Plan Deductible LPPO/RPPO Base 1

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

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Do you offer an Annual Deductible?
- Yes
- No

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

Indicate Annual Deductible Amount:

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

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

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

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

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

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

Plan Deductible LPPO/RPPO Base 2

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

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

- Yes
- No

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

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

Plan Deductible LPPO/RPPO Base 3

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

- Yes
- No

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

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

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

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

Plan Deductible LPPO/RPPO Base 4

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Indicate Differential Deductible Amounts for Inpatient Hospital Services including Acute Tiers 1, 2, and 3, where appropriate:

Indicate Differential Deductible Amounts for Inpatient Psychiatric Hospital Services Tiers 1, 2, and 3, where appropriate:

Indicate Differential Deductible Amount for Skilled Nursing Facility (SNF)

Indicate Differential Deductible Amount for Cardiac and Pulmonary Rehabilitation Services:

Indicate Differential Deductible Amount for Emergency Care:

Indicate Differential Deductible Amount for Urgently Needed Services:

Indicate Differential Deductible Amount for Partial Hospitalization:

Indicate Differential Deductible Amount for Home Health Services:

Indicate Differential Deductible Amount for Primary Care Physician Services:

Indicate Differential Deductible Amount for Chiropractic Services:

Indicate Differential Deductible Amount for Occupational Therapy Services:

Indicate Differential Deductible Amount for Physician Specialist Services

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.

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

Plan Deductible LPPO/RPPO Base 5

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Indicate Differential Deductible Amount for Mental Health Specialty Services - Non-Psychiatric:

Indicate Differential Deductible Amount for Podiatry Services:

Indicate Differential Deductible Amount for Other Health Care Professional Services:

Indicate Differential Deductible Amount for Psychiatric Services:

Indicate Differential Deductible Amount for Physical Therapy and Speech-Language Pathology Services:

Indicate Differential Deductible Amount for Outpatient Diagnostic Procedures and Test and Lab Services:

Indicate Differential Deductible Amount for Outpatient Diagnostic and Therapeutic Radiological Services:

Indicate Differential Deductible Amount for Outpatient Hospital Services:

Indicate Differential Deductible Amount for Ambulatory Surgical Center (ASC) Services:

Indicate Differential Deductible Amount for Outpatient Substance Abuse Services:

Indicate Differential Deductible Amount for Outpatient Blood Services:

Indicate Differential Deductible Amount for Ambulance Services:

Indicate Differential Deductible Amount for Transportation Services:

Indicate Differential Deductible Amount for Durable Medical Equipment (DME):

Indicate Differential Deductible Amount for Prosthetics/Medical Supplies:

Indicate Differential Deductible Amount for Diabetic Supplies and Services:

Indicate Differential Deductible Amount for End-Stage Renal Disease:

Indicate Differential Deductible Amount for Acupuncture and Other Alternative Therapies:

Indicate Differential Deductible Amount for OTC:

Indicate Differential Deductible Amount for Meal Benefit:

Indicate Differential Deductible Amount for Other 1:

Indicate Differential Deductible Amount for Other 2:

Indicate Differential Deductible Amount for Other 3:

Indicate Differential Deductible Amount for Dual Eligible SNPs with Highly Integrated Services:

Plan Deductible LPPO/RPPO Base 6

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Indicate Differential Deductible Amount for the Annual Physical Exam:

Indicate Differential Deductible Amount for Supplemental Education/Health Management Programs:

Indicate Differential Deductible Amount for Kidney Disease Education Services:

Indicate Differential Deductible Amount for Diabetes Self-Management Training:

Indicate Differential Deductible Amount for Medicare Part B Rx Drugs:

Indicate Differential Deductible Amount for Preventive Dental:

Indicate Differential Deductible Amount for Comprehensive Dental:

Indicate Differential Deductible Amount for Eye Exams:

Indicate Differential Deductible Amount for Eyewear:

Indicate Differential Deductible Amount for Hearing Exams:

Indicate Differential Deductible Amount for Hearing Aids:

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

Plan Deductible (Combined) – Base 1

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Is there a Combined (In-Network and Out-of-Network) Deductible amount?
- Yes
- No

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

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

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

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

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

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

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

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

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

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

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

Plan Deductible (Combined) – Base 2

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Does the Combined 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 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:

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 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:

Plan Deductible (In-Network)

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Go To: Plan Deductible (In-Network)

Is there an In-Network Plan Deductible?
- Yes
- No

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

Indicate In-Network Plan Deductible Amount:

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

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

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

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

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

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

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

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

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

Plan Deductible (Out-of-Network)

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

- Yes
- No

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

- 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:

Plan Deductible (Non-Network)

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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:

Max Enrollee Cost Limit (Combined) – Base 1

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

- Yes
- No

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

- Voluntary
- Mandatory

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

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

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

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

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

- Yes
- No

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

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

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

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

- Yes
- No

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

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

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

Max Enrollee Cost Limit (Combined) – Base 2

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

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

- Yes
- No

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:

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 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:

Max Enrollee Cost Limit (In-Network)

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

- Yes
- No

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

- Voluntary
- Mandatory

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

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

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

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

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

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

- Yes
- No

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

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

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

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

- Yes
- No

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

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

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

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:

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:
3: Pulmonary Rehabilitation Services:
4a: Emergency Care:
4b: Urgently Needed Care:

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

- Yes
- No

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

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

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

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:
- 4c: Worldwide Coverage:
- 6: Home Health Services:
- 7b: Chiropractic Services:

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.

Is there a Maximum Plan Benefit Coverage Amount?

- Yes
- No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

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

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

- Yes
- No

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

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

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

Plan Premium/Rebate Reduction

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:

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:

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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:

MSA Annual Deductible/Deposit

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

File Help

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

Indicate Annual MSA Deductible amount:

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

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

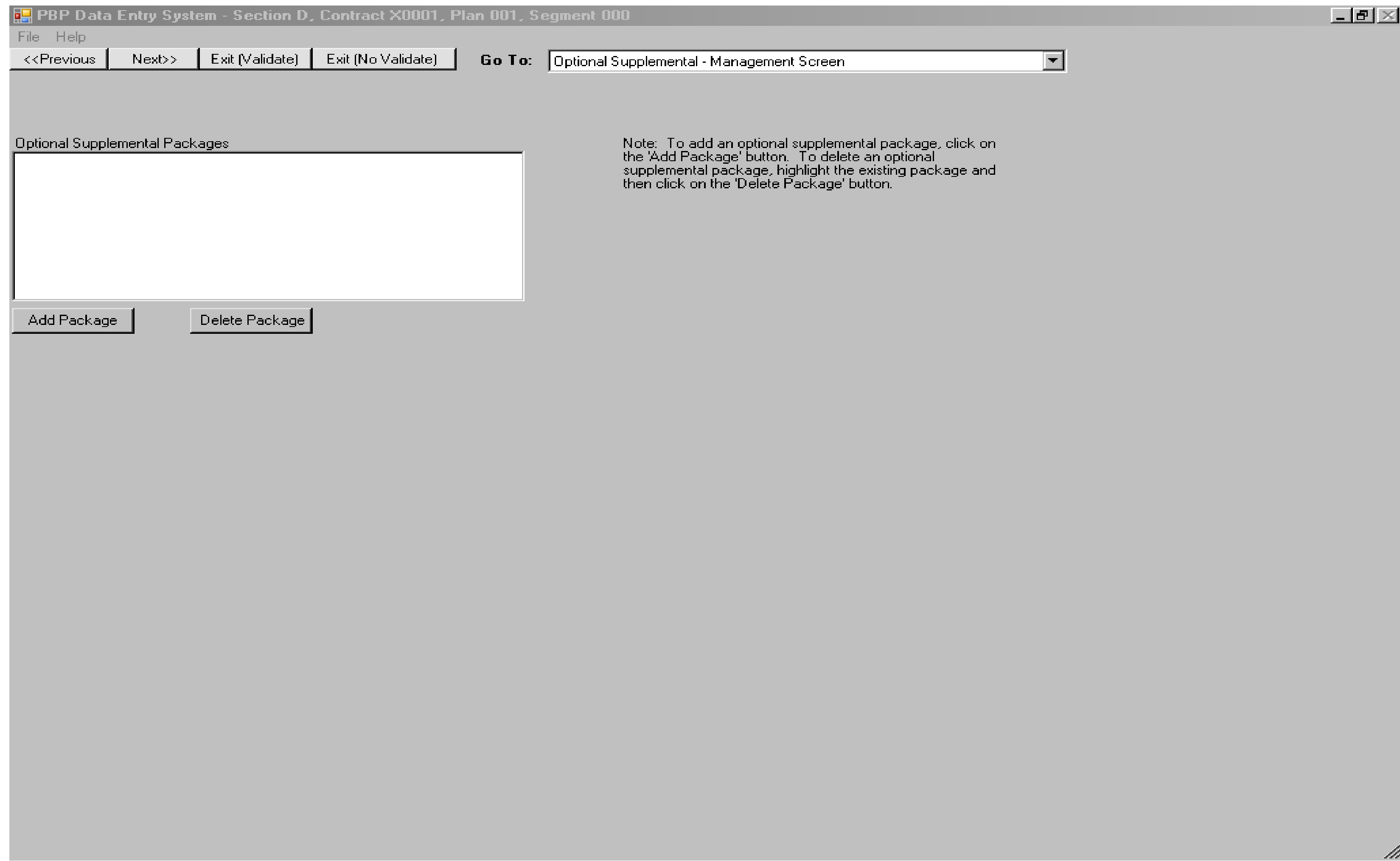
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

Notes (Optional):

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

Optional Supplemental – Management Screen



Optional Supplemental – Label and Premium

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

File Help

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

Optional Supplemental Benefits ID:

Optional Supplemental Package Description:

Indicate Optional Supplemental Premium Amount:

Is there a Maximum Plan Benefit Coverage Amount for this package?

- Yes
- No

Indicate Maximum Plan Benefit Coverage Amount for this package:

Select the Maximum Plan Benefit Coverage periodicity:

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

Is there an enrollee Deductible for this package?

- Yes
- No

Indicate Deductible Amount:

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

Notes:

Optional Supplemental – Service Categories

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 - POS 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 - POS 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.

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 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:

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:

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

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?
- Yes
- No

Indicate Coinsurance percentage:

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Step Up #10b Transportation 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 #10b Transportation Services - Base 3

Is there an enrollee Copayment?

- Yes
- No

Indicate Copayment amount per trip:

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

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

Is a referral required for Transportation Services?

- Yes
- No

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

Notes (Optional):

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

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

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:

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

Step Up #16a Preventive Dental – Base 4

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

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Go To: Step Up #16a Preventive Dental - Base 4

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- Yes
- No

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

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

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

Indicate Copayment amount for Office Visit:

Indicate Minimum Copayment amount for Oral Exams:

Indicate Maximum Copayment amount for Oral Exams:

Indicate Minimum Copayment amount for Prophylaxis (Cleaning):

Indicate Maximum Copayment amount for Prophylaxis (Cleaning):

Indicate Minimum Copayment amount for Fluoride Treatment:

Indicate Maximum Copayment amount for Fluoride Treatment:

Indicate Minimum Copayment amount for Dental X-Rays:

Indicate Maximum Copayment amount for Dental X-Rays:

Step Up #16a Preventive Dental – Base 5

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

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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):

Step Up #16b Comprehensive Dental – Base 1

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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

Is this benefit unlimited for Non-routine Services?

- Yes
- No, indicate number

Indicate number of visits for Non-routine Services:

Select the Non-routine Services periodicity:

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

Select type of benefit for Diagnostic Services:

- Mandatory
- Optional

Is this benefit unlimited for Diagnostic Services?

- Yes
- No, indicate number

Indicate number of visits for Diagnostic Services:

Select the Diagnostic Services periodicity:

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

Step Up #16b Comprehensive Dental – Base 2

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Select type of benefit for Restorative Services:
- Mandatory
- Optional

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

Indicate number of visits for Restorative Services:

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

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

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

Indicate number of visits for Endodontics/Peridontics/Extractions:

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

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

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

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

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

Step Up #16b Comprehensive Dental – Base 3

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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

Step Up #16b Comprehensive Dental – Base 4

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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:

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Step Up #16b Comprehensive Dental – Base 5

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Is there an enrollee Copayment?
- Yes
- No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Non-routine Services:

Indicate Maximum Copayment amount for Non-routine Services:

Indicate Minimum Copayment amount for Diagnostic Services:

Indicate Maximum Copayment amount for Diagnostic Services:

Indicate Minimum Copayment amount for Restorative Services:

Indicate Maximum Copayment amount for Restorative Services:

Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions:

Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions:

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

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

Step Up #16b Comprehensive Dental – Base 6

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

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

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

Is a referral required for Comprehensive Dental Services?

- ( ) Yes
- ( ) No

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

Notes (Optional):

Step Up #17a Eye Exams – Base 1

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CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Eye Exams as a supplemental benefit under Part C?
- Yes
- No

Select enhanced benefit:
- Routine Eye Exams

Select type of benefit for Routine Eye Exams:
- Mandatory
- Optional

Is this benefit unlimited for Routine Eye Exams?
- Yes
- No, indicate number

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Step Up #17a Eye Exams – Base 2

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Is there an enrollee Coinsurance?
- Yes
- No

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

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Eye Exams:

Indicate Maximum Coinsurance percentage for Routine Eye Exams:

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- Yes
- No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount per Routine Eye Exam:

Indicate Maximum Copayment amount per Routine Eye Exam:

Step Up #17a Eye Exams – Base 3

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

- Sometimes, describe
- No

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

- Yes
- No

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

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

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

- Yes
- No

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

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

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

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

Is a referral required for 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):

Step Up #17b Eyewear – Base 1

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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

Step Up #17b Eyewear – Base 2

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Select type of benefit for Eyeglass lenses:
- Mandatory
- Optional

Is this benefit unlimited for Eyeglass lenses?
- Yes
- No, indicate number

Indicate quantity (number of pairs) for Eyeglass lenses:

Select Eyeglass lenses periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Select type of benefit for Eyeglass frames:
- Mandatory
- Optional

Is this benefit unlimited for Eyeglass frames?
- Yes
- No, indicate number

Indicate quantity for Eyeglass frames:

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

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Step Up #17b Eyewear – Base 3

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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

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Step Up #17b Eyewear – Base 4

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

Select the Maximum Enrollee Out-of-Pocket Cost type:
- Covered under Eye Exams Category 17a
- Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?
- Yes
- No

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

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:

Step Up #17b Eyewear – Base 5

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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:

Step Up #17b Eyewear – Base 6

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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 Eyewear?

- ( ) Yes
- ( ) No

Eyewear Notes

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

Notes (Optional):

Step Up #18a Hearing Exams – Base 1

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

CLICK FOR DESCRIPTION OF BENEFIT

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

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

- Yes
- No

Select enhanced benefits:

- Routine Hearing Exams
- Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Exams:

- Mandatory
- Optional

Is this benefit unlimited for Routine Hearing Exams?

- Yes
- No, indicate number

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

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

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

- Mandatory
- Optional

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

- Yes
- No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

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

Step Up #18a Hearing Exams – Base 2

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?
- Yes
- No

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

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Hearing Exams:

Indicate Maximum Coinsurance percentage for Routine Hearing Exams:

Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

Step Up #18a Hearing Exams – Base 3

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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

Step Up #18a Hearing Exams – Base 4

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Hearing Exams Notes

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

Notes (Optional):

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Step Up #18b Hearing Aids – Base 1

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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

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Step Up #18b Hearing Aids – Base 2

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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

Step Up #18b Hearing Aids – Base 3

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

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?
- Yes
- No

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

Indicate Coinsurance percentage for Hearing Aids (all types):

Indicate Coinsurance percentage for Hearing Aids - Inner Ear:

Indicate Coinsurance percentage for Hearing Aids - Outer Ear:

Indicate Coinsurance percentage for Hearing Aids - Over the Ear:

Step Up #18b Hearing Aids – Base 4

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

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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:

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

Step Up #18b Hearing Aids – Base 5

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

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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):

Step Up #7b Chiropractic Services – Base 1

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

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CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?
- Yes
- No

Select enhanced benefit:
- Routine Care

Select type of benefit for Routine Care:
- Mandatory
- Optional

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

Indicate number of visits for Routine Care:

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Step Up #7b Chiropractic Services – Base 2

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

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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:

Step Up #7b Chiropractic Services – Base 3

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

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Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- Yes
- No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount per visit for Routine Care:

Indicate Maximum Copayment amount per visit for Routine Care:

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

Is a referral required for Chiropractic Services?
- Yes
- No

Step Up #7b Chiropractic Services – Base 4

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Chiropractic Services Notes

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

Notes (Optional):

Step Up #7f Podiatry Services – Base 1

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CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Podiatry Services as a supplemental benefit under Part C?
- Yes
- No

Select enhanced benefits:
- Routine Footcare

Select type of benefit for Routine Footcare:
- Mandatory
- Optional

Is this benefit unlimited for Routine Footcare?
- Yes
- No

Indicate number of Routine Footcare visits:

Select the Routine Footcare periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Step Up #7f Podiatry Services – Base 2

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Is there an enrollee Coinsurance?
- Yes
- No

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

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Footcare:

Indicate Maximum Coinsurance percentage for Routine Footcare:

Is there an enrollee Copayment?
- Yes
- No

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

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

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

Indicate Minimum Copayment amount per visit for Routine Footcare:

Indicate Maximum Copayment amount per visit for Routine Footcare:

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Step Up #7f Podiatry Services – Base 3

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

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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):