

PBP 2015 Data Entry System Screens

Plan Deductible LPPO/RPPO Base 1

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Deductible LPPO/RPPO Base 1

Do you offer an Annual Deductible?

Yes
 No

What is the amount of your Annual Deductible?

Medicare-Defined Part A Deductible amount
 Medicare-Defined Part B Deductible amount
 Medicare-Defined Part A and B Deductible amount combined as a single deductible
 Other, Indicate amount

Indicate Annual Deductible Amount:

How is your combined Medicare-defined Part A and B Deductible applied?

Single Deductible
 Differentially applied to Part A and Part B Medicare services, reflecting Original Medicare payment structure.

LPPO and RPPO plans must include ALL OON Medicare-covered Services in the annual Deductible, although they have the option to EXCLUDE 14a: Medicare-Covered Preventive Services. If the plan chooses to use the 2015 rates, please verify that any differential deductibles that are selected will not exceed the 2015 rates that will be released by CMS.

Do you include 14a Medicare-Covered Preventive Services as part of your OON Medicare-covered Services annual Deductible?

Yes
 No

Select the Service Categories that apply to your annual Deductible (Optional):

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

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

Yes
 No

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

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

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

PBP 2015 Data Entry System Screens

Plan Deductible LPPD/RPPO Base 2

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Deductible LPPD/RPPO Base 2

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

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

Yes
 No

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

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

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

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

Yes
 No

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

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

PBP 2015 Data Entry System Screens

Plan Deductible LPPO/RPPO Base 3

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Deductible LPPO/RPPO Base 3

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

Yes
 No

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

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

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

PBP 2015 Data Entry System Screens

Plan Deductible LPPO/RPPO Base 4

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Deductible LPPO/RPPO Base 4

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

PBP 2015 Data Entry System Screens

Plan Deductible LPPO/RPPO Base 5

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Deductible LPPO/RPPO Base 5

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

PBP 2015 Data Entry System Screens

Plan Deductible LPPO/RPPO Base 6

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Deductible LPPO/RPPO Base 6

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

PBP 2015 Data Entry System Screens

Plan Deductible (Combined) – Base 1

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Deductible (Combined) - Base 1

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

Yes
 No

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

Yes
 No

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

Select the benefits that apply to the Combined Deductible:

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

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

Yes
 No

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

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

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

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

Yes
 No

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

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

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

PBP 2015 Data Entry System Screens

Plan Deductible (Combined) – Base 2

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Deductible (Combined) - Base 2

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

Yes
 No

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

Yes
 No

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

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

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

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

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

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

PBP 2015 Data Entry System Screens

Plan Deductible (In-Network)

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

File Help

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

Go To: Plan Deductible (In-Network)

Is there an In-Network Plan Deductible?
 Yes
 No

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

Indicate In-Network Plan Deductible Amount:

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

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

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

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

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

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

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

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

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4c: Worldwide Coverage:
- 6: Home Health Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7f: Podiatry Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 9d: Outpatient Blood Services:

PBP 2015 Data Entry System Screens

Plan Deductible (Out-of-Network)

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Deductible (Out-of-Network)

Is there an Out-of-Network (OON) Plan Deductible?

Yes
 No

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

Indicate Out-of-Network Plan Deductible Amount:

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

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

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

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

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

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

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

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

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

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

PBP 2015 Data Entry System Screens

Plan Deductible (Non-Network)

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

File Help

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

Is there a Plan Deductible?
 Yes
 No

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

Indicate Plan Deductible Amount:

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

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

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

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

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

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

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

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

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

PBP 2015 Data Entry System Screens

Max Enrollee Cost Limit (Combined) – Base 1

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Max Enrollee Cost Limit (Combined) - Base 1

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

Yes
 No

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

Voluntary
 Mandatory

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

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

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

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

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

Yes
 No

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

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

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

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

Yes
 No

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

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

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

PBP 2015 Data Entry System Screens

Max Enrollee Cost Limit (Combined) – Base 2

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Max Enrollee Cost Limit (Combined) - Base 2

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

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

Yes
 No

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

Yes
 No

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

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

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

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

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

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

PBP 2015 Data Entry System Screens

Max Enrollee Cost Limit (In-Network)

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

File Help

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

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

Yes
 No

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

Voluntary
 Mandatory

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

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

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

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

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

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

Yes
 No

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

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

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

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

Yes
 No

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

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

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4c: Worldwide Coverage:
- 6: Home Health Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7f: Podiatry Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:

PBP 2015 Data Entry System Screens

Max Enrollee Cost Limit (Out-of-Network)

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

File Help

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

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

Yes
 No

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

Voluntary
 Mandatory

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

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

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

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

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

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

Yes
 No

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

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

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

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

Yes
 No

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

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

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

PBP 2015 Data Entry System Screens

Max Enrollee Cost Limit (Non-Network)

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

File Help

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

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

Voluntary
 Mandatory

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

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

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

Does the Maximum Enrollee Out-of-Pocket Cost apply to all Medicare-covered plan services?
 Yes
 No

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

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

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

Does the Maximum Enrollee Out-of-Pocket Cost apply to all Non-Medicare-covered plan services?
 Yes
 No

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

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

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

PBP 2015 Data Entry System Screens

Max Plan Benefit Coverage

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

File Help

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

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

Is there a Maximum Plan Benefit Coverage Amount?

Yes
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

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

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

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

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

Yes
 No

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

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

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

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

Yes
 No

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

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

1a: Inpatient Hospital Acute:
1b: Inpatient Hospital Psychiatric:
2: Skilled Nursing Facility (SNF):
3: Cardiac Rehabilitation Services:
3: Intensive Cardiac Rehabilitation Services:
3: Pulmonary Rehabilitation Services:
4: Worldwide Coverage:
6: Home Health Services:
7b: Chiropractic Services:

PBP 2015 Data Entry System Screens

Max Plan Benefit Coverage (Non-Network)

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

File Help

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

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

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

Yes
 No

Is there a Maximum Plan Benefit Coverage Amount?

Yes
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

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

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

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

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

PBP 2015 Data Entry System Screens

Plan Premium/Rebate Reduction

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

File Help

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

Indicate Plan Premium Amount (Part A/B):

Indicate Plan Premium Amount (B Only):

Are you using any of your plan's MA rebates to reduce the Part B Premium?
 Yes
 No

Indicate the Part B Premium reduction amount:

PBP 2015 Data Entry System Screens

MMP – Medicaid/plan covered cost sharing

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: MMP - Medicaid/plan covered cost sharing

Do you offer any Non-Medicare benefits (i.e., services not covered by Medicare)?

Yes
 No

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

Select all of the service categories that include services covered under Medicaid (Optional):

- 1a: Inpatient Hospital Acute;
- 1b: Inpatient Hospital Psychiatric;
- 2: Skilled Nursing Facility (SNF);
- 3: Cardiac Rehabilitation Services;
- 3: Intensive Cardiac Rehabilitation Services;
- 3: Pulmonary Rehabilitation Services;
- 4c: Worldwide Coverage;
- 6: Home Health Services;
- 7b: Chiropractic Services;
- 7c: Occupational Therapy Services;
- 7f: Podiatry Services;
- 7i: Physical Therapy and Speech-Language Pathology Services;
- 9d: Outpatient Blood Services;
- 10b: Transportation Services;
- 11a: Durable Medical Equipment (DME);
- 11b: Prosthetics/Medical Supplies;
- 13a: Acupuncture and Other Alternative Therapies;
- 13b: Over-the-Counter (OTC) Items and Services;
- 13c: Meal Benefit;
- 13d: Other 1;
- 13e: Other 2;
- 13f: Other 3;
- 14b: Annual Physical Exam;
- 14c: Supplemental Education/Health Management Programs;
- 15: Medicare Part B Rx Drugs;
- 16a: Preventive Dental;

Select all of the service categories that include plan-covered supplemental benefits (i.e., services not covered by Medicare or Medicaid) (Optional):

- 1a: Inpatient Hospital Acute;
- 1b: Inpatient Hospital Psychiatric;
- 2: Skilled Nursing Facility (SNF);
- 3: Cardiac Rehabilitation Services;
- 3: Intensive Cardiac Rehabilitation Services;
- 3: Pulmonary Rehabilitation Services;
- 4c: Worldwide Coverage;
- 6: Home Health Services;
- 7b: Chiropractic Services;
- 7c: Occupational Therapy Services;
- 7f: Podiatry Services;
- 7i: Physical Therapy and Speech-Language Pathology Services;
- 9d: Outpatient Blood Services;
- 10b: Transportation Services;
- 11a: Durable Medical Equipment (DME);
- 11b: Prosthetics/Medical Supplies;
- 13a: Acupuncture and Other Alternative Therapies;
- 13b: Over-the-Counter (OTC) Items and Services;
- 13c: Meal Benefit;
- 13d: Other 1;
- 13e: Other 2;
- 13f: Other 3;
- 14b: Annual Physical Exam;
- 14c: Supplemental Education/Health Management Programs;
- 15: Medicare Part B Rx Drugs;
- 16a: Preventive Dental;

PBP 2015 Data Entry System Screens

PFFS Balance Billing

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

File Help

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

Do you permit balance billing?
 Yes
 No

Balance Billing is a percentage of plan payment rate provider may collect.

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

What category of providers do you permit to balance bill?

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

Enter Minimum percentage for balance billing:
[]

Enter Maximum percentage for balance billing:
[]

PBP 2015 Data Entry System Screens

MSA Annual Deductible/Deposit

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The window has a menu bar with "File" and "Help". Below the menu bar are four buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". To the right of these buttons is a "Go To:" label followed by a dropdown menu currently displaying "MSA Annual Deductible/Deposit".

Below the navigation controls, there are two text input fields:

- The first field is preceded by the text "Indicate Annual MSA Deductible amount:".
- The second field is preceded by the text "Indicate the Annual amount CMS will deposit into the Enrollee MSA:".

The main area of the window is a large, empty gray space, likely for data entry or display.

PBP 2015 Data Entry System Screens

Notes

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

File Help

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

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

Notes (Optional):

Notes (Optional):

PBP 2015 Data Entry System Screens

Optional Supplemental – Management Screen

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Optional Supplemental - Management Screen

Optional Supplemental Packages

Note: To add an optional supplemental package, click on the 'Add Package' button. To delete an optional supplemental package, highlight the existing package and then click on the 'Delete Package' button.

Add Package Delete Package

PBP 2015 Data Entry System Screens

Optional Supplemental – Label and Premium

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a navigation bar with buttons for "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "Optional Supplemental - Label and Premium".

The main content area is divided into two columns. The left column contains several input fields and radio button groups:

- Optional Supplemental Benefits ID:** A text input field.
- Optional Supplemental Package Description:** A text input field.
- Indicate Optional Supplemental Premium Amount:** A text input field.
- Is there a Maximum Plan Benefit Coverage Amount for this package?** A radio button group with "Yes" and "No" options.
- Indicate Maximum Plan Benefit Coverage Amount for this package:** A text input field.
- Select the Maximum Plan Benefit Coverage periodicity:** A radio button group with options: "Every three years", "Every two years", "Every year", "Every six months", "Every three months", and "Other, Describe".
- Is there an enrollee Deductible for this package?** A radio button group with "Yes" and "No" options.
- Indicate Deductible Amount:** A text input field.

The right column contains a large text area labeled "Notes:" with a scroll bar. A note is present: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."

PBP 2015 Data Entry System Screens

Optional Supplemental – Service Categories

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Optional Supplemental - Service Categories

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

Select the service categories included in this package that have optional supplemental benefits declared in Section B and/or Section C - PDS and/or Section C - V/T:

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

The "other service categories picklist" is intended to capture any step-up benefits and/or non-standard optional benefits that are not available in Section B.

Service categories with an asterisk (*) in the list have additional step-up data entry screens. After highlighting the category, click on either the dropdown box or the right arrow button above to navigate to these screens.

Service categories can be removed from the Optional Supplemental Package by deselecting them from the list. If service categories with an asterisk (*) are deselected, then the associated step-up data entry screens will also be

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

Select the other service categories included in this package (i.e., that are NOT declared in Section B and/or Section C - PDS and/or Section C - V/T):

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

Important: The following examples cannot be an optional supplemental benefit:

(1) cost-share buy-down of original Medicare benefits and (2) State Medicaid wraparound benefits. Please refer to Chapter 4 of the Medicare Managed Care Manual and the MA Regulation (CFR § 422.102) for additional information.

PBP 2015 Data Entry System Screens

Optional Supplemental – OON Stepup

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

File Help

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

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

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

Is there an OON Copayment?
 Yes
 No

Enter Minimum Copayment Amount:
[Text Input]

Enter Maximum Copayment Amount:
[Text Input]

Is there an OON Coinsurance?
 Yes
 No

Enter Minimum Coinsurance Percentage:
[Text Input]

Enter Maximum Coinsurance Percentage:
[Text Input]

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

Notes:
[Text Area]

PBP 2015 Data Entry System Screens

Optional Supplemental – OON Optional

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

File Help

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

Does this category include Out-of-Network benefits?

Yes
 No

Are the OON cost shares the same as the In-Network cost shares?

Yes
 No

Is there an OON Coinsurance?

Yes
 No

Enter Minimum Coinsurance Percentage:
[]

Enter Maximum Coinsurance Percentage:
[]

Is there an OON Copayment?

Yes
 No

Enter Minimum Copayment Amount:
[]

Enter Maximum Copayment Amount:
[]

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

Notes:
[]

PBP 2015 Data Entry System Screens

Step Up #10b Transportation Services – Base 1

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Yes
 No

Select enhanced benefit:

Plan-approved Location
 Any Location

Select type of benefit for Plan-approved Location:

Mandatory
 Optional

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

Yes
 No

Indicate number of trips for Plan-approved Location:

Select Plan-approved Location Trips periodicity:

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

Select Type of Transportation for Plan-approved Location:

One-way
 Round Trip
 Days
 Other, describe

Indicate number of days for Plan-approved Location:

Select Mode of Transportation for Plan-approved Location:

Taxi
 Bus/Subway
 Van
 Medical Transport
 Other, describe

Select type of benefit for Any Location:

Mandatory
 Optional

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

Yes
 No

Indicate number of trips for Any Location:

Select Any Location Trips periodicity:

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

Select Type of Transportation for Any Location:

One-way
 Round Trip
 Days
 Other, describe

Indicate number of days for Any Location:

Select Mode of Transportation for Any Location:

Taxi
 Bus/Subway
 Van
 Medical Transport
 Other, describe

PBP 2015 Data Entry System Screens

Step Up #10b Transportation Services – Base 2

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

File Help

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

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Plan Benefit Coverage amount: <input type="text"/></p> <p>Select Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Enrollee Out-of-Pocket Cost amount: <input type="text"/></p> <p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Coinsurance percentage: <input type="text"/></p> <p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Deductible Amount: <input type="text"/></p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

PBP 2015 Data Entry System Screens

Step Up #10b Transportation Services – Base 3

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a set of navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "Step Up #10b Transportation Services - Base 3".

Form fields include:

- "Is there an enrollee Copayment?" with radio buttons for "Yes" and "No".
- "Indicate Copayment amount per trip:" with a text input field.
- "Enrollee must receive Authorization from one or more of the following:" with checkboxes for "None", "Primary Care Physician (Internist/Family Practice, General Practice)", "Physician Specialist", "Organization Medical Director/Utilization Management/Utilization Review", and "Other, describe".
- "Is a referral required for Transportation Services?" with radio buttons for "Yes" and "No".
- "Notes (Optional):" with a large text area for additional information.

A note below the "Go To:" dropdown states: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."

PBP 2015 Data Entry System Screens

Step Up #16a Preventive Dental – Base 1

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?

Yes
 No

Select enhanced benefits:

Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Select type of benefit for Oral Exams:

Mandatory
 Optional

Is this benefit unlimited for Oral Exams?

Yes
 No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

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

Select type of benefit for Prophylaxis (Cleaning):

Mandatory
 Optional

Is this benefit unlimited for Prophylaxis (Cleaning)?

Yes
 No, indicate number

Indicate number of visits for Prophylaxis (Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

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

Select type of benefit for Fluoride Treatment:

Mandatory
 Optional

Is this benefit unlimited for Fluoride Treatment?

Yes
 No, indicate number

Indicate number of visits for Fluoride Treatment:

Select the Fluoride Treatment periodicity:

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

PBP 2015 Data Entry System Screens

Step Up #16a Preventive Dental – Base 2

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

File Help

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

Select type of benefit for Dental X-Rays:

Mandatory
 Optional

Is this benefit unlimited for Dental X-Rays?

Yes
 No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

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

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

Yes
 No

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

In-network services only
 Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

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

PBP 2015 Data Entry System Screens

Step Up #16a Preventive Dental – Base 3

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #16a Preventive Dental - Base 3

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

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

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

Is there an enrollee Coinsurance?
 Yes
 No

Select which Preventive Dental Services have a Coinsurance (Select all that apply):
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Is there a combination of services included in a single cost per Office Visit?
 Yes
 No

Select which combination of services are included in a single cost per Office Visit:
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Indicate Coinsurance percentage for Office Visit:
[]

Indicate Minimum Coinsurance percentage for Oral Exams:
[]

Indicate Maximum Coinsurance percentage for Oral Exams:
[]

Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):
[]

Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):
[]

Indicate Minimum Coinsurance percentage for Fluoride Treatment:
[]

Indicate Maximum Coinsurance percentage for Fluoride Treatment:
[]

Indicate Minimum Coinsurance percentage for Dental X-Rays:
[]

Indicate Maximum Coinsurance percentage for Dental X-Rays:
[]

PBP 2015 Data Entry System Screens

Step Up #16a Preventive Dental – Base 4

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

File Help

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

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:
[]

Is there an enrollee Copayment?
 Yes
 No

Select which Preventive Dental Services have a Copayment (Select all that apply):
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Is there a combination of services included in a single cost per Office Visit?
 Yes
 No

Select which combination of services are included in a single cost per Office Visit:
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Indicate Copayment amount for Office Visit:
[]

Indicate Minimum Copayment amount for Oral Exams:
[]

Indicate Maximum Copayment amount for Oral Exams:
[]

Indicate Minimum Copayment amount for Prophylaxis (Cleaning):
[]

Indicate Maximum Copayment amount for Prophylaxis (Cleaning):
[]

Indicate Minimum Copayment amount for Fluoride Treatment:
[]

Indicate Maximum Copayment amount for Fluoride Treatment:
[]

Indicate Minimum Copayment amount for Dental X-Rays:
[]

Indicate Maximum Copayment amount for Dental X-Rays:
[]

PBP 2015 Data Entry System Screens

Step Up #16a Preventive Dental – Base 5

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The window has a menu bar with "File" and "Help". Below the menu bar is a navigation area with buttons for "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "Step Up #16a Preventive Dental - Base 5".

The main content area contains the following fields and options:

- 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 Preventive Dental Services?
 - Yes
 - No
- Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
- Notes (Optional):

PBP 2015 Data Entry System Screens

Step Up #16b Comprehensive Dental – Base 1

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?

Yes
 No

Select enhanced benefits:

Non-routine Services
 Diagnostic Services
 Restorative Services
 Endodontics/Periodontics/Extractions
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory
 Optional

Select type of benefit for Diagnostic Services:

Mandatory
 Optional

Is this benefit unlimited for Non-routine Services?

Yes
 No, indicate number

Indicate number of visits for Non-routine Services:

Select the Non-routine Services periodicity:

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

Is this benefit unlimited for Diagnostic Services?

Yes
 No, indicate number

Indicate number of visits for Diagnostic Services:

Select the Diagnostic Services periodicity:

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

PBP 2015 Data Entry System Screens

Step Up #16b Comprehensive Dental – Base 2

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

File Help

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

Select type of benefit for Restorative Services:
 Mandatory
 Optional

Select type of benefit for Endodontics/Periodontics/Extractions:
 Mandatory
 Optional

Select type of benefit for Prostodontics, Other Oral/Maxillofacial Surgery, Other Services:
 Mandatory
 Optional

Is this benefit unlimited for Restorative Services?
 Yes
 No, indicate number

Is this benefit unlimited for Endodontics/Periodontics/Extractions?
 Yes
 No, indicate number

Is this benefit unlimited for Prostodontics, Other Oral/Maxillofacial Surgery, Other Services?
 Yes
 No, indicate number

Indicate number of visits for Restorative Services:

Indicate number of visits for Endodontics/Periodontics/Extractions:

Indicate number of visits for Prostodontics, Other Oral/Maxillofacial Surgery, Other Services:

Select the Restorative Services periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Select the Endodontics/Periodontics/Extractions periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Select the Prostodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

PBP 2015 Data Entry System Screens

Step Up #16b Comprehensive Dental – Base 3

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Step Up #16b Comprehensive Dental - Base 3

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

Yes
 No

Select the Maximum Plan Benefit Coverage type:

Covered under Preventive Dental Category 16a
 Plan-specified amount per period

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

In-network services only
 Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

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

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

Yes
 No

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

Covered under Preventive Dental Category 16a
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

PBP 2015 Data Entry System Screens

Step Up #16b Comprehensive Dental – Base 4

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

File Help

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

Is there an enrollee Coinsurance?

Yes
 No

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

Medicare-covered Benefits
 Non-routine Services
 Diagnostic Services
 Restorative Services
 Endodontics/Periodontics/Extractions
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Non-routine Services:

Indicate Maximum Coinsurance percentage for Non-routine Services:

Indicate Minimum Coinsurance percentage for Diagnostic Services:

Indicate Maximum Coinsurance percentage for Diagnostic Services:

Indicate Minimum Coinsurance percentage for Restorative Services:

Indicate Maximum Coinsurance percentage for Restorative Services:

Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions:

Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:

Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Is there an enrollee Deductible?

Yes
 No

Indicate Deductible Amount:

PBP 2015 Data Entry System Screens

Step Up #16b Comprehensive Dental – Base 5

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

File Help

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

Is there an enrollee Copayment?
 Yes
 No

Select which Comprehensive Dental Services have a Copayment (Select all that apply):
 Medicare-covered Benefits
 Non-routine Services
 Diagnostic Services
 Restorative Services
 Endodontics/Periodontics/Extractions
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Non-routine Services:

Indicate Maximum Copayment amount for Non-routine Services:

Indicate Minimum Copayment amount for Diagnostic Services:

Indicate Maximum Copayment amount for Diagnostic Services:

Indicate Minimum Copayment amount for Restorative Services:

Indicate Maximum Copayment amount for Restorative Services:

Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions:

Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions:

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

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

PBP 2015 Data Entry System Screens

Step Up #16b Comprehensive Dental – Base 6

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a navigation bar with buttons for "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "Step Up #16b Comprehensive Dental - Base 6".

Below the navigation bar, there is a section titled "Enrollee must receive Authorization from one or more of the following:" with five checkboxes:

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

Next is a question: "Is a referral required for Comprehensive Dental Services?" with two radio button options: "Yes" and "No".

A note below reads: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."

At the bottom, there is a text area labeled "Notes (Optional):" which is currently empty.

PBP 2015 Data Entry System Screens

Step Up #17a Eye Exams – Base 1

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Eye Exams as a supplemental benefit under Part C?

Yes
 No

Select enhanced benefit:
 Routine Eye Exams

Select type of benefit for Routine Eye Exams:

Mandatory
 Optional

Is this benefit unlimited for Routine Eye Exams?

Yes
 No, indicate number

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

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

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

Yes
 No

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

In-network services only
 Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

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

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

Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

PBP 2015 Data Entry System Screens

Step Up #17a Eye Exams – Base 2

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

File Help

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

Is there an enrollee Coinsurance?
 Yes
 No

Is there an enrollee Copayment?
 Yes
 No

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

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

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Eye Exams:

Indicate Minimum Copayment amount per Routine Eye Exam:

Indicate Maximum Coinsurance percentage for Routine Eye Exams:

Indicate Maximum Copayment amount per Routine Eye Exam:

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

PBP 2015 Data Entry System Screens

Step Up #17a Eye Exams – Base 3

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

File Help

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

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

Sometimes, describe
 No

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

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

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

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

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

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

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

Is a referral required for Eye Exams?
 Yes
 No

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

Notes (Optional):

PBP 2015 Data Entry System Screens

Step Up #17b Eyewear – Base 1

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Yes
 No

Select enhanced benefits:

Contact lenses
 Eyeglasses (lenses and frames)
 Eyeglass lenses
 Eyeglass frames
 Upgrades

Select type of benefit for Contact lenses:

Mandatory
 Optional

Is this benefit unlimited for Contact lenses?

Yes
 No, indicate number

Indicate quantity (number of pairs) for Contact lenses:

Select Contact lenses periodicity:

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

Select type of benefit for Eyeglasses (lenses and frames):

Mandatory
 Optional

Is this benefit unlimited for Eyeglasses (lenses and frames)?

Yes
 No, indicate number

Indicate quantity for Eyeglasses (lenses and frames):

Select Eyeglasses (lenses and frames) periodicity:

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

PBP 2015 Data Entry System Screens

Step Up #17b Eyewear – Base 2

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

File Help

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

Select type of benefit for Eyeglass lenses:

Mandatory
 Optional

Select type of benefit for Eyeglass frames:

Mandatory
 Optional

Is this benefit unlimited for Eyeglass lenses?

Yes
 No, indicate number

Is this benefit unlimited for Eyeglass frames?

Yes
 No, indicate number

Indicate quantity (number of pairs) for Eyeglass lenses:

Indicate quantity for Eyeglass frames:

Select Eyeglass lenses periodicity:

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

Select Eyeglass frames periodicity:

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

Select type of benefit for Upgrades:

Mandatory
 Optional

PBP 2015 Data Entry System Screens

Step Up #17b Eyewear – Base 3

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

File Help

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

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

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

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

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

Indicate Combined Maximum Plan Benefit Coverage amount:

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

Select the type of Eyewear with Individual Max Plan Benefit Coverage amount:
 Contact lenses
 Eyeglasses (lenses and frames)
 Eyeglass lenses
 Eyeglass frames
 Upgrades

Indicate Max Plan Benefit Coverage amount for Contact lenses:

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

Indicate Max Plan Benefit Coverage amount for Eyeglasses (lenses and frames):

Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglasses (lenses and frames):
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Indicate Max Plan Benefit Coverage amount for Eyeglass lenses:

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

Indicate Max Plan Benefit Coverage amount for Eyeglass frames:

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

Indicate Max Plan Benefit Coverage amount for Upgrades:

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

PBP 2015 Data Entry System Screens

Step Up #17b Eyewear – Base 4

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

File Help

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

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

Yes
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Indicate Coinsurance percentage for Medicare-covered Benefits:

Indicate Coinsurance percentage for Contact lenses:

Indicate Coinsurance percentage for Eyeglasses (lenses and frames):

Indicate Coinsurance percentage for Eyeglass lenses:

Indicate Coinsurance percentage for Eyeglass frames:

Indicate Coinsurance percentage for Upgrades:

Is there an enrollee Coinsurance?

Yes
 No

Select which Eyewear Benefits have a Coinsurance (Select all that apply):

Medicare-covered Benefits
 Contact lenses
 Eyeglasses (lenses and frames)
 Eyeglass lenses
 Eyeglass frames
 Upgrades

PBP 2015 Data Entry System Screens

Step Up #17b Eyewear – Base 5

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

File Help

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

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Select which Eyewear Benefits have a Copayment (Select all that apply):
 Medicare-covered Benefits
 Contact lenses
 Eyeglasses (lenses and frames)
 Eyeglass lenses
 Eyeglass frames
 Upgrades

Indicate Copayment amount for Medicare-covered Benefits:

Indicate Copayment amount for Contact lenses:

Indicate Copayment amount for Eyeglasses (lenses and frames):

Indicate Copayment amount for Eyeglass lenses:

Indicate Copayment amount for Eyeglass frames:

Indicate Copayment amount for Upgrades:

PBP 2015 Data Entry System Screens

Step Up #17b Eyewear – Base 6

The screenshot shows a web-based data entry form titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a navigation bar with buttons for "<<Previous", "Next>>", "Exit (Validate)", "Exit (No Validate)", and a "Go To:" dropdown menu currently set to "Step Up #17b Eyewear - Base 6".

The main content area contains the following sections:

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

PBP 2015 Data Entry System Screens

Step Up #18a Hearing Exams – Base 1

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Does the plan provide Hearing Exams as a supplemental benefit under Part C?

Yes
 No

Select enhanced benefits:

Routine Hearing Exams
 Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Exams:

Mandatory
 Optional

Is this benefit unlimited for Routine Hearing Exams?

Yes
 No, indicate number

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

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

Select type of benefit for Fitting/Evaluation for Hearing Aid:

Mandatory
 Optional

Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?

Yes
 No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

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

PBP 2015 Data Entry System Screens

Step Up #18a Hearing Exams – Base 2

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

File Help

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

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

PBP 2015 Data Entry System Screens

Step Up #18a Hearing Exams – Base 3

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

File Help

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

Go To: Step Up #18a Hearing Exams - Base 3

Is there an enrollee Copayment?
 Yes
 No

Select which Hearing Exam Benefits have a Copayment(Select all that apply):
 Medicare-covered Benefits
 Routine Hearing Exams
 Fitting/Evaluation for Hearing Aid

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Routine Hearing Exams:

Indicate Maximum Copayment amount for Routine Hearing Exams:

Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:

Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:

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

Is a referral required for Hearing Exams?
 Yes
 No

PBP 2015 Data Entry System Screens

Step Up #18a Hearing Exams – Base 4

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The window contains a menu bar with "File" and "Help". Below the menu bar are navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". To the right of these buttons is a "Go To:" label followed by a dropdown menu currently displaying "Step Up #18a Hearing Exams - Base 4".

Below the navigation controls is the section "Hearing Exams Notes". A text instruction reads: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." Below this instruction is a label "Notes (Optional):" followed by a large, empty text area with a vertical scrollbar on the right side.

PBP 2015 Data Entry System Screens

Step Up #18b Hearing Aids – Base 1

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Hearing Aids as a supplemental benefit under Part C?

Yes
 No

Select enhanced benefits:

Hearing Aids (all types)
 Hearing Aids - Inner Ear
 Hearing Aids - Outer Ear
 Hearing Aids - Over the Ear

Select type of benefit for Hearing Aids (all types):

Mandatory
 Optional

Is this benefit unlimited for Hearing Aids (all types)?

Yes
 No, indicate number

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity:

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

Select type of benefit for Hearing Aids - Inner Ear:

Mandatory
 Optional

Is this benefit unlimited for Hearing Aids - Inner Ear?

Yes
 No, indicate number

Indicate quantity for Hearing Aids - Inner Ear:

Select Hearing Aids - Inner Ear periodicity:

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

Select type of benefit for Hearing Aids - Outer Ear:

Mandatory
 Optional

Is this benefit unlimited for Hearing Aids - Outer Ear?

Yes
 No, indicate number

Indicate quantity for Hearing Aids - Outer Ear:

Select Hearing Aids - Outer Ear periodicity:

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

PBP 2015 Data Entry System Screens

Step Up #18b Hearing Aids – Base 2

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

File Help

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

Select type of benefit for Hearing Aids - Over the Ear:

Mandatory
 Optional

Is this benefit unlimited for Hearing Aids - Over the Ear?

Yes
 No, indicate number

Indicate quantity for Hearing Aids - Over the Ear:

Select Hearing Aids - Over the Ear periodicity:

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

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

Yes
 No

Select the Maximum Plan Benefit Coverage type:

Covered under Hearing Exams Category - 18a
 Plan-specified amount per period

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

In-network services only
 Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

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

PBP 2015 Data Entry System Screens

Step Up #18b Hearing Aids – Base 3

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

File Help

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

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

Indicate Coinsurance percentage for Hearing Aids (all types):

Select the Maximum Enrollee Out-of-Pocket Cost type:
 Covered under Hearing Exams Category - 18a
 Plan-specified amount per period

Indicate Coinsurance percentage for Hearing Aids - Inner Ear:

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Coinsurance percentage for Hearing Aids - Outer Ear:

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

Indicate Coinsurance percentage for Hearing Aids - Over the Ear:

Is there an enrollee Coinsurance?
 Yes
 No

Select which Hearing Aids Benefits have a Coinsurance (Select all that apply):
 Hearing Aids - Inner Ear
 Hearing Aids - Outer Ear
 Hearing Aids - Over the Ear

PBP 2015 Data Entry System Screens

Step Up #18b Hearing Aids – Base 4

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

File Help

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

Is there an enrollee Copayment?
 Yes
 No

Select which Hearing Aids Benefits have a Copayment (Select all that apply):
 Hearing Aid - Inner Ear
 Hearing Aid - Outer Ear
 Hearing Aids - Over the Ear

Indicate Minimum Copayment amount per Hearing Aid (all types):

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

Indicate Copayment amount per Hearing Aid - Inner Ear:

Indicate Copayment amount per two Hearing Aids - Inner Ear:

Indicate Copayment amount per Hearing Aid - Outer Ear:

Indicate Copayment amount per two Hearing Aids - Outer Ear:

Indicate Copayment amount per Hearing Aid - Over the Ear:

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

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

PBP 2015 Data Entry System Screens

Step Up #18b Hearing Aids – Base 5

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

File Help

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

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

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

Is a referral required for Hearing Aids?

Yes
 No

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

Notes (Optional):

PBP 2015 Data Entry System Screens

Step Up #7b Chiropractic Services – Base 1

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Yes
 No

Select enhanced benefit:
 Routine Care

Select type of benefit for Routine Care:
 Mandatory
 Optional

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

Indicate number of visits for Routine Care:

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

PBP 2015 Data Entry System Screens

Step Up #7b Chiropractic Services – Base 2

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

File Help

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

Is there an enrollee Coinsurance?

Yes
 No

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

Medicare-covered Chiropractic Services
 Routine Care

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

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

Indicate the Minimum Coinsurance percentage per visit for Routine Care:

Indicate the Maximum Coinsurance percentage per visit for Routine Care:

PBP 2015 Data Entry System Screens

Step Up #7b Chiropractic Services – Base 3

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

File Help

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

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount per visit for Routine Care:

Indicate Maximum Copayment amount per visit for Routine Care:

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

Is a referral required for Chiropractic Services?
 Yes
 No

PBP 2015 Data Entry System Screens

Step Up #7b Chiropractic Services – Base 4

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help". Below the menu bar are navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "Step Up #7b Chiropractic Services - Base 4". The main area is labeled "Chiropractic Services Notes" and contains a text instruction: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." Below this is a section for "Notes (Optional)" with a large, empty text input area.

PBP 2015 Data Entry System Screens

Step Up #7f Podiatry Services – Base 1

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Yes
 No

Select enhanced benefits:

Routine Footcare

Select type of benefit for Routine Footcare:

Mandatory
 Optional

Is this benefit unlimited for Routine Footcare?

Yes
 No

Indicate number of Routine Footcare visits:

Select the Routine Footcare periodicity:

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

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

Yes
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

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

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

Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

PBP 2015 Data Entry System Screens

Step Up #7f Podiatry Services – Base 2

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

File Help

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

Is there an enrollee Coinsurance?
 Yes
 No

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

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Footcare:

Indicate Maximum Coinsurance percentage for Routine Footcare:

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

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

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

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

Indicate Minimum Copayment amount per visit for Routine Footcare:

Indicate Maximum Copayment amount per visit for Routine Footcare:

PBP 2015 Data Entry System Screens

Step Up #7f Podiatry Services – Base 3

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

File Help

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

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

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

Is a referral required for Podiatrist Services?

Yes

No

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

Notes (Optional):