Pharmacy:	Indicate Copayment amount for Group 4 Designated Retail Pharmacy:	Up to a day supply covered for Group 4 Designated Retail Pharmacy:	
Indicate Coinsurance percentage for Group 4 HMO-Owned Pharmacy:	Indicate Copayment amount for Group 4 HMO- Owned Pharmacy:	Up to a day supply covered for Group 4 HMO-Owned Pharmacy:	
Indicate Coinsurance percentage for Group 4 Mail Order:	Indicate Copayment amount for Group 4 Mail Order:	Up to a day supply covered for Group 4 Mail Order:	
Indicate Coinsurance percentage for Group 4 Other:	Indicate Copayment amount for Group 4 Other:	Up to a day supply covered for Group 4 Other:	

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

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File         Help           < <previous< td="">         Next&gt;&gt;         Exit (Validate)         Exit (No Validate)</previous<>		
Select a label for Group 5:	Go To: #20 Outpatient Drugs - Group 5 - Base 1 Indicate Maximum Plan Benefit Coverage annual amount for Group 5:	
Select the drug type(s) covered for Group 5: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 5:	
Is there a Maximum Plan Benefit Coverage amount for Group 5? C Yes C No	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:	
Indicate Maximum Plan Benefit Coverage for Group 5 periodicity: Annually Semi-annually Quarterly Monthly	Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:	
Per Prescription  Other, describe	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 5:	
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 5:	
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Section B – 20 – Outpatient Drugs-Group 5 – Base 2 Screen

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File Help < <pre> </pre> Kit (Validate) Exit (No Validate) Exit (No Validate)	e) Go To: #20 Outpatient Drugs - Group 5 -	Base 2	
Select from where Group 5 Drugs can be acquired: Designated Retail Pharmacy Mail Order Other, describe	ej do ro. j#20 Outpatienk Drugs - Group o -	base 2	
Is there an enrollee Coinsurance for Group 5?	Is there an enrollee Copayment for Group 5?		
© Yes © No	C Yes C No		
Indicate Coinsurance percentage for Group 5 Designated Retail Pharmacy:	Indicate Copayment amount for Group 5 Designated Retail Pharmacy.	Up to a day supply covered for Group 5 Designated Retail Pharmacy:	
Indicate Coinsurance percentage for Group 5 HMO- Owned Pharmacy:	Indicate Copayment amount for Group 5 HMO- Owned Pharmacy:	Up to a day supply covered for Group 5 HMO-Owned Pharmacy:	
Indicate Coinsurance percentage for Group 5 Mail Order:	Indicate Copayment amount for Group 5 Mail Order:	Up to aday supply covered for Group 5 Mail Order:	
Indicate Coinsurance percentage for Group 5 Other:	Indicate Copayment amount for Group 5 Other:	Up to a day supply covered for Group 5 Other:	

Section B – 20 – Home Infusion Bundled Services – Screen

Fu Associates, Ltd.

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🔛 PBP Data Entry System - Section B-20, Contract X0001, Plan 001	1, Segment 000 7	5
File Help		
	#20 Home Infusion Bundled Services	
Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?		
O Yes		
O 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.		
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