PBP Data Entry System - Section B-1, Contract X000	01, Plan 001, Segment 000	
Eile Help	Go To: #1a Inpatient Hospital-Acute - Base 1	
Previous Next (Validate) Vali	Co To: #1a Inpatient Hospital-Acute - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Non-Medicare-covered stay:	
Does the plan provide Inpatient Hospital-Acute Services a supplemental benefit under Part C?	as a C Mandatory C Optional	
C Yes C No	Select type of benefit for Upgrades:	
Select enhanced benefits:	C Mandatory C Optional	
Non-Medicare-covered Stay		
Select type of benefit for Additional Days:		
C Mandatory C Optional		
Is this benefit unlimited for Additional Days?		
C Yes C No, indicate number		
Indicate number of Additional Days per benefit period		

Previous Next
Maximum Plan Benefit Covera- s there a service-specific Max C Yes No Indicate the Maximum Enroll Every three years Every two years Every two years Every six months Every six months Every six months Every six months Every Stay Other, Describe Does this plan's costsharing viare? Yes No How many cost sharing tie What is your lowest cost ti C Tier 1 C Tier 2 C Tier 3 What is your invest cost ti Original Medicare Annual Other, describe

🖳 PBP Data Ent	ry System - S	Section B-1, Contract	X0001, Plan	001, Segm	ent 000	
<u>F</u> ile <u>H</u> elp						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1a Inpatient Hospital-Acute - Base 3	•
		e Cost Sharing for Tie			Medicare-covered Coinsurance Cost Sharing for Tier 3:	
		lefined cost shares? (ed to the enrollee in the			Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
C Yes C No					O Yes O No	
					U NO	
Indicate Coir	nsurance per	centage for the Medica	re-covered s	stay:	Indicate Coinsurance percentage for the Medicare-covered stay:	
Indicate the	number of day	y intervals for the Medi	icare-covere	d stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No C One	Coinsurance	e per Day)			C Zero (No Coinsurance per Day)	
O Two					O Two	
C Three					C Three	
		percentage and day int .g., 1 to 30; 31 to 90):	terval(s) for t	he	Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):	
Coinsurance	% Interval 1	Begin Day Interval 1	End Day	nterval 1:	Coinsurance % Interval 1 Begin Day Interval 1 End Day Interval 1:	
Coinsurance	% Interval 2	Begin Day Interval 2	End Day I	nterval 2:	Coinsurance % Interval 2 Begin Day Interval 2 End Day Interval 2:	
Coinsurance	% Interval 3	Begin Day Interval 3	End Day	nterval 3:	Coinsurance % Interval 3 Begin Day Interval 3 End Day Interval 3:	

Medicare-covered Life Time Reserve Days Tier 1 Medicare-covered Life Time Reserve Days Tier 2 Medicare-covered Life Time Reserve Days Tier 3 Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: C Zero (No Coinsurance per Day) C One C Two C Three C Zero (No Coinsurance per Day) C One C Two C Three C Zero (No Coinsurance per Day) C One C Two C Three C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Interval Days Interval Days Interval Days Interval Days Interval Days Interval Days Interval 1: Interval 1: Interval 2: Interval 2: Interval 2: Interval 3: Interval 3: Interval 3: Interval 3:
C Two C Two C Two C Two C Three Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Interval Days Interval Days Interval Days Interval Days Coinsurance % Begin Day End Day Coinsurance % Begin Day Interval Days Interval 1: Interval 1: Interval 1: Interval 1: Interval 2: Interval 2: Interval 2: Interval 2: Interval 2: Interval 2:
Coinsurance % Begin Day End Day Coinsurance % Begin Day End Day Coinsurance % Begin Day End Day Interval 1: Interval 1
Interval 2: Interv

	System	- Section B-1, Contra	ct X0001, Plan	001, Segn	gment 000	0
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	o: #1a Inpatient Hospital-Acute - Base 5	
dicate the numbe	r of dav i	ntervals for Additional	Davs:			
Zero (No Coins One Two Three						
ndicate the coins Days (enter "999"	urancep if unlimit	ercentage and day inte ed days are offered; e	rval(s)for Addi g., 91 to 999):	tional		
Coinsurance % In	terval 1	Begin Day Interval 1:	End Day Inter	val 1:		
Coinsurance % In	terval 2	Begin Day Interval 2:	End Day Inter	val 2:		
oinsurance % In	terval 3	Begin Day Interval 3:	End Day Inter	val 3:		

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1a Inpatient Hospita	II-Acute - Base 6		<u>·</u>
		the Non-Medicare- ture for the Medicare						
Yes No								
dicate Coinsur	ance percent	age for the Non-Med	icare-covered	l stay:				
	-	ervals for the Non-M	edicare-cove	red stay:				
Zero (No Co One Two	insurance pe	r Day)						
Three								
Medicare-cove 1 to 999):	ed stay (ente	centage and day inte r "999" if unlimited d egin Day Interval 1:	ays are offere	d; e.g.;				
Coinsurance %	Interval 2 B	egin Day Interval 2:	End Day Inte	erval 2:				
Coinsurance %	Interval 3 B	egin Day Interval 3:	End Day Inte	erval 3:				
ndicate Coinsu	rance percen	tage for Upgrades:						

Previous	Next (Validate)	Exit (No Validate)	Go To: #1a Inpatient Hospital-Acute - Base 7
	Amount for Tier 1: Amount for Tier 2: Amount for Tier 3:		t Medicare-covered Copayment Cost Sharing for Tier 1: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrolleein the inpatient facility.) C Yes No Indicate Copayment amount for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Copayment per Day) C One C Two Indicate the copayment amount and day interval(s) for the Medicare-covered stay: C Two C Three Indicate the copayment amount and day interval(s) for the Medicare-covered stay: C Two C Three Indicate the copayment amount and day interval(s) for the Medicare-covered stay: Dease view the variable help. Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 2: End Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3: End Day Interval 3:

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<u>File H</u> elp Previous Next (Validate) Go To Exit (No Validate)	o: #1a Inpatient Hospital-Acute - Base 8	
Medicare-covered Copayment Cost Sharing for Tier 2: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.) C Yes C No	Medicare-covered Copayment Cost Sharing for Tier 3: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.) C Yes C No	
Indicate Copayment amount for the Medicare-covered stay:	Indicate Copayment amount for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Copayment per Day) C One C Two C Three	C 2ero (No Copayment per Day) C One C Two C Three	
Indicate the copayment amount and day interval(s) for the Medicare- covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help. Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help. Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	
Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	

Previous Nex	t (Valid	t Exit	Go (No date)	To: #1a Inpatier	nt Hospital-Aci	ite - Base 9			•		
Medicare-covered Life Tim Indicate the number of day covered Lifetime Reserve [intervals for the		Indicate the	overed Life Time F number of day int etime Reserve Day	tervals for the		Medicare-covered Life Time Reserve Days Tier 3 Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:				
C Zero (No Copaymentp C One C Two C Three	er Day)		C Zero (N C One C Two C Three	o Copaymentper	Day)		C Zero (No Copayment per Day) C One C Two C Three				
Indicate the copayment am the 60 Medicare-covered L				copayment amou care-covered Life				opayment amount are-covered Lifetir			
	Interva	Days			Interval	Days			Interva	I Days	
Copay Amount	Begin Day	End Day		Copay Amount	Begin Day	End Day		Copay Amount	Begin Day	End Day	
Interval 1:			Interval 1:				Interval 1:				
Interval 2:			Interval 2:				Interval 2:	[]			
Interval 3:			Interval 3:				Interval 3:				

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1a Inpatient Hospital-Acute - Base 10
dicate the numb	o <mark>er of day i</mark> r	ntervals for Additional [Days:		
Zero (No Cop One Two	paymentpe	r Day)			
Three					
dicate the copa inter "999" if unli	yment amo mited days	unt and day interval(s) are offered; e.g., 91 to	for Additiona 999):	al Days	
opayment Amt	Interval 1	Begin Day Interval 1:	End Day	interval 1:	
opayment Amt	Interval 2	Begin Day Interval 2:	End Day	nterval 2:	
opayment Amt I	interval 3	Begin Day Interval 3:	End Day	nterval 3:	

ile <u>H</u> elp					
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1a Inpatient Hospital-Acute - Base 11
		the Non-Medicare-co e Medicare-covered s		he same as	Indicate Copayment amount for Upgrades per stay:
ີ Yes ີ No					Indicate Copayment amount for Upgrades per day:
ndicate Copayı	ment amount f	or the Non-Medicare	-covered stay	γ:	
					Enrollee must receive Authorization from one or more of the following:
		ervals for the Non-M	edicare-cove	ered stay:	Primary Care Physician (Internist/Family Practice, General Practice)
C Zero (No Co C One C Two C Three	opaymentper	Dayj			Physician Specialist Organization Medical Director/Utilization Management/Utilization Revie Other, describe
covered stay (enter "999" if i	unt and day interval(s unlimited days are of Begin Day Interval 1:	fered; e.g.; 1	to 999):	
Copayment An	nt Interval 2	Begin Day Interval 2:	End Day Ir	nterval 2:	
Copayment An	nt Interval 3	Begin Day Interval 3:	End Day Ir	nterval 3:	

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #1a Inpatient Hospital-Acute - Base 12	
	red for Inpatie	ent Hospital - Acute	Services	Inpatient Hospital - Acute Notes	
Yes No				Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
				Notes:	
				*	
				· ·	

File Help Or To: #1a Inpatient Hospital-Acute (B Only) - Base 1 Click FOR DESCRIPTION OF BENEFIT Do you offer Inpatient Hospital - Acute Services as a benefit? Is there a service-specific Maximum Plan Benefit Coverage amoun C Yes No Indicate Maximum Plan Benefit Coverage amount: Select type of benefit for Inpatient Hospital - Acute Services: Select Maximum Plan Benefit Coverage amount: C Mandatory Select Maximum Plan Benefit Coverage periodicity: Select Maximum Plan Benefit Coverage periodicity: Does this benefit have unlimited days? Select Maximum Plan Benefit Coverage periodicity: Select Maximum Plan Benefit Coverage periodicity:
CLICK FOR DESCRIPTION OF BENEFIT C Yes Do you offer Inpatient Hospital - Acute Services as a benefit? C Yes C Yes No Indicate Maximum Plan Benefit Coverage amount: Indicate Maximum Plan Benefit Coverage periodicity: Select type of benefit for Inpatient Hospital - Acute Services: Select Maximum Plan Benefit Coverage periodicity: C Mandatory Select Maximum Plan Benefit Coverage periodicity: C Optional C Every three years Does this benefit have unlimited days? C Every two years
C Yes C Every year No, indicate number C Every six months Indicate number of days per period: C Every three months C Every three months C Every Stay C Every year C Every year C Every year C Every year C Every three months C Every stay C Every year C Every year C Every three months C Every stay C Every three months C Every stay C Every Stay C Other, Describe

Previous Next (Validate) Go T	o: #1a Inpatient Hospital-Acute (B Only) - Base 2
s there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Indicate the Maximum Enrollee Out-of-Pocket Cost amount: Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every three months Every bar C Every Stay Other, Describe Is there an enrollee Coinsurance? Yes No Indicate Coinsurance percentage per stay:	Indicate the number of day intervals for the stay: Zero (No Coinsurance per Day) One Two Three Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999): Coinsurance % interval 1 Begin Day Interval 1: End Day Interval 1: Coinsurance % interval 2 Begin Day Interval 2: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:

	Go To: #1a Inpatient Hospital-Acute (B Only) - Base 3
s there an enrollee Deductible? Yes Indicate Deductible Amount: Is there an enrollee Copayment? Yes No	Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999): Copayment Amt Interval 1 Begin Day Interval 1: Copayment Amt Interval 2 Begin Day Interval 2: Copayment Amt Interval 3: End Day Interval 3:
Indicate Copayment amount per stay: Indicate the number of day intervals for the stay: C Zero (No Copayment per Day) C One C Two C Three	Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for Inpatient Hospital - Acute Services? C Yes C

e <u>H</u> elp		ction B-1, Contra									
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1a Inpatien	t Hospital-Acuti	e (B Only) - Bas	ie 4		•	
atient Hospita	- Acute Notes										
e may include	additional info	rmation to descril	be benefit in this	service ca	tegory. Do not	repeat informa	tion captured i	n data entry.			
es:											
									*		
									*		

Previous Next (Validate) Validate)	#1b Inpatient Hospital Psychiatric - Base 2
Previous Next (Validate) Validate) oes this plan's costsharing vary by hospital(s) in which an enrollee obtains are? Yes Yes No low many cost sharing tiers do you offer? Tier 1 Tier 2 Tier 3 Vhat is your inpatient hospital benefit period? Original Medicare Annual Other, describe Enter Other description for benefit period: there an enrollee Coinsurance? Yes No	Medicare-covered Coinsurance Cost Sharing for Tier 1: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.) C Yes No Indicate Coinsurance percentage for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay: Zero (No Coinsurance per Day) C One Two C Three Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30, 31 to 90): Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 2: End Day Interval 2: End Day Interval 3:

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Medicare-covered	l Coinsuranc	e Cost Sharing for T	lier 2:		Medicare-covered Coinsurance Cost Sharing for Tier 3:	
		efined cost shares? ed to the enrollee in t			Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
O Yes O No					C Yes C No	
Indicate Coin	surance perc	centage for the Medi	care-covered	stay:	Indicate Coinsurance percentage for the Medicare-covered stay:	
Indicate the r	umber of day	y intervals for the Me	edicare-covere	ed stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No C One C Two C Three	Coinsurance	⊧perDay)			 C Zero (No Coinsurance per Day) ○ One ○ Two ○ Three 	
		percentage and day a.g., 1 to 30; 31 to 90;		he	Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):	
Coinsurance	% Interval 1	Begin Day Interval	1: End Day	Interval 1:	Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
Coinsurance	% Interval 2	Begin Day Interval	2: End Day	Interval 2:	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
Coinsurance	% Interval 3	Begin Day Interval	3: End Day	Interval 3:	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	

File Help Previous Nex	t (Validat	Exit (No te) Validate)	Go To: #1b Inp	atient Hospital	Psychiatric - B	ase 4			•
Medicare-covered Life Tim ndicate the number of day Medicare-covered Lifetime C Zero (No Coinsurance C One C Two C Three ndicate the coinsurance p	intervals for the Reserve Days: per Day)	Inc Me C C C C	Jicare-covered Life T icate the number of c dicare-covered Lifeti Zero (No Coinsuran One Two Three icate the coinsurance	lay intervals f me Reserve D ice per Day)	or the Days:	Indicate th Medicare- C Zero (C One C Two C Three	covered Life Time ie number of day i covered Lifetime i No Coinsurance p e coinsurance pe	ntervals for th Reserve Days per Day)	1e ::
interval(s) for the 60 Medic Reserve Days (i.e., 1 - 60): Coinsurance %	Interval	Re	erval(s) for the 60 Me erve Days (i.e., 1 - 6 Coinsurance %	0): Inter	val Days		for the 60 Medica ays (i.e., 1 - 60): Coinsurance %	Interva	
Interval 1:		Inter	val 1: val 2: val 3:			Interval 1: Interval 2: Interval 3:			

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric - Base 5	
dicate the numb	er ofday i	ntervals for Additiona	Days:			
Zero (No Coir One Two Three						
ndicate the coir	surancep	ercentage and day inte ed days are offered; e	erval(s)for Add .g., 91 to 999):	tional		
		Begin Day Interval 1:		val 1:		
Coinsurance %	nterval 2	Begin Day Interval 2:	End Day Inte	val 2:		
oinsurance %	nterval 3	Begin Day Interval 3:	End Day Inte	val 3:		

	ry System -	Section B-1, Contrac	t X0001, Plan	001, Segn	nent 000	
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric - Base 6	•
the Coinsuranc ame as the Coin	e structure surance str	for the Non-Medicare- ucture for the Medicar	covered stay t e-covered sta	he v?		
Yes No						
ndicate Coinsur	ance perce	ntage for the Non-Mec	licare-covered	l stay:		
		ntervals for the Non-M	ledicare-cove	red stay:		
C Zero (No Co C One C Two C Three	insurance	ber Day)				
Indicate the coi	nsurance p red stay (er	ercentage and day int hter "999" if unlimited c	erval(s) for the lays are offere	Non- d; e.g.;		
Coinsurance %	Interval 1	Begin Day Interval 1:	End Day Inte	erval 1:		
Coinsurance %	Interval 2	Begin Day Interval 2:	End Day Inte	erval 2:		
Coinsurance %	Interval 3	Begin Day Interval 3:	End Day Inte	erval 3:		

File Help Previous N	Exit (Validate)	Exit (No Validate)	Go To: #1b Inpatient Hospital Psychiatric - Base 7
ffer a plan-specific de section D.	vice-specific deductible ductible, then enter the p		Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrolleein the inpatient facility.)
s there an enrollee De	ductible?		C Yes C No
O No	2025 2026 at		Indicate Copayment amount for the Medicare-covered stay:
Indicate Deductible A	mount for Tier 1:		Indicate the number of day intervals for the Medicare-covered stay:
Indicate Deductible A	mount for Tier 2:		C Zero (No Copayment per Day) C One C Two C Three
Indicate Deductible A	mount for Tier 3:		Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.
Is there an enrollee C	onsyment?		Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:
C Yes			Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:
C No			Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:

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Medicare-covered Do you charge the charges for all ser O Yes O No Indicate Copayn Indicate the numb O Zero (No Cop O One O Three Indicate the copay covered stay (e.g. share limitations p Copayment Amt In Copayment Amt In	d Copayme e Medicare vices provi ment amour er of day ir ayment per yment amour , 1 to 30; 3' nterval 1	Exit (Validate) Int Cost Sharing for T -defined cost shares ided to the enrollee in ht for the Medicare-co	Exit (No Validate)	re- il 1: al 1: al 2:	Medicare-covered Copayment Cost Sharing for Tier 3: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrolleein the inpatient facility.) Yes No Indicate Copayment amount for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered sta Zero (No Copayment per Day) One Two Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help. Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	

Interval 2: Interv	File Help Previo		Ð	cit Exi	K Go t (No date)	To: #1b Inpatien	it Hospital P	sychiatric - Base	9		•	
C One C One C One C Two C Two C Two C Two C Two C Three Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Interval Days Interval Day Copay Amount Begin Day End Day Copay Amount Begin Day End Day Interval 1: Interval 1: Interval 2:	ndicate the covered Life	e number of day etime Reserve	rintervals for th Days:		Indicate the covered Lif	e number of day int fetime Reserve Day	ervals for th		Indicate the r covered Lifet	number of day inter time Reserve Days	rvals for the I	
the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - Interval Days Interval Days Interval Days Interval Days Copay Amount Begin Day End Day Copay Amount Begin Day End Day Interval 1: Interval 1: Interval 1: Interval 1: Interval 2: Interval 2: Interval 2: Interval 2: Interval 2: Interval 2: Interval 2: Interval 2:	C One C Two C Three				C One C Two C Three				C One C Two C Three			
Copay Amount Begin Day End Day Copay Amount Begin Day Copay Amount Begin Day End Day Interval 1:					the 60 Med							
Interval 2: Interv	3	Copay Amount				Copay Amount		5		Copay Amount		
	Interval 1: Interval 2: Interval 3:				Interval 2:				Interval 2:			

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dicate the num	per of day in	ntervals for Additional E	Days:		
Cero (No Co) One Two Three	payment pe	r Day)			
ndicate the copa	yment amo	ount and day interval(s) s are offered; e.g., 91 to	for Additiona	l Days	
Copayment Amt		Begin Day Interval 1:		nterval 1:	
opayment Amt	Interval 2	Begin Day Interval 2:	End Day In	nterval 2:	
opayment Amt	Interval 3	Begin Day Interval 3:	End Day In	nterval 3:	

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		the Non-Medicare-co e Medicare-covered s		hesame as	Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice)	
	nent amount	for the Non-Medicare	-covered stay	r:	Physician Specialist Organization Medical Director/Utilization Management/Utilization Revie Other, describe Is a referral required for Inpatient Psychiatric Hospital Services?	
C Zero (No Co C One C Two		tervals for the Non-M Day)	edicare-cove	red stay:	C Yes C No	
covered stay (enter "999" if	ount and day interval(s unlimited days are off Begin Day Interval 1:	fered; e.g.; 1	to 999):		
		Begin Day Interval 2:				
Copayment An	nt Interval 3	Begin Day Interval 3:	End Day In	terval 3:		

le <u>H</u> elp							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric - Base 12	•	
atient Psychia	ric Hospital N	otes					
te may include	additional info	ormation to descril	be benefit in this	service cate	tegory. Do not repeat information captured in data e	entry.	
tes:							
						*	
						-	

Help	01, Segment 000
	Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 1
	Is there a service-specific Maximum Plan Benefit Coverage amount? Yes No Select the Maximum Plan Benefit Coverage type: Covered under Inpatient Hospital Services Category 1a Plan-specified amount per period Indicate Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage periodicity: Every three years Every two years Every six months Every Stay Other, Describe

ile <u>H</u> elp					
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric (B Only) - Base 2
there a service	-specific Maxi	mum Enrollee Out-	of-Pocket Cost	,	
Yes No					
Select the Maxir	num Enrollee	Out-of-Pocket Cos	t type:		
Covered un Plan-specifi		ent Hospital Servic r period	es Category 1a		
Indicate Maxim	um Enrollee (Dut-of-Pocket Cost	amount:		
Select the Max	ximum Enrolle	e Out-of-Pocket C	ost periodicity:		
C Every thre					
C Every two C Every yea					
C Every six					
C Every thre	ee months				
C Every Ber	efit Period				
C Every Sta	y				
C Other, De	scribe				

Previous Next	Exit Exit (No (Validate) Validate	Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 3
there an enrollee Coinsuran Yes No <u>dicate</u> Coinsurance percen dicate the number of day in Zero (No Coinsurance pe One Two Three	tage per stay: tervals for the stay:	Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999): Coinsurance % Interval 1 Begin Day Interval 1: Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:

Previous Next (Validate)	Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 4
there an enrollee Deductible? Yes No Indicate Deductible Amount: Yes No Indicate Copayment amount per stay: C Zero (No Copayment per Day) C One C Two C Three	Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999): Copayment Amt Interval 1 Begin Day Interval 1: Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3: Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for Inpatient Psychiatric Hospital Services? Yes No

e <u>H</u> elp							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric (B Only) - Base 5		
atient Psychiat	ric Hospital N	oter					
allent Fsychiat	neriospitariti						
te may include a	additional info	ormation to descril	be benefit in this	service cate	tegory. Do not repeat information captured in data entr	γ.	
tes:						100	
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#2 SNF – Base 1

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segme	ent 000
	#2 SNF - Base 1
Previous Next (Validate) Validate)	
CLICK FOR DESCRIPTION OF BENEFIT	Do you allow less than 3 day inpatient hospital stay prior to SNF admission? C Yes
nefit under Part C? Yes No	C No Indicate the Number of Hospital Days Required Prior to SNF
Select enhanced benefits: Additional days beyond Medicare-covered Non-Medicare-covered stay	Admission (0-2): C Zero C One C Two
Select type of benefit for Additional Days beyond Medicare-covered: C Mandatory C Optional	Maximum Plan Benefit Coverage is not applicable for this Service Category.
Is this benefit unlimited for Additional Days?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
C Yes C No, indicate number	C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Indicate the number of Additional Days beyond Medicare-covered per benefit period:	Select the Maximum Enrollee Out-of-Pocket Cost and unit.
Select type of benefit for the Non-Medicare-covered stay:	C Every three years C Every two years C Every year
C Mandatory C Optional	C Every year C Every six months C Every three months C Every Stay C Other, Describe

#2 SNF – Base 2

Previous Next Exit (No Validate) Does this plan's costsharing vary by hospital(s) in which an enrollee obtains: are? Is there an enrollee Coinsurance? Object Yes Is there an enrollee Coinsurance Cost Sharing for Tier 1: No How may costsharing tiers do you offer? Is there an enrollee Coinsurance Cost Sharing for Tier 1: Do you charge the Medicare-defined costshares? (These are the total charges for all services provided to the enrollee in the SNF.) Tier 1 Original Medicare C annual Indicate the number of day intervals for the Medicare-covered stay: Indicate the coinsurance percentage for the Medicare-covered stay: Indicate the coinsurance percentage and day interval(s) for Medicare- covered stay (e.g.; 110 20; 21 to 100): C originary cost sharing the val 1: Begin Day Interval 2: Coinsurance % Interval 2: Begin Day Interval 3: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:		#2 SNF - Base 2
care? C Yes C No Medicare-covered Coinsurance Cost Sharing for Tier 1: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.) C Tier 1 C Yes C Tier 2 No What is your inpatient hospital benefit period? C Yes C Original Medicare Indicate Coinsurance percentage for the Medicare-covered stay: C Annual C Zero (No Coinsurance per Day) C Other, description for benefit period: C Two Enter Other description for benefit period: C Two C Three Indicate the coinsurance percentage and day interval(s) for Medicare-covered stay (e.g., 1 to 20, 21 to 100); Coinsurance % Interval 1: Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 2: Begin Day Interval 2:		
How many cost sharing tiers do you offer? Medicare-covered Coinsurance Cost Sharing for Tier 1: What is your lowest cost tier? Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.) C Tier 1 C Tier 2 Indicate Coinsurance percentage for the Medicare-covered stay: What is yourinpatient hospital benefit period? C Original Medicare C Annual C Other, description for benefit period: C Two C Two Indicate the coinsurance percentage and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): Coinsurance % Interval 1: End Day Interval 1: Coinsurance % Interval 2: End Day Interval 2:	are? C Yes	C Yes
C Tier 2 C Tier 3 Matis yourinpatient hospital benefit period? C Original Medicare C Annual C Other, describe Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): Coinsurance % Interval 1: Begin Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	How many cost sharing tiers do you offer?	Do you charge the Medicare-defined cost shares? (These are the
C Original Medicare C Annual C Other, describe Enter Other description for benefit period: C Two Two C Three Indicate the coinsurance percentage and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): Coinsurance % Interval 1: End Day Interval 1: Coinsurance % Interval 2: End Day Interval 2:	C Tier 2 C Tier 3	C No
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	C Original Medicare C Annual C Other, describe	C Zero (No Coinsurance per Day) C One C Two
Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3:		covered stay (e.g.; 1 to 20; 21 to 100): Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:
		Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

#2 SNF – Base 3

🖳 PBP Data Entry System - Section B-2, Contra	ct X0001, Plan 001, Segment	t 000
Eile Help Previous Next (Validate)	Go To: Exit (No Validate)	2 SNF - Base 3
Medicare-covered Coinsurance Cost Sharing for Do you charge the Medicare-defined cost shares? total charges for all services provided to the enrol C Yes C No Indicate Coinsurance percentage for the Medicare	? (These are the ee in the SNF.)	Medicare-covered Coinsurance Cost Sharing for Tier 3: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.) Yes No Indicate Coinsurance percentage for the Medicare-covered stay:
Indicate the number of day intervals for the Medica C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day inter covered stay (e.g.; 1 to 20; 21 to 100):		Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Coinsurance per Day) C One C Two C Two C Three Indicate the coinsurance percentage and day interval(s) for Medicare- covered stay (e.g.; 1 to 20; 21 to 100):
Coinsurance % Interval 1: Begin Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2:	End Day Interval 1: End Day Interval 2:	Coinsurance % Interval 1: Begin Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: Coinsurance % Interval 2: End Day Interval 2:
Coinsurance % Interval 3: Begin Day Interval 3:	End Day Interval 3:	Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

File Hep Previous Next Exit (No Validate So To: #2.5MF-Base4
Zero (No Coinsurance per Day) One Two Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999): Coinsurance % Interval 1: End Day Interval 1: Coinsurance % Interval 2: End Day Interval 2: Coinsurance % Interval 2: End Day Interval 2:
One Two Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999): Coinsurance % Interval 1: End Day Interval 1: Coinsurance % Interval 2: End Day Interval 2:
C Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999): Coinsurance % Interval 1: End Day Interval 1: Coinsurance % Interval 2: End Day Interval 2: Coinsurance % Interval 2: End Day Interval 2:
Days (enter "999" if unlimited days are offered; e.g., 101 to 999): Coinsurance % Interval 1: End Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:
Coinsurance % Interval 2: End Day Interval 2: End Day Interval 2:
Coinsurance % Interval 3: End Day Interval 3:

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment (000
Eile Help Previous Next (Validate) Go To: 2 Exit Exit (No Validate)	SNF - Base 5
Previous Next Exit (Validate) Exit (No Validate) s the Coinsurance structure for the Non-Medicare-covered stay the same as he Coinsurance structure for the Medicare-covered stay? S Yes S S No S S Indicate Coinsurance percentage for the Non-Medicare-covered stay: S Indicate the number of day intervals for the Non-Medicare-covered stay: S C Zero (No Coinsurance percentage for the Non-Medicare-covered stay: S C Zero (No Coinsurance percentage and day interval(s) for the Non-Medicare-covered stay: S Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g., 1 to 9 Coinsurance % Interval 1: End Day Interval 1: End Day Interval 1: End Day Interval 1: Coinsurance % Interval 2: End Day Interval 2:	Is there an enrollee Deductible? Yes No Indicate Deductible Amount Tier 1: Indicate Deductible Amount Tier 2: Indicate Deductible Amount Tier 3:
Coinsurance % Interval 3: End Day Interval 3:	

🖳 PBP Data Ent	ry System - Se	ection B-2, Contrac	t X0001, Plan	001, Segn	nent 000
File Help	Next	Exit (Validate)	X Exit (No Validate)	Go To:	#2 SNF - Base 6
Is there an enroll C Yes No Medicare-covered Do you charge ti charges for all so C Yes No Indicate Copayn Indicate the num C Zero (No Co C One C Two C Three Indicate the cop stay (e.g.; 1 to 2 limitations pleas Copayment Amt	ee Copayment d Copayment (ne Medicare-d ervices provid ment amount fo ber of day into the of day into the of day into the of day into the of day into the of day into the of	Exit (Validate) (Validate) Cost Sharing for Tie lefined cost shares? led to the enrollee in or Medicare-covered ervals for the Medici Day) nt and day interval(s For more informatio	Exit (No Validate)	tay: -covered re erval 1:	Medicare-covered Copayment Cost Sharing for Tier 2: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.) Yes No Indicate Copayment amount for Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay: Cero (No Copayment per Day) O ne Three Indicate the copayment amount and day interval(s) for Medicare-covered stay: Copayment Amount and day interval 1: Endicate the copayment amount and pay interval 1: Endicate the copayment amount and pay interval 1: Endicate the copayment amount and pay interval 1: End Day Interval 1: Copayment Amt Interval 1 Begin Day Interval 2: End Day Interval 2:
Copayment Amt	Interval 3 Be	egin Day Interval 3:	End Day Int	erval 3:	Copayment Amt Interval 3 Begin Day Interval 3:

	Previous Ne	Exit xt (Validate)	Exit (No Validate)	o To:	#2 SNF - Base 7
C One C Two C Two C Three Indicate the copayment amount and day interval (s) for Medicare-covered Indicate the copayment amount and day interval (s) for Medicare-covered Indicate the copayment Amt Interval 3 Begin Day Interval 3: Copayment Amt Interval 2 Begin Day Interval 1: Copayment Amt Interval 2 Begin Day Interval 2: Copayment Amt Interval 2 Begin Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: Copayment Amt Interval 2 Begin Day Interval 2: Copayment Amt Interval 2 Begin Day Interval 2: Copayment Amt Interval 2 Begin Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: Copayment Amt Interval 4 Begin Day Interval 2: Copayment Amt Interval 4 Begin Day Interval 4 Begin Day Interval 5 Begin Day Inte	Do you charge the Medic harges for all services p Yes No Indicate Copayment am	are-defined cost shares? rovided to the enrollee in ount for Medicare-covere ay intervals for the Medic	(These are the tota the SNF.) d stay:	J	C Zero (No Copayment per Day) C One C Two C Three Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999):
Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	C One C Two C Three Indicate the copayment stay (e.g.; 1 to 20; 21 to limitations please view t	amount and day interval(s 100): For more informatic ne variable help.	n on costshare		

the Copayment structure for the Non-Medicare-covered stay? Yes No Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for SNF Services? Care (No Copayment amount and day intervals for the Non-Medicare-covered stay: One Two Care (No Copayment amount and day interval(s) for the Non-Medicare-covered stay: Indicate the copayment amount and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999); Copayment Amt Interval 1 Begin Day Interval 2: End Day Interval 3: End Day Interval 3: End Day Interval 3:	Previous Next	Exit (Validate)	Exit (No Validate)	Fo: #2 SNF - Base 8	
Zero (No Copayment per Day) One Two Three Indicate the copayment amount and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999): Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 2: End Day Interval 2: Copayment Amt Interval 2 End Day Interval 2:	e Copayment structure for th Yes No ndicate Copayment amount	e Medicare-covered	stay? vered stay:	None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for SNF Services? Yes	
	One Two Three Indicate the copayment amo covered stay (enter "999" if	ount and day interval(unlimited days are of	fered; e.g.; 1 to 999):	ure-	

e <u>H</u> elp Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #2 SNF - Base 9	
F Notes					
te may include	additional info	ormation to descri	be benefit in this	service category. Do not repeat information captured in da	ata entry.
es:					
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Previous Next (Validate)	Go To: #2 SNF (B Only) - Base 1
LICK FOR DESCRIPTION OF BENEFIT	Is a hospital stay required before admission to a SNF?
you offer SNF Care as a benefit?	C Yes C No
Yes No	Indicate number of days required for hospital sta
elect type of benefit for SNF Care:	
Optional	Is there a service-specific Maximum Plan Benefit Coverage amount?
bes this benefit have unlimited days?	C Yes C No
No, indicate number	Indicate Maximum Plan Benefit Coverage amoun
ndicate number of days per period:	
Select the days periodicity:	Select Maximum Plan Benefit Coverage periodicity:
C Every three years C Every two years	○ Every three years ○ Every two years
C Every year	C Every year
C Every six months	C Every six months C Every three months
C Every three months	C Every Stay
C Every Stay C Other, Describe	C Other, Describe

File Help Previous Next Exit (No Vest Validate V yes Indicate the number of day intervals for the stay: Vest Consurance perDay) Indicate amount for Maximum Enrollee Out-of-Pocket Cost Indicate the consurance percentage and day intervals (s) for the stay: Select the Maximum Enrollee Out-of-Pocket Cost Indicate the consurance percentage and day interval (s) for the stay (ener "999" if unlimited days are offered, e.g.; 1 to 999): Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every three years Consurance % interval 1 Begin Day interval 2: Every star (bery three years) Coinsurance % interval 2 Begin Day interval 2: Coinsurance % interval 3 Begin Day interval 3: End Day interval 3: Every star Coinsurance % interval 3 Begin Day interval 3: Coinsurance % interval 3 Begin Day interval 3: End Day interval 3: Maidate Coinsurance percentage: Not for the star (the provide coinsurance) Not for the star (the provide coinsurance)	PBP Data Entry System - Section B-2, Contract X0001, Plan	001, Segment 000
C Yes C Zero (No Coinsurance per Day) C No One Indicate amount for Maximum Enrollee Out-of-Pocket Cost: C Two Indicate the Maximum Enrollee Out-of-Pocket Cost: Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g.; 1 to 999): Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Coinsurance % Interval 1 Begin Day Interval 1: C Every three years Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1: C Every three months Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2: C Every Stay Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Is there an enrollee Coinsurance? Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	Exit Exit (No	Go To: #2 SNF (B.Only) - Base 2
	Previous Next (Validate) Validate) is there a service-specific Maximum Enrollee Out-of-Pocket Cost? ? Yes No Indicate amount for Maximum Enrollee Out-of-Pocket Cost? Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every three years C Every six months C Every six months C Every stay O Other, Describe is there an enrollee Coinsurance? C Yes No	C Zero (No Coinsurance per Day) O One Two Two Three Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g.; 1 to 999): Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #2 SNF (B Only) - Base 3
there an enroll	ee Deductible?	ų.		Indicate the copayment amount and day interval(s) for the stay (enter
Yes				"999" if unlimited days are offered; e.g., 1 to 999):
No				Copayment Amt Interval 1_Begin Day Interval 1: End Day Interval 1:
Indicate Deduct	ible Amount:			
indicate Decide				
				Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:
there an enroll	ee Copayment	?		
Yes				Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:
No				
C One C Two C Three				

rollee must receive Authorization from one or more of the following:	le <u>H</u> elp											
None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Ireferral required for SNF Services? Yes No te may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	Previous	Next	Exit	Exit (No Validate)	Go To:	#2 SNF ((B Only) - Base 4				•	
None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Ireferral required for SNF Services? Yes No te may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	rollee must rece	eive Authoriza	tion from one or m	ore of the follow	vina:							
Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe I referral required for SNF Services? Yes No te may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	None											
Organization Medical Director/Utilization Management/Utilization Review Other, describe I referral required for SNF Services? Yes No te may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.			ernist/Family Pract	ice, General Pra	actice)							
Other, describe I referral required for SNF Services? Yes No te may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.				1.0.14717								
referral required for SNF Services? Yes No te may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.			or/Utilization Mana	igement/Utilizat	ion Review							
Yes No te may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.			aniasa 2									
No te may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.		EQ TOT SINE SE	ervices									
te may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	Yes No											
					190310-110	11.7.1.5.1			7.0.000	000000	10	
es:	ote may include a	additional inf	ormation to descri	be benefit in this	service ca	tegory. Do	not repeat infor	mation captu	red in data	a entry.		
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#3 Cardiac and Pulmonary Rehabilitation Services – Base 1

File Help Previous Next Exit (No Validate) Go To: #2 Cardiac and Pulmonary Rehabilitation Services - Base 1 CUCK FOR DESCRIPTION OF BENEFIT Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services as a supplemental benefit under Part C? Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services C Yes Indicate number of visits for Additional Intensive Cardiac Rehabilitation Services Additional Cardiac Rehabilitation Services Indicate number of visits for Additional Intensive Cardiac Rehabilitation Services C Yes Select the Additional Cardiac Rehabilitation Services? C Yes Select the Additional Cardiac Rehabilitation Services? Mandatory Every two years C Yes Select the Additional Cardiac Rehabilitation Services periodicity: Mice a number Select the Additional Cardiac Rehabilitation Services periodicity: C Yes Cotter, Describe Select the Additional Cardiac Rehabilitation Services periodicity: Mandatory C Yes Other, Describe Select the Additional Cardiac Rehabilitation Services periodicity: Yes C Yery three years Select the Additional Pulmonary Rehabilitation Services: C No, Indicate number Select the Additional Pulmonary	9 PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segmen	it 000	
Previous Next Exit No Validate) Previous Next Exit No Validate) CLICK FOR DESCRIPTION OF BENEFIT	File Help		
Dest he plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C? Yes Or Yes No, indicate number Select enhanced benefit: Additional Cardiac Rehabilitation Services Additional Cardiac Rehabilitation Services Select the Additional Intensive Cardiac Rehabilitation Services Additional Pulmonary Rehabilitation Services Select the Additional Intensive Cardiac Rehabilitation Services C Mandatory Every three years C Pointal Select the Additional Cardiac Rehabilitation Services? Indicate number Every three months C Yes Select the Additional Cardiac Rehabilitation Services? C Yes C Every three months C No, indicate number Select the Additional Cardiac Rehabilitation Services? Select the Additional Cardiac Rehabilitation Services? C Wary three years C Every three wars C Every three months C Every three wars C Every three months C Every three works C Other, Describe Select the Additional Cardiac Rehabilitation Services: C Mandatory C Every three works C Yes C Every three works C Yes C Every three months Select the Additional Pulmonary Rehabilitation Services: <th>Exit Exit (No</th> <th>#3 Cardiac and Pulmonary Rehabilitation Services - Base 1</th> <th></th>	Exit Exit (No	#3 Cardiac and Pulmonary Rehabilitation Services - Base 1	
C Optional C Every two years C Every year C Every six months C Every three months C Other, Describe	CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C? Yes No Select enhanced benefit: Additional Cardiac Rehabilitation Services Additional Pulmonary Rehabilitation Services Additional Pulmonary Rehabilitation Services Select type of benefit for Additional Cardiac Rehabilitation Services: Mandatory Optional Is this benefit unlimited for Additional Cardiac Rehabilitation Services: Yes No, indicate number Indicate number of visits for Additional Cardiac Rehabilitation Services: Select the Additional Cardiac Rehabilitation Services periodicity: Select the Additional Cardiac Rehabilitation Services periodicity: Every three years Every three years Every three months Other, Describe Select type of benefit for Additional Intensive Cardiac Rehabilitation Services:	○ Yes ○ No, indicate number Indicate number of visits for Additional Intensive Cardiac Rehabilitation Service ○ Select the Additional Intensive Cardiac Rehabilitation Services periodicity: ○ ○ Every three years ○ Every three years ○ </td <td></td>	

#3 Cardiac and Pulmonary Rehabilitation Services – Base 2

🖳 PBP Data Entry System - Section B-3, Contract X0001, Plan 00:	1, Segment 000	
Eile Help Previous Next (Validate) Exit (No (Validate)	Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 2	
Maximum Plan Benefit Coverage is not applicable for this Service Ca 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 three years Every two years Every two years Other, Describe You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please util the minimum and maximum fields to reflect the lowest and highest of sharing that a beneficiary may pay. Is there an enrollee Coinsurance? Yes No	have a Coinsurance (Select all that apply): Medicare-covered Cardiac Rehabilitation Services Medicare-covered Intensive Cardiac Rehabilitation Services Medicare-covered Pulmonary Rehabilitation Services Additional Cardiac Rehabilitation Services Additional Cardiac Rehabilitation Services Additional Cardiac Rehabilitation Services Additional Pulmonary Rehabilitation Services Indicate Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services: Indicate Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services: Indicate Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:	

#3 Cardiac and Pulmonary Rehabilitation Services – Base 3

PBP Data Entry System - Section B-3, Contract X0001, Plan 0	J01, Segment 000	Warman Lord		- 0			
Previous Next (Validate)							
there an enrollee Deductible? Yes No ndicate Deductible Amount: there an enrollee Copayment? Yes No Select which Cardiac and Pulmonary Rehabilitation Services have Copayment (Select all that apply): Medicare-covered Cardiac Rehabilitation Services Medicare-covered Intensive Cardiac Rehabilitation Services Additional Cardiac Rehabilitation Services Additional Intensive Cardiac Rehabilitation Services Additional Intensive Cardiac Rehabilitation Services Additional Pulmonary Rehabilitation Services Additional Pulmonary Rehabilitation Services	Indicate Copayment amount for Medicare- covered Cardiac Rehabilitation Services: Indicate Copayment amount for Medicare- covered Intensive Cardiac Rehabilitation Services Indicate Copayment amount for Medicare- covered Pulmonary Rehabilitation Services: Indicate Copayment amount for Additional Cardiac Rehabilitation Services: Indicate Copayment amount for Additional Intensive Cardiac Rehabilitation Services: Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:	Minimum Copayment	Maximum Copayment				

#3 Cardiac and Pulmonary Rehabilitation Services - Base 4

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: 📕	Cardiac and	Pulmonary Reha	bilitation Service	s - Base 4		•	
rollee must re	ceive Authoriz	ation from one or i	more of the follo	wing:							
None											
		ernist/Family Prac	ctice, General P	actice)							
Physician Sp											
Organization Other, descri		tor/Utilization Man	agement/Utiliza	tion Review							
diac and Puli	monary Rehab	ilitation Programs	Notes								
e may include	additional int	formation to descr	ibe benefit in thi	s service catego	ry. Do not re	peat information	n captured in da	ta entry.			
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#4a Emergency Care – Base 1

🖳 PBP Data Entry System - Section B-4, Contract X0001, Plan 0	01, Segment 000	and the state of the	
File Help Previous Next (Validate) Validate	Go To: #4a Emergency Care - Base 1	•	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every two years Every two years Every three months Other, Describe	Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage for Medicare- covered Benefits: Indicate Maximum Coinsurance percentage for Medicare- covered Benefits: Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital? Yes No Select either Days or Hours within which admission must occur for waiver: Days Hours Enter number of Days or Hours:		

#4a Emergency Care – Base 2

evious Next (Validate)	Go To: #4a Emergency Care - Base 2
re an enrollee Copayment?	Authorization is not applicable for this Service Category. Referral is not applicable for this Service Category. Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:

#4b Urgently Needed Services – Base 1

🖳 PBP Data Entry System - Section B-4, Contract X0001, Pla	an 001, Segment 000	
Eile Help Previous Next (Validate) Exit (No Validate)	Go To: #4b Urgently Needed Services - B	ase 1
CLICK FOR DESCRIPTION OF BENEFIT Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket C C Yes No Select the Maximum Enrollee Out-of-Pocket Cost type: C Covered under Emergency Care Service Category 4a C Plan-specified amount per period	Indicate Maximum Enrollee Out-of- Pocket Cost amount:	Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital? Select either Days or Hours within which admitsion must occur for waiver: Days Inter number of Days or Hours:

#4b Urgently Needed Services – Base 2

evious	Next	Exit (Validate)	Go To: #4b Urgently Needed Services - Base 2 Exit (No Validate)	•
re an enrol	lee Copaymer	nt?	Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?	
es Io				
t sharing ca icare-cover	innot be great ed Urgently N	er than \$65 for leeded Services.	Select either Days or Hours within which admission must occur for waiver:	
	m Copaymen	t amount for Medicar		
			Enter number of Days or Hours:	
ate Maximu ered Benefi	um Copaymen its:	nt amount for Medica	re	

#4b Urgently Needed Services – Base 3

Previous Previous Fixit (Validate) Fixit (No Validate) Go To: #4b Urgently Needed Services - Base 3 Image: Comparison of Compari	le <u>H</u> elp			an 001, Segment 000
erral is not applicable for this Service Category. e may include additional information to describe benefit in this service category. Do not repeat rmation captured in data entry. nu have entered a range of cost sharing, you must describe the reason for this range.	4	Exit (Validate)	Exit (No Validate)	
e may include additional information to describe benefit in this service category. Do not repeat rmation captured in data entry. whave entered a range of cost sharing, you must describe the reason for this range.	thorization is not app	plicable for this Service	Category.	
rmation captured in data entry. Whave entered a range of cost sharing, you must describe the reason for this range.	erral is not applicab	le for this Service Categ	ory.	
	te may include additi ormation captured in	ional information to des 1 data entry.	cribe benefit in this	nis service category. Do not repeat
	ou have entered a ra	nge of cost sharing, you	u must describe th	the reason for this range.
	tes:			
ν.				
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#4c Worldwide Emergency/Urgent Coverage – Base 1

PBP Data Entry System - Section B-4, Contract X000	1, Plan 001, Segment 000	
<u>File</u> <u>H</u> elp		
Exit Exit	Go To: #4c Worldwide Emergency/Urgent C	overage - Base 1
Previous Next (Validate) Valid	(No	
(validate) valid		
CLICK FOR DESCRIPTION OF BENEFIT	Is there a Maximum Plan Benefit Coverage amount	Is there a service-specific Maximum
	for Worldwide Emergency/UrgentCoverage?	Enrollee Out-of-Pocket Cost?
Does the plan provideWorldwideEmergency/Urgent Coverage as a supplemental benefit under Part C?	C Yes C No	C Yes C No
C Yes	Is the service-specific Maximum Plan Benefit	Indicate Maximum Enrollee Out-of-
C No	Coverage amount unlimited?	Pocket Cost amount:
Select type of benefit for Worldwide Emergency/Urgent	C Yes C No	
Coverage:	Indicate Maximum Plan Benefit Coverage	Select Maximum Enrollee Out-of-Pocket
C Optional	amount:	Cost periodicity:
		C Every three years C Every two years
		C Every year
		C Every six months C Every three months
		C Other, Describe
		1

#4c Worldwide Emergency/Urgent Coverage – Base 2

Previous Next	Exit Exit (N (Validate) Validate	Go To: #4c Worldwide Emergency/Urgent Coverage - Base 2
there an enrollee Coinsuran	ce?	Is there an enrollee Copayment?
Yes No		C Yes C No
Indicate Minimum Coinsurar Emergency/Urgent Coverag	nce percentage for Worldwide le: nce percentage for Worldwide	Indicate Minimum Copayment amount for Worldwide Emergency/Urgent Coverage:
Emergency/Urgent Coverag	e:	Emergency/Urgent Coverage:
Is this Coinsurancewaived for Coverage if admitted to hosp	orWorldwideEmergency/Urge pital?	Coverage if admitted to hospital?
C Yes C No		C Yes C No
No dicate Deductible Amount:		

#4c worldwide Emergency/Urgent Coverage – Base 3

le <u>H</u> elp				
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #4c Worldwide Emergency/Urgent Coverage - Base 3
thorization is n	otapplicable	for this Service Cal	tegory.	
		s Service Categor		
te may include	additional info	ormation to descri	be benefit in this	s service category. Do not repeat
ormation captu	red in data en	try.		
				*

#5 Partial Hospitalization – Base 1

PBP Data Entry System - Section B-5, Contract X0001, Plan	001, Segm	ent 000	
File Help Previous Next Exit (Validate) Exit (No Validate)	Go To:	#5 Partial Hospitalization - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every three years C Every three months C Other, Describe		Is there an enrollee Coinsurance? Yes Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Denefits: Is there an enrollee Deductible? Yes No Indicate Deductible Amount:	
			1

#5 Partial Hospitalization – Base 2

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#5 Partial Hospitalization - Base 2
s there an enrollee (
	Copayment	?			Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
C Yes C No					Notes:
Indicate Minimum C day: Enrollee must receiv None Primary Care Phy Physician Specia Organization Mec Other, describe Is a referral required C Yes C No	Copayment ve Authoriza ysician (Inte alist edical Directo	amount for Medic tion from one or i rnist/Family Prac or/Utilization Man	care-covered Be more of the follo ctice, General Pr	nefits per wing: actice)	

#6 Home Health Services – Base 1

PBP Data Entry System - Section B-6, Contr	act X0001, Plan 001, Segment 000	and the second s	
File Help Previous Next (Validate)	Go To: #6 Home Health Services Exit (No Validate)	- Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category, except for MMPs. Maximum Plan Benefit Coverage is not applicable for this Service Category.	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?	

#6 Home Health Services – Base 2

ile <u>H</u> elp						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: 📕	Home Health Services - Base 2	
here an enroll	ee Deductible?	?				
Yes No						
ndicate Deduct	ible Amount:					
there an enroll	ee Copayment	1?		1.00		
Yes No						
ndicate Minimu	m Copayment	amount per visit f	or Medicare-co	vered Benefits:		
idicate Maximu	um Copayment	t amount pervisit f	for Medicare-co	overed Benefits:		

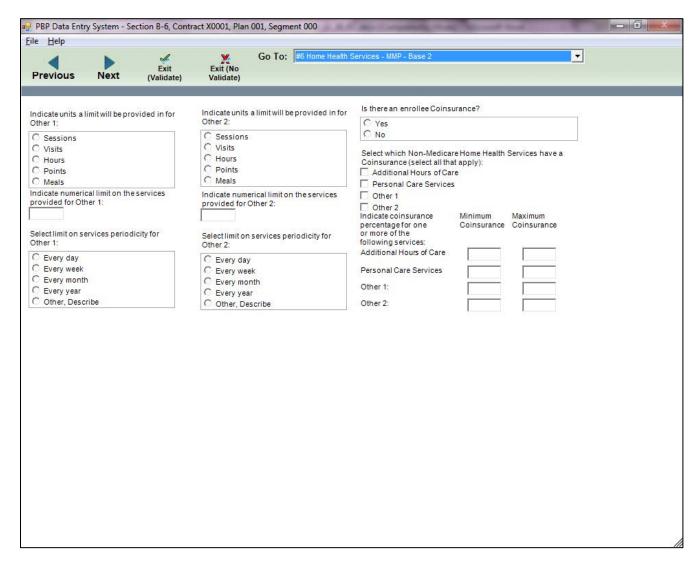
#6 Home Health Services – Base 3

	ry System - Se	ection B-6, Contra	act X0001, Plan	001, Segme	ent 000		Contraction	and the second division of the	 the state of the s	1	х
Eile Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#6 Home H	Health Service	es - Base 3			•	
None Primary Care F Physician Spe Organization I Other, describ	Physician (Inte cialist Medical Direct e	tion from one or m ernist/Family Pract or/Utilization Mana	ice, General Pra	ctice)							
	red for Home I	Health Services?								-1	
C Yes C No											
Notes:		ormation to descri								F	

#6 Home Health Services – MMP – Base 1

Previous Next	Exit (Validate)	Exit (No Validate)	To:	#6 Home Health Services - MMP - Base 1	•
LICK FOR DESCRIPTION		th Services?		Is there a limit on the services provided?	
Yes No Select Non-Medicare Hon Additional Hours of Ca Personal Care Service Other 1 Other 2	ie Health Services: re			Select Non-Medicare Home Health Service Additional Hours of Care Personal Care Services Other 1 Other 2	es where limit applies: Indicate units a limit will be provided in for Personal Care Services:
Enter name of Other 1 Service: Enter name of Other 2 Service:				C Sessions C Visits C Hours C Points C Meals	C Sessions C Visits C Hours C Points C Meals
Is there a service-specific C Yes C No	Maximum Plan Ben	efit Coverage Amount	17	Indicate numerical limit on the services provided for Additional Hours of Care:	Indicate numerical limit on the services provided for Personal Care Services:
Indicate Maximum Plan	Benefit Coverage a	mount:		Select limit on services periodicity for Additional Hours of Care:	Select limit on services periodicity for Personal Care Services:
Select Maximum Plan B C Every three years Every two years Every year Every six months C Every three months C Other. Describe		iodicity:		C Every day C Every week C Every month C Every year C Other, Describe	C Every day C Every week C Every month C Every year C Other, Describe

#6 Home Health Services – MMP – Base 2



#6 Home Health Services – MMP – Base 3

	n - Section B-6, Co	ntract X0001, Plan	001, Segme	nt 000
Eile Help Previous Nex	t (Validate)	Exit (No Validate)	Go To:	#6 Home Health Services - MMP - Base 3
Is there an enrollee Copay C Yes No Select which Non-Medicar all that apply): Additional Hours of Car Other 1 Other 2 Indicate copayment percentage for one or more of the following services: Additional Hours of Care: Personal Care Services: Other 1: Other 2:	e Home Health Serv e	Maximum Copayment	ment (select	Does any service require qualification for and enrollment in a state-operated waiver program Yes Select which service requires qualification for and enrollment in a state-operated waiver program Additional Hours of Care Other 1 Other 1 Other 2 Enrollee must receive Authorization from one or more of the following: Other 1 Other 2 Enrollee must receive Authorization from one or more of the following: Other 3 Select which services Other 4 Other 4 Select which services Other 5 Services Other 5 Services Se

#7a Primary Care Physician Services – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan	001, Segment 000	
File Help Previous Next (Validate) Validate)	Go To: #7a Primary Care Physician Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there 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 two years Output year to be the months Output of the m	Is there an enrollee Coinsurance?	

#7a Primary Care Physician Services – Base 2

🖳 PBP Data Entr	y System - Se	ection B-7, Contra	ct X0001, Plan	001, Segn	ment 000	1.24	Marrie W	-	-	Sec. 1	Sec.	-		x
<u>File H</u> elp														
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7a Prin	mary Care I	Physician	Services - I	Base 2				•	
Authorization is n	otapplicablef	or this Service Cat	egory.											
Note may include	additional info	ormation to descril	be benefit in this	service ca	ategory. Do	notrepea	at informat	tion captur	ed in data	entry.				
Notes:														
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r.												-		

🖷 PBP Data Entry System - Section B-7, Contrac	ct H5505, Plan 003, Segment 0		
File Help			
Previous Next (Validate)	Go To: #7b Chiropractic Services - Bi Exit (No Validate)	ase 1 💌	
		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 three years Every year Every six months Every three months Other, Describe	

ile <u>H</u> elp						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7b Chiropractic Services - Base 2	•
s there an enrol	lee Coinsurar	ice?				
C Yes C No]		
all that apply): Medicare-co	vered Chirop	rvices have a Coin ractic Services	surance (Select			
Routine Care		e percentage per	visitfor			
Medicare-cover	ed Benefits:					
Indicate Maximu Medicare-cover		ce percentage per	visitfor			
Indicate the Min Routine Care/Ot	imum Coinsur her:	ance percentage p	ervisit for			
ndicate the Max Routine Care/Ot	imum Coinsu	rance percentage	per visit for			

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segm File Help	nent 000
	#7b Chiropractic Services - Base 3
there an enrollee Deductible? Yes No Indicate Deductible Amount: Tyes No Select which Chiropractic Services have a Copayment (Select all that apply): Medicare-covered Chiropractic Services Routine Care/Other 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/Other:

le <u>H</u> elp											
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7b Chiroprad	tic Services - Bas	e 4			•	
iropractic Serv	ices Notes										
te may include	additional info	ormation to descri	be benefit in this	service ca	ategory. Do not r	epeat information	captured in da	ta entry.			
tes:											
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#7c Occupational Therapy Services – Base 1

PBP Data Entry System - Section B-7, Cor	ntract X0001, Plan 001, Segment 000	
File Help Previous Next (Validate)	Go To: #7c Occupational Thera Exit (No Validate)	py Services - Base 1
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category, except for MMPs. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years E Every two years Every year C Every six months Other, Describe You must include total cost sharing to the beneficiary, including any facility cost sharing. Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:	Is there an enrollee Deductible?

#7c Occupational Therapy Services – Base 2

ile <u>H</u> elp											_
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7c Occ	upational Thera	py Services - Ba	ise 2	•]	
None Primary Care I Physician Spe Organization Other, descrit a referral requir	Physician (Inte ecialist Medical Direct pe	tion from one or n ernist/Family Pract or/Utilization Mana tional Therapy Se	tice, General Pri agement/Utilizat	actice)	R						
Yes											
ិ No									12		
ote may include	additional inf	ormation to descri	be bene <mark>f</mark> it in this	service ca	tegory. Do	not repeat info	rmation capture	ed in data entry			
lotes:											
									*		

#7c Occupational Therapy Services – MMP – Base 1

e <u>H</u> elp				
Previous Next	Exit (Validate)	Exit (No Validate)	Go To:	#7c Occupational Therapy Services - MMP - Base 1
CLICK FOR DESCRIPTIO es this plan provide Non-I Yes No	at the second second	nal Therapy Serv	rices?	Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage:
ter name of Non-Medicar			unt?	Indicate Maximum Coinsurance percentage:
Yes No Indicate Maximum Plan Be				Is there an enrollee Copayment?
Select Maximum Plan Ben C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	efit Coverage perioc	licity:		Indicate Maximum Copayment amount:

#7c Occupational Therapy Services – MMP – Base 2

Eile <u>H</u> elp						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7c Occupational Therapy Services - MMP - Base 2	
None		tion from one or m			Notes:	×
Primary Care P Physician Spec		rnist/Family Pract	ice, General Pra	actice)		
Organization N	Aedical Directo	or/Utilization Mana	igement/Utilizat	ion Review		
Other, describe	e					
a referral requir	ed for Service	s?				
Yes						
No						
						-

#7d Physician Specialist Services – Base 1

ase 1
n enrollee Deductible? Deductible Amount: n enrollee Copayment? Minimum Copayment amount per visit (care-covered Benefits: Maximum Copayment amount per visit (care-covered Benefits:

#7d Physician Specialist Services – Base 2

	ry System - S	ection B-7, Contra	act X0001, Plan	001, Segment 000	A R. P. March		Suma State		
File Help	Next	Exit (Validate)	Exit (No Validate)	Go To: #7d Phy	vsician Specialist Ser	vices - Base 2		<u>-</u>	
None Primary Care P Physician Spe	Physician (Inte cialist Medical Direct	tion from one or m ernist/Family Pract or/Utilization Mana	ice, General Pri	actice)					
ls a referral requir	ed for Physici	an Specialist Serv	ices?						
C Yes C No									
Note may include Notes:	additional inf	ormation to descri	be benefit in this	s service category. Do	o not repeat informa	tion captured in data	a entry.	*	

#7e Mental Health Specialty Services – Base 1

<u>File</u> <u>H</u> elp					
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7e Mental Health Specialty Services - Base 1
CLICK FOR DE	SCRIPTION C	OF BENEFIT			
inhanced Benef	its are not app	licable for this Ser	vice Category.		
/laximum Plan Be	enefit Coverag	ie is not applicable	e for this Service	Category.	
	-specific Maxi	mum Enrollee Out-	of-Pocket Cost	?	
C Yes C No					
Indicate Maximu	um Enrollee O	ut-of-Pocket Cost	amount:		
/					
	an- isseed about as	t-of-Pocket Cost p	eriodicity:		-
C Every three C Every two	e years vears				
C Every year					
C Every six r C Every three	nonths e months				
C Other, Des	cribe				

#7e Mental Health Specialty Services – Base 2

	tem - Section B-7, Contra	act X0001, Plan	001, Segment 000
Eile Help	ext (Validate)	Exit (No Validate)	Go To: #7e Mental Health Specialty Services - Base 2
Is there an enrollee Coi C Yes No Select which Mental H Coinsurance (Selecta Medicare-covered Indicate minimum Cc covered Individual S Indicate maximum C covered Individual S Indicate minimum Cc covered Group Sess	ext (Validate) Insurance? Idealth Specialty Services I If that apply): Individual Sessions Group Sessions Dinsurance percentage for Dessions: Dinsurance percentage for Dinsur	Validate) have a r Medicare- r Medicare-	Is there an enrollee Copayment? Yes No Select which Mental Health Specialty Services have a Copayment (elect all that apply): Medicare-covered Individual Sessions Medicare-covered Group Sessions Individual Sessions: Individual Sessions: Individual Sessions: Individual Sessions: Indicate minimum Copayment Amount for Medicare-covered Individual Sessions: Indicate minimum Copayment amount for Medicare-covered Group Sessions: Indicate minimum Copayment amount for Medicare-covered Group Sessions:

#7e Mental Health Specialty Services – Base 3

PBP Data Ent	ry System - Se	ection B-7, Contra	act X0001, Plan	001, Segment 000	A Real Manufactory		Manual Look		
File Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: <mark>#7e Mer</mark>	ntal Health Specialty Se	ervices - Base 3		<u> </u>	
None Primary Care Physician Sp Organization Other, descril	Physician (Inte ecialist Medical Direct pe	tion from one or m ernist/Family Pract or/Utilization Mana	ice, General Pri agement/Utilizat	actice) tion Review					
	red for Mental	Health Specialty S	ervices - Non-P	Physician?					
C Yes C No									
Notes:								*	

#7f Podiatry Services – Base 1

CLICK FOR DESCRIPTION OF BENEFIT Select the Routine Footcare periodicity: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Does the plan provide Podiatry Services as a upplemental benefit under Part C? Every two years Yes No Every two remoths Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select the hanced benefits: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost amount: Select type of benefit for Routine Footcare Yes Mandatory Indicate Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage amount: Every three years Select Maximum Plan Benefit Coverage amount: Every three years Yes No Indicate Maximum Plan Benefit Coverage periodicity: Every three years Yes No Select Maximum Plan Benefit Coverage periodicity: Every three years Yes Select Maximum Plan Benefit Coverage periodicity: Every year Every year Every yix months Other, Describe	Eile Help Previous Next (Validate)	Go To: #71 Podiatry Services - Base 1 Exit (No Validate)	
C Mandatory Indicate Maximum Plan Benefit Coverage amount: C Every three years Is this benefit unlimited for Routine Footcare? Indicate Maximum Plan Benefit Coverage amount: C Every three years C Yes Select Maximum Plan Benefit Coverage periodicity: C Every three months C No C Every three years C Other, Describe Indicate number of Routine Footcare visits: C Every three years C Other, Describe Indicate number of Routine Footcare visits: C Every six months C Every three years C Every six months C Every three years C Every year C Every three works C Every three years C Every three years C Every three works C Every three years C Every three years	Noes the plan provide Podiatry Services as a upplemental benefit under Part C? Yes No Select enhanced benefits: Routine Footcare	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes	-of-Pocket Cost? Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select the Maximum Enrollee Out-of-Pocket
C No C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Every three months	C Mandatory O Optional Is this benefit unlimited for Routine Footcare?	Indicate Maximum Plan Benefit Coverage amount:	C Every two years C Every year C Every six months C Every three months
	C No	C Every three years C Every two years C Every year C Every six months C Every three months	

#7f Podiatry Services – Base 2

<u>File H</u> elp		ection B-7, Contr				
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7f Podiatry Services - Base 2.	
s there an enroll	ee Coinsurand	e?			Is there an enrollee Copayment?	
C Yes C No					C Yes C No	
	vered Podiatr	s have a Coinsura y Services	nce (Select all the	at appl <mark>y</mark>):	Select which Podiatry Services have a Copayment (Select all that apply): Medicare-covered Podiatry Services Routine Footcare	
Indicate Minimu	m Coinsuranc	e percentage for N	ledicare-covered	Benefits:	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Maxim	um Coinsuranc	ce percentage for I	Medicare-covered	l Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Minimu	m Coins <mark>ur</mark> anc	e percentage for R	outine Footcare:		Indicate Minimum Copayment amount per visit for Routine Footcare:	
Indicate Maxim	um Coinsuranc	ce percentage for F	Routine Footcare:		Indicate Maximum Copayment amount per visit for Routine Footcare:	
s there an enrol C Yes C No	ee Deductible	?				
Indicate Ded	uctible Amount	D)				

#7f Podiatry Services – Base 3

<u>File</u> <u>H</u> elp	1955-00								
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #7ff	Podiatry Services -	Base 3			•
None Primary Care F Physician Spe	Physician (Intecialist Medical Direct	tion from one or m ernist/Family Pract or/Utilization Mana rist Services?	ice, General Pra	actice)					
ੇ Yes									
No									
ote may include	additional inf	ormation to descri	be benefit in this	service category.	Do not repeat info	rmation captured i	n data entry.		
otes:									
								*	
								Ψ.	

#7g Other Health Care Professional – Base 1

PBP Data Entry System - Section B-7, Contrac	t X0001, Plan 001, Segment 000	
File Help Previous Next (Validate)	Go To: #7g Other Health Care Prof Exit (No Validate)	essional - Base 1
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out- of-Pocket Cost? C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years E Every year C Every six months E Very three months O ther, Describe Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Is there an enrollee Deductible? Yes Indicate Deductible Amount: Is there an enrollee Copayment? Yes No Indicate Minimum Copayment amount per visit for Medicare-covered Benefits: Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:

#7g Other Health Care Professional – Base 2

🖳 PBP Data Ent	y System - Se	ection B-7, Contra	act X0001, Plan	001, Segment 0	00	Section and	and the second diversity of the	Second Second		
<u>File</u> <u>H</u> elp										
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: 479	Other Health Ca	ire Professional	- Base 2		<u>•</u>	
1	eive Authoriza Physician (Intr cialist Medical Direct e ed for Other H	tion from one or n ernist/Family Pract or/Utilization Mana Health Care Profes	nore of the follow ice, General Pri agement/Utilizat sional Services	actice) ion Review ?	, Do notrepeat	information cap	ptured in data en	ıry.	*	

#7h Psychiatric Services – Base 1

PBP Data Entry System -	Section B-7, Contra	act X0001, Plan	001, Segment 000	A PARTY NAMES OF TAXABLE	and the second	the state of the s	
<u>F</u> ile <u>H</u> elp						, I	
Previous Next	Exit (Validate)	Exit (No Validate)	Go To: #7h Psyc	hiatric Services - Base 1			
CLICK FOR DESCRIPTION	OF BENEFIT						
Enhanced Benefits are not ap	plicable for this Ser	vice Category.					
Maximum Plan Benefit Covera	ge is not applicable	e for this Service	e Category.				
Is there a service-specific Max							
C Yes		OFFOCKEL COST					
C No							
Indicate Maximum Enrollee	Dut-of-Pocket Cost	amount:					
Select the Maximum Enrolle	e Out-of-Pocket Co	st periodicity:					
C Every three years							
C Every two years C Every year							
C Every six months C Every three months							
C Other, Describe							

#7h Psychiatric Services – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment	000
<u>F</u> ile <u>H</u> elp	
Previous Next (Validate) Go To:	7h Psychiatric Services - Base 2
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?
C Yes C No	C Yes C No
Select which Psychiatric Services have a Coinsurance (Select all that apply): Medicare-covered Individual Sessions	Select which Psychiatric Services have a Copayment (Select all that apply): Medicare-covered Individual Sessions
Medicare-covered Group Sessions	Medicare-covered Group Sessions
Indicate minimum Coinsurance percentage for Medicare-covered Individual Sessions:	Indicate minimum Copayment amount for Medicare-covered Individual Sessions:
Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:	Indicate maximum Copayment amount for Medicare-covered Individual Sessions:
Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:	Indicate minimum Copayment amount for Medicare-covered Group Sessions:
Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:	Indicate maximum Copayment amount for Medicare-covered Group Sessions:
Is there an enrollee Deductible?	
C Yes	
C No	
Indicate Deductible Amount:	

#7h Psychiatric Services – Base 3

HPBP Data Ent	ry System - Se	ection B-7, Contra	ict X0001, Plan	001, Segmer	nt 000		State of Street, or other	AND DESCRIPTION OF		(MC	
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7h Psych	niatric Servio	ces - Base 3		Ŧ		
None Primary Care F Physician Spe Organization I Other, describ	Physician (Inte cialist Medical Direct pe	tion from one or m ernist/Family Pract or/Utilization Mana	ice, General Pra	ictice)							
s a referral requir	red for Psychia	atric Services?							1		
ିYes ℃No											
									Υ.		

#7i PT and SP Services – Base 1

PBP Data Entry System - Section B-7, Con	ntract X0001, Plan 001, Segment 000	And the Party of t	
Eile Help Previous Next (Validate)	Go To: #71 PT and SP Services Exit (No Validate)	- Base 1	•
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category, except for MMPs. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every year E Every six months C Other, Describe You must include total cost sharing to the beneficiary, including any facility cost sharing. Is there an enrollee Coinsurance? C Yes C No Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:	Is there an enrollee Deductible? Yes No Indicate Deductible Amount: Sthere an enrollee Copayment? Yes No Indicate Minimum Copayment amount per visit for Medicare-covered Benefits: Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	

#7i PT and SP Services – Base 2

	ry System - Se	ection B-7, Contra	act X0001, Plan	001, Segme	ant 000	-	-		 	×
File Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#7i PT and	I SP Servic	ces - Base 2		•	
None Primary Care F Physician Spe Organization N Other, describ	Physician (Inte cialist Medical Direct e	tion from one or m ernist/Family Pract or/Utilization Mana	ice, General Pra agement/Utilizati	ctice) on Review						
	ed for Physica	al Therapy and Spe	eech-Language	Pathology S	Services?					
ੇ Yes ੇ No										
lotes:								 	 *	
									-	

#7i PT and ST – MMP – Base 1

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	7iPT and ST - MMP - Base	1		T
					14 M 14 M 14	an and		
CLICK FOR DE	SCRIPTION O	FBENEFIT			Is there an enrollee Co	insurance?		
Does this plan pro Therapy services'		licare Physical ar	nd/orSpeech		C Yes C No			
C Yes C No	~				Select which Non-Med services have a Coins Other 1		nd/or Speech Therapy I that apply):	
Select Non-Med	licare Physical	and/or Speech T	herapy Service		Other 2			
C Other 2	Other 1 Servi	ce:			Indicate coinsurance percentage for one or more of the	Minimum Coinsurance	Maximum Coinsurance	
		681000			following services:			
Enter name of	Other 2 Servi	ce:			Other 1:			
					Other 2:			
s there a service- O Yes	-specific Maxi	num Plan Benefit	Coverage amou	nt o				
C No								
Indicate Max	timum Plan Be	nefit Coverage a	mount:					
ļ								
		fit Coverage peri	iodicity:					
C Every the C Every two	o years							
C Every ye C Every siz								
C Every the	ree months							
C Other, D	escribe							

#7i PT and ST – MMP – Base 2

<u>File</u> <u>H</u> elp				
Previous	Next (1	Exit /alidate)	Go To: #7i PT and ST - MMP - Base 2 Exit (No Validate)	•
Is there an enrolled (Yes No Select which Non-Me Therapy services hav apply): Other 1 Other 2 Indicate copayment percentage for one or more of the following services: Other 1: Other 2:	Copayment? dicare Physical	and/or Speec (select all that Maximur	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 Revie t Other, describe Is a referral required for Services? O Yes O No	

ile <u>H</u> elp						
Previous Next	Exit (Validate)	Exit (No Validate)	Go To: #8a 0	utpatient Diag Procs/Tests/Lab Services	- Base 1	<u> </u>
CLICK FOR DESCRIPTION	OF BENEFIT					
nhanced Benefits are not a	plicable for this Ser	vice Category.				
aximum Plan Benefit Cover	ige is not applicable	e for this Service	Catego			
there a service-specific Ma	ximum Enrollee Out	-of-Pocket Cost	1.1.1			
Yes No						
No dicate Maximum Enrollee		amount				
Greate Maximum Enrollee	OUL-OI-FOCKEL COST	antourit.				
Select Maximum Enrollee (ut of Booket Cost a	ariodicity				
C Every three years	Jul-01-POCKELOOSI P	renoulcity.				
C Every two years C Every year						
C Every six months						
C Every three months C Other, Describe						

<u>F</u> ile <u>H</u> elp					
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#8a Outpatient Diag Procs/Tests/Lab Services - Base 2
haring. If you hav	e a variety of reflect the lov	cost sharing, ple vest and highest o	ase utilize the m	inimum and	Indicate Minimum Coinsurance percentage for Medicare-covered Lab Servic
(Select all that ap Medicare-cov Medicare-cov Indicate Mini Diagnostic P	oply): vered Diagno vered Lab Ser mum Coinsur rocedures/Te mum Coinsu	rance percentage ests: rance percentage	ests for Medicare-co	overed	

<u>File</u> <u>H</u> elp						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#8a Outpatient Diag Procs/Tests/Lab Services - Base 3	•
s there an enroll	ee Deductible?	?				
C Yes						
C No						
Indicate Deducti						
s there an enroll O Yes	ee Copayment	?				
C No						
Copayment (Sel Medicare-cov Medicare-cov Indicate Minimu Diagnostic Proc	ect all that app vered Diagnos vered Lab Serv m Copayment edures/Tests: m Copayment	tic Procedures/Te	sts are-covered			
-		amount for Medica	are covered Lab			
Services:						
Indicate Maximu Services:	m Copayment -	amount for Medic	are-covered Lai	D		

<u>Eile H</u> elp								
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#8a Outpatient Diag Procs/Tests/Lab Servi	ices - Base 4	•	
None Primary Care P Physician Spe	hysician (Inte cialist Iedical Directo	ion from one or m rnist/Family Pract pr/Utilization Mana	ice, General Pra	actice)	Enter Notes for Medicare-covered Lab) Services:	· •	
		ent Diagnostic Pro	ocedures/Test/L	ab				
C Yes C No								
iter Notes for M		tion captured in d ed Diagnostic Pro		service				
ter Notes for Mr				*				
ter Notes for Mr				*				
ter Notes for Me				*				
ter Notes for Me				*				

#8b Outpatient Diag/Therapeutic Rad Services – Base 1

🖳 PBP Data Entry Sys	tem - Section B-8, Cont	ract X0001, Plan (01, Segm	ient 000	
<u>F</u> ile <u>H</u> elp					
Previous N	ext (Validate)	Exit (No Validate)	Go To:	#8b Outpatient Diag/Therapeutic Rad Services - Base 1	
Maximum Plan Benefit i Category. Is there a service-spec Ves No Indicate Maximum En Select Maximum En Cevery three year Every three year Every year Every year Every six month Every three mon Other, Describe You must include total of facility cost sharino.	PTION OF BENEFIT not applicable for this Se Coverage is not applicab ific Maximum Enrollee Ou follee Out-of-Pocket Cost oblee Out-of-Pocket Cost s s ths ost sharing to the benefit ou have a variety of cost num fields to reflect the lo ry may pay.	ervice Category. vle for this Service ut-of-Pocket Cost? t amount: periodicity: periodicity: sharing, please uti	lize	Select which Outpatient Diag/Therapeutic Rad Services have a Coinsurance (Select all that apply): Imedicare-covered Diagnostic Radiological Services Imedicare-covered Therapeutic Radiological Services Imedicare-covered Therapeutic Radiological Services Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): Indicate Maximum Coinsurance percentage for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): Indicate Minimum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services (e.g., CT, MRI, etc): Indicate Minimum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services: Indicate Minimum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services: Indicate Maximum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services: Indicate Minimum Coinsurance percentage for Medicare-covered X-Ray Services:	

#8b Outpatient Diag/Therapeutic Rad Services – Base 2

<u>File</u> <u>H</u> elp							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#8b Outpatient Diag/Therapeutic Rad Services - Base 2	•	
s there an enroll	ee Deductible	?					
C Yes C No							
Indicate Deduct	ible Amount:						
I Is there an enroll	ee Copaymen	it?					
C Yes C No							
Select which Outp (Select all that ap		heapeutic Rad Ser	vices have a C	opayment	-		
Medicare-cov	ered Diagnost	tic Radiological Se utic Radiological S					
Medicare-cov		100	ervices				
Indicate Minim	um Copaymer	nt amount for other vices (e.g., CT, MF		ered			
I Indicate Maxim Diagnostic Ra	num Copayme diological Ser	nt amount for othe vices (e.g., CT, MF	r Medicare-cov RI, etc):	vered			
Indicate Minim Radiological S		nt amount for Medi	care-covered T	herapeutic			
Indicate Maxin Radiological S		nt amount for Medi	icare-covered	Therapeutic			
l Indicate Minim	um Copaymer	nt amount for Medi	care-covered X	-Ray Service			
I Indicate Maxim	um Copayme	nt amount for Med	icare-covered)	K-Ray Servic			
1							

#8b Outpatient Diag/Therapeutic Rad Services – Base 3

Eile <u>H</u> elp					
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#8b Outpatient Diag/Therapeutic Rad Services - Base 3
	eive Authorizat	tion from one or m	iore of the follow	ving:	Enter Notes for Medicare-covered Therapeutic Radiological Services:
Physician Spe	cialist Medical Directo	rnist/Family Pract pr/Utilization Mana			
s a referral requir <-Ray Services?	ed for Outpatie	ent Diagnostic/The	erapeutic Radio	logical, and	
C Yes C No					
lote may include	additional info	apeutic Radiologio prmation to descrit tion captured in d	be benefit in this		Enter Notes for Medicare-covered X-Ray Services:
and the state of t		ed Diagnostic Rad	v monthe second	ces (e.g., CT	
				~	

#9a Outpatient Hospital Services – Base 1

🤗 PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segme	ent 000 💼 💼 💼
File Help Go To: Exit (Validate) Exit (No Validate)	#9a Outpatient Hospital Services - Base 1
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category Astimum Plan Benefit Coverage is not applicable for this Service Category Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? ? Yes ? No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: ? Every three years ? Every three years ? Every six months ? Other, Describe	You must include total costs haring to the beneficiary, including any facility costs haring. If you have a variety of cost sharing please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay. Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits Indicate Maximum Coinsurance percentage for Medicare-covered Benefit

#9a Outpatient Hospital Services – Base 2

🧧 PBP Data Entry System - Sectio	n B-9, Contract X0001, Pl	n 001, Segment 000	
Previous Next	Exit Exit (No Validate) Validate)	Go To: #9a O	utpatient Hospital Services - Base 2
s there an enrollee Deductible? 7 Yes 7 No Indicate Deductible Amount:			Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Revie Other, describe
there an enrollee Copayment?			Is a referral required for Outpatient Hospital Services?
C Yes C No			C Yes C No

#9a Outpatient Hospital Services – Base 3

1	1	Exit	×	Go To: #9a Outpatient Ho	spital Services - Base 3		•	
revious	Next	Exit (Validate)	Exit (No Validate)					
p <mark>a</mark> tient Hospit	tal Services N	otes						
may include	additional info	ormation to descri	be benefit in this	service category. Do not repe	at information captured in	data entry.		
5:								
5							*	
							T	

#9b ASC Services – Base 1

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

#9b ASC Services – Base 2

PBP Data Entr	y System - S	ection B-9, Contra	act X0001, Plan	n 001, Segment 000	<u> </u>
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #9b ASC Services - Base 2	
there an enrolle Yes No ndicate Deductit		?		Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for Ambulatory Surgical Center Services?	
Benefits:	n Copayment	t? amount per visit f		Vered	

#9b ASC Services – Base 3

e <u>H</u> elp				_						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: 🗮	9b ASC Services	- Base 3			•	1
C Services Not	es									
e may include	additional info	ormation to descri	be benefit in this	service catego	ory. Do not repea	at information ca	aptured in data	entry.		
es:										
									*	
									*	

#9c Outpatient Substance Abuse – Base 1

🖳 PBP Data Entry S	ystem - Se	ection B-9, Contra	act X0001, Plan	001, Segm	nent 000	And in case of the local division of the loc	
<u>F</u> ile <u>H</u> elp							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#9c Outpatient Substance Abuse - Base 1		•
CLICK FOR DESC		F BENEFIT					
Enhanced Benefits a	re not app	licable for this Ser	vice Category.				
Maximum Plan Benef	it Coverag	e is not applicable	for this Service	Categor			
Is there a service-sp	ecific Maxiu	num Enrollee Out	of-Pocket Cost	,			
C Yes							
C No				-			
Select the Maximum			14 M				
C Covered under C Plan-specified a			Category 9a				
Indicate Maximum	Enrollee C)ut-of-Pocket Cos	t amount:				
Select Maximum E	Enrollee O	ut-of-Pocket Cost	periodicity:				
C Every three y							
C Every two year C Every year	ars						
C Every six mo C Every three m							
C Other, Descri							
							,

#9c Outpatient Substance Abuse – Base 2

📴 PBP Data Entry System - S	Section B-9, Contra	act X0001, Plan	001, Segm	ent 000
Eile Help Previous Next	Exit (Validate)	Exit (No Validate)	Go To:	#9c Outpatient Substance Abuse - Base 2
You must include total cost sha facility cost sharing. If you hav the minimum and maximum fiel sharing that a beneficiary may Is there an enrollee Coinsuran C Yes C No Select which Outpatient Sub: Coinsurance (Select all that i Medicare-covered Individ Medicare-covered Group Indicate minimum Coinsuran Individual Sessions: Indicate maximum Coinsuran Group Sessions: Indicate maximum Coinsuran Group Sessions:	e a variety of costs ds to reflect the low pay. cce? stance Abuse Servi apply): ual Sessions Sessions ice percentage for i nce percentage for i	haring, pleaseut vest and highest ices have a Medicare-covere Medicare-covere	ilize cost id ed	Is there an enrollee Deductible?

#9c Outpatient Substance Abuse – Base 3

1000000	Section B-9, Contract	X0001, Plan 001, Segme	ent 000
Previous	Exit (Validate)	Go To: Exit (No Validate)	#9c Outpatient Substance Abuse - Base 3
Enrollee must receive Authoriz None Primary Care Physician (In Physician Specialist Organization Medical Direct Other, describe Is a referral required for Outp Yes No	ternist/Family Practic	e, General Practice) ement/Utilization Review	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:

#9d Outpatient Blood Services – Base 1

🖳 PBP Data Entry System - :	Section B-9, Contr	act X0001, Plan	001, Segm	ent 000	
Eile Help Previous Next	Exit (Validate)	Exit (No Validate)	Go To:	#9d Outpatient Blood Services - Base 1	-
CLICK FOR DESCRIPTION If blood is given as a part of an the blood should beincluded in Does the plan provide Outpati benefit under Part C? C Yes C No Select enhanced benefit: Three (3) pint deductible w	inpatient hospital n the inpatient hosp ent Blood Services	oital costsharing.		Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years E Every two years E Every year E Every six months E Every three months Other, Describe Is there an enrollee Coinsurance? Yes No	
Select type of benefit for Thr C Mandatory C Optional Maximum Plan Benefit Coverage Is there a service-specific Max C Yes C No	ge is not applicable	e for this Service		Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits:	
Indicate Maximum Enrollee C)ut-of-Pocket Cost	amount:			

#9d Outpatient Blood Services – Base 2

Previous					
	Next	Exit (Validate)	Exit (No Validate)	Go To:	#9d Outpatient Blood Services - Base 2
Is there an enrolle	ee Deductible	?			Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
C Yes C No					Notes:
Indicate Deducti	ble Amount:				
is there an enrolle	e Copayment	17			
C Yes C No					
Indicate Maximur Enrollee must rece None Primary Care P Physician Spec	m Copayment eive Authoriza hysician (Inte cialist fedical Directo e	rnist/Family Prac	or Medicare-cov nore of the follo tice, General Pr agement/Utilizat	vered Ben wing: actice)	
C No				2	

Fu Associates, Ltd.

#10a Ambulance Services – Base 1

PBP Data Entry System - Section B-10, Contra Eile Help		Base 1	
Previous Next (Validate)	Go To: #10a Ambulance Services - Exit (No Validate)	203v)	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category.	Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	C Yes C No	C Yes C No	
Is there a service-specific Maximum Enrollee Out- of-Pocket Cost?	Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate the Minimum Copayment amount for Medicare-covered Benefits:	
C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate the Maximum Copayment amount for Medicare-covered Benefits:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Is this Coinsurance waived if admitted to hospital	Is this Copaymentwaived if admitted to hospital?	
C Every three years C Every two years C Every year C Every six months C Every three months	Is there an enrollee Deductible?	C No	
C Other, Describe	Indicate Deductible Amount:		

#10a Ambulance Services – Base 2

	, ,	ection B-10, Cont			
File Help	Next	Exit (Validate)	Exit (No Validate)	Go To: #10a Ambulance Services - Base 2	_
None Primary Care P Physician Spec Organization N Other, describe	hysician (Inte cialist ledical Directo e licable for thi:	rnist/Family Pract pr/Utilization Mana s Service Category	ice, General Pra Igement/Utilizati 7.		
otes:	laanonainna	innation to descrit	be benenit in this	ervice category. Do not repeat mormation captured in data entry.	
					*

#10b Transportation Services – Base 1

Previous Next (Validate)	Go To: #10b Transportation Servic Exit (No Validate)	ces - Base 1
CLICK FOR DESCRIPTION OF BENEFIT Des the plan provide Transportation Services as a upplemental benefit under Part C? Yes No Select enhanced benefit: C Plan-approved Location C Any Location Select type of benefit for Plan-approved Location:	Select Type of Transportation for Plan-approved Location: C One-way C Round Trip Days O Other, describe Indicate number of days for Plan-approved Location: Select Mode of Transportation for Plan-	Indicate number of trips for Any Location: Select Any Location Trips periodicity: Every three years Every three years Every year Every year Every six months Every three months Other, Describe Select Type of Transportation for Any Location:
C Mandatory C Optional Is this benefit unlimited for number of trips for Plan approved Location? C Yes C No	approved Location: Taxi Bus/Subway Van Medical Transport Other, describe Select type of benefit for Any Location:	C One-way C Round Trip C Days C Other, describe Indicate number of days for Any Location:
Indicate number of trips for Plan-approved Location: Select Plan-approved Location Trips periodicity: C Every three years	C Mandatory C Optional Is this benefit unlimited for number of trips for Any Location? C Yes C No	Select Mode of Transportation for Any Location: Taxi Bus/Subway Van Medical Transport
C Every two years C Every year C Every six months C Every three months C Other, Describe		☐ Other, describe

#10b Transportation Services – Base 2

🖳 PBP Data Entry System - Section B-10, Contra	ct X0001, Plan 001, Segment 000	Contraction in the local division of	
Eile Help Previous Next (Validate)	Go To: #10b Transportativ Exit (No Validate)	on Services - Base 2	
Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes C No Indicate Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage periodici	Pocket Cost amount:	Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage: Indicate Maximum Coinsurance percentage:	
C Every two years C Every year Every six months Every three months C Other, Describe	Pocket Cost periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	Is there an enrollee Deductible? Yes No Indicate Deductible Amount:	

#10b Transportation Services – Base 3

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#10b Transportation Services - Base 3
s there an enrol	lee Copaymen	t?			Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
C No					Notes:
		amount per trip: t amount per trip:			
None Primary Care Physician Sp Organization Other, descril	Physician (Inte ecialist Medical Direct be	tion from one or n ernist/Family Pract or/Utilization Mana ortation Services?	tice, General Pr agement/Utilizati	actice)	
C Yes C No					
				1	

#11a DME – Base 1

PBP Data Entry System - Section B-11, Contra	ct X0001, Plan 001, Segment 000	
File Help Previous Next (Validate)	Go To: #11a DME - Base 1 Exit (No Validate)	_
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category, except for MMPs. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out- of-Pocket Cost? C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select Maximum Enrollee Out-of-Pocket Cost periodicit C Every three years Every two years Every year Every six months C Every three months Other, Describe Is there an enrollee Coinsurance? C Yes Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits: Indi	Is there an enrollee Deductible?

#11a DME – Base 2

	ry System - S	ection B-11, Cont	tract X0001, Pla	in 001, Segn	ent 000	And in case of the local division of the loc	4.0.0	
File Help	Next	Exit (Validate)	Exit (No Validate)	Go To:	#11a DME - Base 2			
Physician Spe	eive Authoriza hysician (Inte cialist fedical Directo e	tion from one or m ernist/Family Pract or/Utilization Mana	nore of the follow tice, General Pri agement/Utilizat	wing: actice)	Note may include additional i category. Do not repeat infor Notes:	nformation to describe bene mation captured in data entr	efit in this service ry.	

#11a DME – MMP – Base 1

Previous Next (Validate) Go To: Validate)	#11a DME - MMP - Base 1
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance? Yes No Select which Non-Medicare Durable Medical Equipment(s) (select all that apply): Ourable Medical Equipment for use outside the home Other 1 Other 2 Indicate coinsurance percentage for one or more of the Coinsurance Coinsurance Durable Medical Equipment for use outside the home: Other 1: Other 2:

#11a DME – MMP – Base 2

Previous Next	Exit (Validate)	Go To: #11a Exit (No Validate)	IDME - MMP - Base 2	
select all that apply): Durable Medical Equipm Other 1 Other 2 dicate copayment Mi	Durable Medical Equi	m	Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for Services? Yes No Notes:	

#11b Prosthetics/Medical Supplies – Base 1

PBP Data Entry System - S	ection B-11, Cont	tract X0001, Plar	n 001, Segr	nent 000
File Help	Exit (Validate)	Exit (No Validate)	Go To:	#11b Prosthetics/Medical Supplies - Base 1
CLICK FOR DESCRIPTION (Enhanced Benefits are not app MMPs. Maximum Plan Benefit Coverage Is there a service-specific Maxi C Yes No Select Maximum Enrollee Out C Covered under DME Cate C Plan-specified amount pe Indicate Maximum Enrollee O Select Maximum Enrollee O C Every three years C Every three years C Every three years C Every sear C Every sear C Every sear C Every three months C Other, Describe	DF BENEFIT licable for this Ser ge is not applicable imum Enrollee Out -of-Pocket Cost ty gory 11a r period Out-of-Pocket Cos	vice Category, ex e for this Service -of-Pocket Cost? pe: 	Category	Is there an enrollee Coinsurance? Yes No Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply): Medicare-covered Prosthetic Devices Medicare-covered Medical Supplies Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices: Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices: Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies: Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies: Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:

#11b Prosthetics/Medical Supplies – Base 2

	ry System - Se	ection B-11, Cont	ract X0001, Plan	n 001, Segn	nent 000
File Help	Next	Exit (Validate)	Exit (No Validate)	Go To:	#11b Prosthetics/Medical Supplies - Base 2
Is there an enroll C Yes C No Indicate Deducti					Indicate Minimum Copayment amount per item for Medicare- covered Prosthetic Devices: Indicate Maximum Copayment amount per item for Medicare- covered Prosthetic Devices:
(Select all that	rosthetics/Me apply):	dical Supplies hav	re a Copayment	C	Indicate Minimum Copayment amount per item for Medicare- covered Medical Supplies: Indicate Maximum Copayment amount per item for Medicare- covered Medical Supplies:
Medicare-c					

#11b Prosthetics/Medical Supplies – Base 3

le <u>H</u> elp	, ,	ection B-11, Cont		, ,			
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: 📕	11b Prosthetics/Medical Supplies - Base 3		
None Primary Care P Physician Spec Organization N Other, describe	hysician (Inte cialist fedical Direct e	tion from one or m ernist/Family Pract or/Utilization Mana s Service Categor	ice, General Pra Igement/Utilizati	actice)	Note may include additional information to desc category. Do not repeat information captured in Notes:	ribe benefit in this service data entry.	

#11b Prosthetics/Medical Supplies – MMP – Base 1

File Help Previous Next Exit No CLICK FOR DESCRIPTION OF BENEFIT Is there an enrollee Coinsurance? Cyes No Indicate Coinsurance Percentage: Is there an enrollee Copayment? Is there a service-specific Maximum Plan Benefit Coverage amount? Indicate Copayment Amount: Indicate Copayment Amount:	PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segr	ment 000 📃 💼 💼 💼 👘
CLICK FOR DESCRIPTION OF BENEFIT Does this plan provide Non-Medicare Prosthetics/Medical Supplies? C Yes C Yes Indicate Coinsurance Percentage: C No Enter name of Non-Medicare Service: Is there a service-specific Maximum Plan Benefit Coverage amount? Indicate Copayment Amount:	Go To:	#11b Prosthetics/Medical Supplies - MMP - Base 1
Indicate Maximum Plan Benefit Coverage amount: Enrollee must receive Authorization from one or more of the following: Select Maximum Plan Benefit Coverage periodicity: Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Revi Every two years Other, describe Every tyree months Is a referral required for Services? Yes Notes: Notes: Notes:	Does this plan provide Non-Medicare Prosthetics/Medical Supplies? Yes No Enter name of Non-Medicare Service: Is there a service-specific Maximum Plan Benefit Coverage amount? Yes No Indicate Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage periodicity: Every three years Every two years Every two years Every six months Every three months	C Yes No Indicate Coinsurance Percentage: Is there an enrollee Copayment? C Yes C No Indicate Copayment Amount: Indicate Copayment Amount: Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Revi Other, describe Is a referral required for Services? C Yes C No

#11c Diabetic Supplies and Services – Base 1

🖳 PBP Data Entry System - S	ection B-11, Cont	tract X0001, Plan	n 001, Segr	ment 000	
<u>F</u> ile <u>H</u> elp					
Previous Next	Exit (Validate)	Exit (No Validate)	Go To:	#11c Diabetic Supplies and Services - Base 1	
CLICK FOR DESCRIPTION O Enhanced Benefits are not app Maximum Plan Benefit Coverag Is there a service-specific Maxi C Yes No Select Maximum Enrollee Out C Covered under DME Cate C Plan-specified amount per Indicate Maximum Enrollee O Select Maximum Enrollee O C Every three years C Every three years C Every three years C Every three months C Other, Describe Is there an enrollee Coinsuran C Yes C No	olicable for this Ser ge is not applicable mum Enrollee Out -of-Pocket Cost ty gory 11a r period Out-of-Pocket Cost	e for this Service -of-Pocket Cost? -pe: 		Select which Diabetic Supplies and Services have a Coinsurance (Select all that apply): Medicare-covered Diabetic Supplies Medicare-covered Diabetic Therapeutic Shoes or Inserts Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Supplies: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Supplies: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts: Indicate Deductible? Yes No Indicate Deductible Amount:	

#11c Diabetic Supplies and Services – Base 2

ile <u>H</u> elp	b.	4	×	Go To: #11c Diabetic Supplies and Services - Base 2	
Previous	Next	Exit (Validate)	Exit (No Validate)		
there an enrolle	e Copaymen	t?		Do you limit Diabetic Supplies and Services to those from specified manufacturer	
Yes				C Yes	
No	1 60 24 90	80.000 Ref 177		C No	
Select which Dia Select all that ap		s and Services hav	ve a Copayment	Enrollee must receive Authorization from one or more of the following:	
Medicare-cov				Primary Care Physician (Internist/Family Practice, General Practice)	
Medicare-cov	ered Diabetic	Therapeutic Shoe	s or inserts	Physician Specialist Organization Medical Director/Utilization Management/Utilization Review	
ndicate Minimur overed Diabete		amount per item fo	or Medicare-	C Other, describe	
overed Diabele.	s coppiles.			Referral is not applicable for this Service Category.	
ndicate Maximu covered Diabete		t amount per item f	or Medicare-	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
				Notes:	
covered Diabetic	Therapeutic m Copaymen	amount per item fo Shoes or Inserts: t amount per item f Shoes or Inserts:			

#12 End-Stage Renal Disease – Base 1

Previous Next (Validate)	Go To: #12 End-Stage Renal Di Exit (No Validate)	ease - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years Every two years Every year C Every six months C Other, Describe You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Is there an enrollee Deductible?	

#12 End-Stage Renal Disease – Base 2

	ry System - Se	ection B-12, Contr	act X0001, Pla	n 001, Segr	ment 000		and in strength	-		4.0.40		×
File Help	Next	Exit (Validate)	Exit (No Validate)	Go To:	#12 End-5	Stage Renal	l Disease - B	ase 2			•	
None Primary Care F Physician Spe Organization N Other, describ	eive Authoriza Physician (Inte cialist Medical Directo e	tion from one or m rnist/Family Pract pr/Utilization Mana age Renal Disease	ore of the follov ce, General Pra gement/Utilizati	ctice)								
C Yes		-										
C No												
Note may include Notes:	additional inf	ormation to descri	be benefit in this	service cat	tegory. Do r	notrepeat i	information o	captured in c	lata entry.			
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											*	

#13a Acupuncture – Base 1

- PBP Data Entry System - Section B-13, Contract	t H5505, Plan 003, Segment 0		And the second	
File Help				
Previous Next (Validate)	Go To: #13a Acupuncture - Ba Exit (No Validate)	sse 1		
CLICK FOR DESCRIPTION OF BENEFIT				
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Indicate Number of Treatments periodicity:	Is there a service-specific Maximum Enrollee Out- of-Pocket Cost?		
C Yes C No	© Every two years © Every year	C Yes C No		
Select enhanced benefit:	C Every six months C Every three months C Other, Describe	Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
Select type of benefit for Number of Treatments:	Is there a service-specific Maximum Plan Benefit Coverage amount?			
C Mandatory C Optional	C Yes C No	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:		
Is this benefit unlimited for Number of Treatments?	Indicate Maximum Plan Benefit Coverage amount:	 C Every three years C Every two years C Every year C Every year C Every six months 		
© No	Indicate Maximum Plan Benefit Coverage periodicity:	 Every three months Other, Describe 		
Indicate limit for Number of Treatments:	C Every three years Every two years			
Do you offer a combined Acupuncture and Chiropractor Services benefit? C Yes C No	 Every year Every six months Every three months Other, Describe 			

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#13a Acupuncture – Base 2

<u>File</u> <u>H</u> elp	
Previous Next (Validate)	Go To: #13a Acupuncture - Base 2
Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage: Indicate Maximum Coinsurance percentage: Is there an enrollee Deductible? Yes No Indicate Deductible Amount:	Is there an enrollee Copayment? Yes No Indicate Minimum Copayment amount per treatment: Indicate Maximum Copayment amount per treatmen

#13a Acupuncture – Base 3

le <u>H</u> elp							
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#13a Acupuncture - Base 3		
upuncture Note	es						
te may include	additional info	ormation to descri	be benefit in this	service ca	tegory. Do not repeat information captured in data entry.		
tes:							
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#13b OTC Items – Base 1

Eile <u>H</u> elp	
Previous Next (Validate)	Go To: #13b OTC tems - Base 1
	Indicate Maximum Enrollee Out-of-Pocket Cost amount:

#13b OTC Items – Base 2

ile <u>H</u> elp				
Previous	Next	Exit (Validate)	Go To: #13b OTC tems - Base 2 Exit (No Validate)	
there an enroll	ee Coinsuranc	e?	Is there an enrollee Copayment?	
`Yes `No			C Yes C No	
ndicate Minimu	m Coinsuranc	e percentage:	Indicate Minimum Copayment amount:	
ndicate Maximu	im Coinsurand	e percentage:	Indicate Maximum Copayment amount:	
s there an enro	llee Deductible	9?	Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	
⊖Yes ⊖No			C Yes C No	
Indicate Deduc	tible Amount:		Authorization is not applicable for this service category.	
			Referral is not applicable for this service category.	

#13b OTC Items – Base 3

e <u>H</u> elp		Exit	Exit (No Validate)	Go To:	#13b OTC to	ems - Base 3				•	
revious	Next	(Validate)	Validate)		_			_			-
C Items Notes											
e may include	additional info	ormation to descri	be benefit in this	service ca	ategory. Do not	repeat informat	ion captured in	data entry.			
15:											
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#13c Meal Benefit – Base 1

File Heip Go To: Previous Next Culok FOR DESCRIPTION OF BENEFIT Does the plan provide a Meal Benefit as supplemental benefit under Part CP Yes No Select type of benefit: Mondatory Control of the plan provide a Meal Benefit last? Indicate Maximum Plan Benefit Coverage amount: C Every three years C Every three months C Other, Describe O the years C Every the years C Every the months C Other, Describe	9 PBP Data Entry System - Section B-13, Contract X0001, Plan C	n 001, Segment 000	
Previous Next Exit No Validate) CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide a Meal Benefit as a supplemental benefit under Part C? C Yes C Yes Select type of benefit: C Mandatory Optional How many days does your Meal Benefit last? What is the maximum number of meals the benefit provides? Is there a service-specific Maximum Enrollee Out-of-Pocket Cost periodicity: C Yes Mon many days does your Meal Benefit last? Indicate Maximum Plan Benefit Coverage amount C Yes Indicate Maximum Plan Benefit Coverage amount Indicate Maximum Plan Benefit Coverage periodicity: C Every three years C Every three years C Every three years C Every three months C Every three months C Every three months C Every star months C Every three months C Every three months			
Does the plan provide a Meal Benefit as a supplemental benefit under Part C? Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes No Select type of benefit: Indicate Maximum Enrollee Out-of-Pocket Cost amount: C Mandatory Indicate Maximum Enrollee Out-of-Pocket Cost amount: What is the maximum number of meals the benefit provides? Indicate Maximum Plan Benefit Coverage amount: V Yes C Every three years C No C Every three months Indicate Maximum Plan Benefit Coverage amount: C Every three months Indicate Maximum Plan Benefit Coverage amount: C Every three months Indicate Maximum Plan Benefit Coverage periodicity: C Every three months C Every three years C Every three months C Every type ar C Other, Describe	Exit Exit (No	Go To: #13c Meal Benefit - Base 1	
	Previous Next Exit (Validate) Exit (No Validate) CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every three years C Every three years C Every six months C Every three months	
			1

#13c Meal Benefit – Base 2

🖳 PBP Data Entry Syste	em - Section B-13, Cont	ract X0001, Pla	n 001, Segment 000	
Eile Help Previous Ne	Exit (Validate)	X Exit (No Validate)	Go To: #13c Meal Benefit - Base 2	<u> </u>
Is there an enrollee Coir C Yes C No Indicate Minimum Coin: Indicate Maximum Coir	surance percentage:		Is there an enrollee Copayment? C Yes C No Indicate Minimum Copayment amount: Indicate Maximum Copayment amount:	
Is there an enrollee Dec C Yes C No Indicate Deductible Am	00000		Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for the Meal Benefit? Yes	
			C No	

#13c Meal Benefit – Base 3

e <u>H</u> elp									 	
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#13c Meal E	lenefit - Base 3			<u>•</u>	
al Benefit Note	s									
te may include	additional inf	ormation to descri	be benefit in this	s service ca	tegory. Do no	t repeat informa	tion captured ir	n data entry.		
tes:									 	
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#13d Other 1 – Base 1

PBP Data Entry System - Section B-13, Contract X0	0001, Plan 001, Segment 000
	Go To: #13d Other 1 - Base 1
CLICK FOR DESCRIPTION OF BENEFIT Note: After completing your data entry in this category, i ALL text in the 'Enter name of Service (Optional).' field y all previously entered data. You may edit the name of the service text partially without previously entered data. Do not put Medicare-covered benefits in this service cat do not include homehealth, nutritional support, transpor- nedical devices etc). Diver-the-Counter (e.g., adult diapers, band-aids, etc) be should only be entered in B-13C. fproviding a supplemental benefit, enter a descriptive ti s not an acceptable title. Enter name of Service (Optional):	ou will lose Indicate Maximum Plan Benefit Coverage periodicity: at losing all C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Select type of benefit: C Mandatory C Optional Is there a service-specific Maximum Plan Benefit Covera C Yes C No	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe

#13d Other 1 – Base 2

<u>File H</u> elp				
Previous	Next	Exit (Validate)	Go To: #13d Other 1 - Base 2 Exit (No Validate)	•
ls there an enroll	ee Coinsuranc	:e?	Is there an enrollee Copayment?	
C Yes C No			C Yes C No	
Indicate Minimu	m Coinsuranc	e percentage:	Indicate Minimum Copayment amount:	
Indicate Maximu	im Coinsurand	e percentage:	Indicate Maximum Copayment amount:	
	- Brancella		Enrollee must receive Authorization from or None Primary Care Physician (Internist/Family Physician Specialist	
Is there an enroll C Yes C No	ee Deductible	<i>(</i>	Organization Medical Director/Utilization Other, describe	n Management/Utilization Review
Indicate Deduct	ible Amount:		Is a referral required for Other Services?	
				70

#13d Other 1 – Base 3

ile <u>H</u> elp				n 001, Segment 000					
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #13d Of	her 1 - Base 3				
ther Services N	otes								
ote may include	additional info	ormation to descri	be benefit in this	s service category. Do	not repeat informat	ion captured in da	ta entry.		
otes:									
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#13e Other 2 – Base 1

#13e Other 2 – Base 2

📮 PBP Data Entry System - Section B-13, Contract 2	K0001, Plan 001, Segment 000	
File Help Previous Next (Validate)	Go To: #13e Other 2 - Base 2 Exit (No Validate)	•
Is there an enrollee Coinsurance? C Yes C No Indicate Minimum Coinsurance percentage: Indicate Maximum Coinsurance percentage:	Is there an enrollee Copayment? C Yes C No Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Enrollee must receive Authorization from one or more of the following:	
Is there an enrollee Deductible? C Yes No Indicate Deductible Amount:	Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for Other Services? C Yes No	

#13e Other 2 – Base 3

<u>H</u> elp	ry System - Se					
revious	Next	Exit (Validate)	Exit (No Validate)	Go To: #13e Other 2 - Base 3	<u>·</u>	
er Services N	otes					
e may include	additional inf	ormation to descri	he benefit in this	service category. Do not repeat information capt	ured in data entry	
	additionarini	officiation to descri	be benefit in this	service category. Do not repeat mormatori capa	dicom data cita y.	
es:					*	
					*	

#13f Other 3 – Base 1

Eile Help Previous Next (Validate) Go Validate	To: #13f Other 3 - Base 1
CLICK FOR DESCRIPTION OF BENEFIT Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional):' field you will lose all previously entered data. You may edit the name of the service text partially without losing all previously entered data. Do not put Medicare-covered benefits in this service category (e.g., do not include homehealth, nutritional support, transportation, medical devices etc). Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13B. If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title. Enter name of Service (Optional):	Indicate Maximum Plan Benefit Coverage amount: Indicate Maximum Plan Benefit Coverage periodicity: C Every three years C Every two years C Every year C Every six months C Every six months C Other, Describe Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Select type of benefit: C Mandatory C Optional Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every year C Every year C Every six months C Every three months C Other, Describe
C No	

#13f Other 3 – Base 2

	ection B-13, Contra	act X0001, Plan 001, Segment 000	
Eile Help	Exit (Validate)	Go To: #13f Other 3 - Base 2	
Is there an enrollee Coinsuran C Yes C No Indicate Minimum Coinsuran Indicate Maximum Coinsuran Is there an enrollee Deductible C Yes No Indicate Deductible Amount:	ce percentage: ce percentage:	Is there an enrollee Copayment?	

#13f Other 3 – Base 3

File Help Previous Next Exit No Validate) Co To: F13f Other 3 - Base 3 Other Services Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	
lote may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
lotes:	
ж. Т	

#13g Dual Eligible SNPs with Highly Integrated Services – Base 1

new quality for the new supplemental benefit flexibility for certain Dual Eligible SNPs ith Highly Integrated Services. nual Eligible SNPs with Highly Integrated Services Benefit Attestation I attest that I have received written notification from CMS that this individual SNP plan qualifies for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services for CY 2016. I further attest that the eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside. You may edit the name of the service text partially without losing all previously intered data. Providing a supplemental benefit, enter a descriptive title. "Other" is not an	<u>F</u> ile <u>H</u> elp							
CuberPork Description OP Benefit	Previous	Next	Exit	Exit (No	Go To: <u>#13</u> g	Dual Eligible SNPs with Highly Integrated Services - Base 1	•	
Ians only fill outhis section if they have received written notification from CMS that highly Integrated Services.	CLICK FOR DE	SCRIPTION C				Is there a service-specific Maximum Plan Benefit Coverage amount?		
hey qualify for the new supplemental benefit flexibility for certain Dual Eligible SNPs Indicate Maximum Plan Benefit Coverage amount: Dual Eligible SNPs with Highly Integrated Services. Indicate Maximum Plan Benefit Coverage periodicity: I attest that 1 have received written notification from CMS that this individual SNP plan qualifies for the new supplemental benefit (5 that the SNP describes in this section of the PBP do notinappropriately duplicate an existing service(s) thatenrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside. Indicate Maximum Plan Benefit Coverage periodicity: Course waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside. Indicate Maximum Enrollee Out-of-Pocket Cost? Course out and a supplemental benefit, enter a descriptive title. "Other" is not an cceptable title. Indicate Maximum Enrollee Out-of-Pocket Cost? Enter name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost amount: Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Select type of benefit: C Every three years Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Select type of benefit: C Every three years E very three years C Mandatory Optional E very three years E very three years C Every three months C						C Yes		
with Highly Integrated Services. Indicate Maximum Plan Benefit Coverage amount: Dual Eligible SNPs with Highly Integrated Services Benefit Attestation Indicate Maximum Plan Benefit Coverage periodicity: I attest that I have received written notification from CMS that this individual SNP plan qualifies for the new supplemental benefit (s) that the SNP describes in this section of the additional supplemental benefit (s) that the SNP describes in this section of the eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or Broving the local jurisdiction in which they reside. Indicate Maximum Plan Benefit Coverage amount: You may edit the name of the service text partially without losing all previously intered data. Indicate Maximum Plan Benefit Coverage amount: You may edit the name of Service (Optional): Enter name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost amount: Enter name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Select type of benefit: C Every three years Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Select type of benefit: C Every three years C Every three years C Every three years C Every three years C Every three years C Mandatory Optional C Every three years C Every three years								
Dual Eligible SNPs with Highly Integrated Services Benefit Attestation Indicate Maximum Plan Benefit Coverage periodicity: I attest that I have received written notification from CMS that this individual SNP plan qualifies for the new supplemental benefit; blatthe SNP describes in this section of the PBP do notinappropriately duplicate an existing service(s) thatenrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside. Indicate Maximum Plan Benefit Coverage periodicity: You may edit the name of the service text partially without losing all previously entered data. Indicate Maximum Enrollee Out-of-Pocket Cost? You may edit the name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost amount: Enter name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Select type of benefit: Civery three years Civery three years Civery three years Civery type Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Select type of benefit: Civery three years Civery three years Civery ye				ibility for certain	Dual Eligible SNPS			
Latest that L have received written notification from CMS that this individual SNP plan qualifies for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services for CY 2016. If urther attest that the additional supplemental benefit (s) that the SNP describes in this section of the PBP do not inappropriately duplicate an existing service(s) that encodes are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside. Indicate Maximum Plan Benefit Coverage periodicity: You may edit the name of the service text partially without losing all previously entered data. Indicate Maximum Enrollee Out-of-Pocket Cost? You may edit the name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost amount: Enter name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Select type of benefit: C Every three years C Mandatory C Every sear C Dytional C Every sear	Dual Eligible SND	s with Highly	Integrated Servic	er Benefit Attes	tation	a contract the second		
Instruction from CMS tracting individual sNP plan qualifies for the new supplemental benefit (s) that the SNP describes in this section of the additional supplementale) duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside. C Every three years Por dumay editthe name of the service text partially without losing all previously intered data. C Usery three months You may editthe name of the service text partially without losing all previously intered data. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes C Yes Enter name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select type of benefit: C Every three years C Mandatory C Optional	and the second second		arata a nte son rationnan.			Indicate Maximum Dian Benefit Coverage periodicity:		
SNPs with Highly Integrated Services for CY 2016. I further attest that the additional supplemental benefit (s) that the SNP describes in this section of the PBP do not inappropriately duplicate an existing service(s) thaternollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside. C. Every two years You may edit the name of the service text partially without losing all previously entered data. C. Every three months C. Other, Describe You may edit the name of the service text partially without losing all previously entered data. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes C. Yes Indicate Maximum Enrollee Out-of-Pocket Cost? Select type of benefit: C. Every three years C. Mandatory C. Every two years C. Every three months C. Every three months C. Optional C. Every three months								
additional supplemental benefit; C Every year PBP do not inappropriately duplicate an existing service(s) thaternollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside. C Every year You may edit the name of the service text partially without losing all previously entered data. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? You may edit the name of the service (optional): Is there a service service text partially without losing all previously entered data. If providing a supplemental benefit, enter a descriptive title. *Other* is not an acceptable title. C Yes Enter name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select type of benefit: C Every three years C Mandatory C Every year C Optional Every year	SNPs with Hig	hly Integrated	Services for CY	2016. I further a	ttest that the	Every mile years		
eligible to receive under a waiver, the State Medical of plan, Medicare Part A or B, or through the local jurisdiction in which they reside. C Every six months You may edit the name of the service text partially without losing all previously entered data. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? You may edit the name of the service text partially without losing all previously entered data. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost amount: Enter name of Service (Optional): Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Select type of benefit: C Every six months C Mandatory C Every six months C Every years C Every year C Every three months C Every three months								
or through the local jurisdiction in which they reside. C Every three months Other, Describe Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Select type of benefit:								
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entered data. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? If providing a supplemental benefit, enter a descriptive title. *Other* is not an acceptable title.						C Other, Describe		
Indicate Maximum Enrollee Out-of-Pocket Cost amount: Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Select type of benefit: C Every three years C Mandatory C Every two years C Optional C Every two years C Every six months C Every three months		name of the se	rvice text partially	without losing	all previously	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
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Select type of benefit: C Every three years C Mandatory C Every two years C Optional C Every six months C Every three months C Every three months		promortarioon	oni, onior a dosor	pure lue. out	or is not an	C No		
Select type of benefit: C Every three years C Mandatory C Every two years C Optional C Every six months C Every three months C Every three months	Enter name of S	ervice (Ontio	nal):			Indicate Maximum Enrollee Out-of-Pocket Cost amount		
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	optonar							
C Other, Describe								
						C Other, Describe		

#13g Dual Eligible SNPs with Highly Integrated Services – Base 2

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Exit	Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 2 Exit (No Validate)	•
s there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes C No	C Yes C No	
Indicate Minimum Coinsurance percentage:	Indicate Minimum Copayment amount: Indicate Maximum Copayment amount:	
s there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:	
C Yes C No	│ None │ Primary Care Physician (Internist/Family Practice, General Practice) │ Physician Specialist	
Indicate Deductible Amount:	Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for Other Services? O Yes O No	

#13g Dual Eligible SNPs with Highly Integrated Services – Base 3

e <u>H</u> elp				
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 3
al Eligible SNP:	s with Highly	Integrated Service	s Notes	
te may include	additional inf	ormation to descri	be benefit in thi	is service category. Do not repeat information captured in data entry.
es:				A
				2

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	Additional Services - Base 1
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(validate) validate)	
CLICK FOR DESCRIPTION OF BENEFIT	
CEICKT OK DESCRIPTION OF BENEFIT	Enter name of Other 1 Service:
es the plan provide Additional Services?	A set of the set of th
	Enter name of Other 2 Service:
Yes	
No	Enter name of Other 3 Service:
Select Additional Services (select all that apply):	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Enter name of Other & Service:
Tobacco Cessation Counseling for Pregnant Women	Enter name of Other 4 Service:
Freestanding Birth Center Services Respiratory Care Services	
Family Planning Services	Enter name of Other 5 Service:
Nursing Home Services	
Home and Community Based Services	Enter name of Other 6 Service:
Personal Care Services	
Self-Directed Personal Assistance Services	
Private Duty Nursing Services	Enter name of Other 7 Service:
Case Management (Long Term Care)	
Institution for Mental Disease Services for Individuals 65 or Older	Enter name of Other 8 Service:
Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities	Enter hame of other o service.
Case Management Other 1	
Other 2	Enter name of Other 9 Service:
Other 3	
Other 4	Enter name of Other 10 Service:
Other 5	
Other 6	
Other 7	Enter name of Other 11 Service:
Other 8	
Other 9 Other 10	Enter name of Other 12 Service:
Other 11	
Other 12	
Other 13	Enter name of Other 13 Service:
Other 14	
Other 15	
Other 16	
Other 17	
Other 18	
Other 19	
Other 20	
Other 21 Other 22	

Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #13h Additional Services - Base 2	
				Is there a limit on the Additional Services provided?	
Enter name of Ot	ner 14 Service:			C Yes	
				C No	
Enter name of Ot	her 15 Service:			Select Additional Services where limit applies:	
				Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	
Enter name of Ot	her 16 Service:			Tobacco Cessation Counseling for Pregnant Women	
				Freestanding Birth Center Services	
	h == 47 C			Respiratory Care Services Family Planning Services	
Enter name of Ot	ner 17 Service:			Nursing Home Services	
				Home and Community Based Services	
Enter name of Ot	her 18 Service:			Personal Care Services	
				Self-Directed Personal Assistance Services	
Enter name of Ot	her 19 Service			Private Duty Nursing Services	
				Case Management (Long Term Care) Institution for Mental Disease Services for Individuals 65 or Older	
				Services in an Intermediate Care Facility for Individuals 65 of Older	
Enter name of Ot	her 20 Service:			Case Management	
				Other 1	
Enter name of Ot	her 21 Service:			Other 2	
				Other 3	
				Other 4 Other 5	
Enter name of Otl	her 22 Service:			Other 6	
				Other 7	
Enter name of Oth	her 23 Service:			Other 8	
				Other 9	
				Other 10	
				Other 11	
				Other 12 Other 13	
				Other 13	
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				Other 23	

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Indicate units a and Treatment (limit will be prov	ided in for Early	and Periodic Sc	reening, Diagnostic,	Indicate units a limit will be provided in for Freestanding Birth Center Services:	
	(EPSDT) Servic	es:			C Sessions	
C Sessions C Visits					C Visits	
O Visits O Hours					O Hours O Points	
C Points					O Points O Meals	
O Meals					O Other, Describe	
C Other, Desc						
Diagnostic, and	cal limit on the: 1 Treatment (EF	services provide	d for Early and F	eriodic Screening,	Indicate numerical limit on the services provided for Freestanding Birth Center Services	285
	a riounioni (Ei	00170011000				
Select limit on s Treatment (EPS	ervices periodi	city for Early and	Periodic Screen	ing,Diagnostic, and	Select limit on services periodicity for Freestanding Birth Center Services:	
C Every day	S r / Services:				C Every day	
C Every day C Every week					C Every week	
O Every mont					C Every month	
C Every year					C Every year C Every Session/Visit	
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C Every Pregr					C Every Lifetime	
C Every Lifetin C Other, Desc					C Other, Describe	
Indicate units a		ided in for Toba	one Constition C	ouncoling for	Indicate units a limit will be provided in for Respiratory Care Services:	
Pregnant Wom	en:	nucumorroba	cco cessaion c	ounsening for		
C Sessions					C Sessions C Visits	
C Visits					C Hours	
C Hours					C Points	
C Points C Meals					C Meals	
C Meals C Other, Desc	oriha				O Other, Describe	
io oalei, bese	2100					
Indicate numerio	cal limiton the s	ervices provide	d for Tobacco Ce	ssationCounseling	Indicate numerical limit on the services provided for Respiratory Care	
for Pregnant We	omen:				Services:	
Select limit on se	ervices periodi	city for Tobacco	Cessation Coun	seling for Pregnant	Select limit on services periodicity for Respiratory Care Services:	
Women:	0111005 poiledi			, and a second		
C Every day					C Every day C Every week	
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PBP Data Entr	y System - S	ection B-13, Co	ntract X0001,	Plan 001, 5	egment 000	
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		(vanuate)	valuate)			
Indicate units a li	imit will be pro	vided in for Fam	ly Planning Ser	vices:	Indicate units a limit will be provided in fo	r Home and Community Based Services
C Sessions					C Sessions	
O Visits O Hours					O Visits O Hours	
C Points					C Points	
C Meals C Other, Descr	riba				C Meals C Other, Describe	
Indicate numeric		services provide	d for Family Pla	nning Servic		ovided for Home and
					Community Based Services:	
Select limit on se	rvices periodi	city for Family Pl	anning Services	c.	Select limit on services periodicity for Ha	me and Community Based Services:
C Every day C Every week					C Every day C Every week	
C Every month	1				C Every month	
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Indicate units a li	mit will be prov	vided in for Nurs	ing Home Servi	ces:	Indicate units a limit will be provided in fo	r Personal Care Services:
C Sessions					C Sessions	
C Visits C Hours					C Visits C Hours	
C Points					C Points	
C Meals C Other, Descri	ihe				C Meals C Other, Describe	
Indicate numeric		services provide	d for Nursing H	ome		
Services:					Indicate numerical limit on the services p	rovided for Personal Care Services:
					L	
Select limit on se	ervices period	icity for Nursing	Home Services:		Select limit on services periodicity for Pe	rsonal Care Services:
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ile <u>H</u> elp					
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Indicate units a limit will	be provided in for Self-	-Directed Persor	al Assistance Services:	Indicate units a limit will be provided in for Case Management (Long Term Care):	
C Sessions				© Sessions	
C Visits				C Visits	
O Hours				C Hours	
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O Other, Describe				C Other, Describe	
	on the services provide	ed for Self-Direct	ed Personal Assistance	Indicate numerical limit on the services provided for Case Management (Long Term	
Services:				Care):	
Selectlimit on services p	periodicity for Self-Dire	cted Personal A	ssistance Services:	Select limit on services periodicity for Case Management (Long Term Care):	
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C Every month				C Every month	
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Other, Describe				C Other, Describe	
dianto unito a limiturill	be provided in for Priv	ata Dutu Nursina	Services	Indicate units a limit will be provided in for Institution for Mental Disease Services for	
Sessions	be provided in for Priv	ate Duty Nursing	Services.	Indicate units a minit will be provided in for institution for wental Disease services for Individuals 65 or Older:	
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Hours				C Visits	
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Meals				C Points C Meals	
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ndicate numerical limit	on the services provid	ed for Private Du	ty Nursing Services:	Indicate numerical limit on the services provided for Institution for Mental Disease	
				Services for Individuals 65 or Older:	
electlimit on services p	periodicity for Private D	outy Nursing Ser	vices:	Select limit on services periodicity for Institution for Mental Disease Services for	
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e <u>H</u> elp			
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ndicate units a limit will be provided in for Serv ndividuals with Intellectual Disabilities:	rices in an Intermediate Care Facility for	Indicate units a limit will be provided in for Other 1:	
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ndicate numerical limit on the services provide	ad for Services in an Intermediate Care		
acility for Individuals with Intellectual Disabilit	es:	Indicate numerical limit on the services provided for Other 1:	
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C Every Pregnancy		C Every Lifetime	
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ndicate units a limit will be provided in for Cas	e Management:	Indicate units a limit will be provided in for Other 2:	
C Sessions		C Sessions	
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dicate numerical limit on the services provid	ed for Case Management:	Indicate numerical limit on the services provided for Other 2:	
elect limit on services periodicity for Case Ma	nagement:	Select limit on services periodicity for Other 2:	
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C Every week		C Every week	
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	y System - S	iection B-13, Co	ontract X0001	Plan 001, Segment 000
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Indicate units a lir	and the second	uided in fee Othe		In directory with a literatively becaused and in fact Others 0.
C Sessions	mit will be pro	vided in for Othe	84.	Indicate units a limit will be provided in for Other 6:
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ovided in for Other 7: Indicate units a limit will be provided Sessions Ses	invices provided for Other 9:
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a services provided for Other 7: Indicate numerical limit on the service dicity for Other 7: Select limit on services periodicity fi C Every week C Every week C Every month C Every month C Every Session/Visit C Every Pregnancy C Every Visit C Every Cletime O Other, Describe ovided in for Other 8: Indicate units a limit will be provided C Sessions C Visits C Hours C Points C Other, Describe	ty for Other 9:
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C Every month C Every session/Visit C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe	ted in for Other 10:
O Every year C Every year C Every Session/Nsit C Every Lifetime O Other, Describe ovided in for Other 8: Indicate units a limit will be provided ovided in for Other 8: Indicate units a limit will be provided O Sessions O Visits O Hours O Hours O Hours O Hours O Other, Describe	ied in for Other 10:
C Every Session/Nait C Every Session/Nait C Every Pregnancy C Every Utetime C Other, Describe ovided in for Other 8: Indicate units a limit will be provided C Sessions C Visits C Hours C Points C Neals C Other, Describe	ted in for Other 10:
O Every Pregnancy O Every Lifetime Order, Describe avided in for Other 8: Indicate units a limit will be provided O Cher Sessions O Hours O Hours O Hours O Cheals O Other, Describe	led in for Other 10:
ovided in for Other 8: C Sessions C Visits C Hours C Points C Mours C Meals C Other, Describe	led in for Other 10:
C Other, Describe ovided in for Other 8: C Sessions C Visits C Hours C Points C Meals C Other, Describe	ted in for Other 10:
ovided in for Other 8: Indicate units a limit will be provided C Sessions C Visits O Hours C Points C Meals O Other, Describe	led in for Other 10:
C Sessions C Visits C Hours C Points C Neals C Other, Describe	led in for Other 10:
C Sessions C Visits C Hours C Points C Neals C Other, Describe	led in for Utter 10:
C Visits C Hours C Points C Meals C Other, Describe	
C Hours C Points C Meals C Other, Describe	
C Points C Meals C Other, Describe	
C Meals C Other, Describe	
C Other, Describe	
Indicate Humerical Infit of the servic	nines accuided for Other 10.
	vices provide ior other ro.
dicity for Other 8: Select limit on services periodicity for	y for Other 10:
C Every Session/Visit	
C Every Pregnancy C Every Lifetime	
C Every Litetime	
indig for Onter 6.	C Every day C Every week C Every month C Every year C Every Session/Visit

	System - S	ection B-13, Co	ontract X0001	Plan 001, Segment 000
<u>E</u> ile <u>H</u> elp				
		Sec.	X Exit (No	Go To: #13h Additional Services - Base 9
Previous	Next	(Validate)	Validate)	
Indicate units a lin	nit will be pro	vided in for Oth	er 11:	Indicate units a limit will be provided in for Other 13:
C Sessions C Visits				C Sessions C Visits
C Hours				C Hours
C Points				C Points
C Meals C Other, Descril				C Meals C Other, Describe
Indicate numerica		services provide	ed for Other 11	Indicate numerical limit on the services provided for Other 13
Select limit on ser				Select limit on services periodicity for Other 13:
C Every day	rvices period	licity for Other 11		© Every day
C Every day C Every week				C Every week
C Every month				C Every month
C Every year C Every Sessio				C Every year C Every Session/Visit
C Every Sessio				C Every Pregnancy
C Every Lifetime	e			C Every Lifetime
C Other, Descri	ibe			C Other, Describe
Indicate units a lin	nit will be pro	vided in for Oth	er 12:	Indicate units a limit will be provided in for Other 14:
C Sessions				C Sessions
C Visits C Hours				C Visits
C Points				C Hours C Points
C Meals				O Meals
C Other, Descril	be			C Other, Describe
Indicate numerica	I limit on the	services provide	ed for Other 12:	Indicate numerical limit on the services provided for Other 1
Select limit on ser	vices period	icity for Other 12	:	Select limit on services periodicity for Other 14:
C Every day C Every week				O Every day O Every week
C Every week				C Every week
C Every year				C Every year
C Every Session C Every Pregna				C Every Session/Visit C Every Pregnancy
C Every Lifetime	h cy			C Every Freghancy
C Other, Descril				C Other, Describe

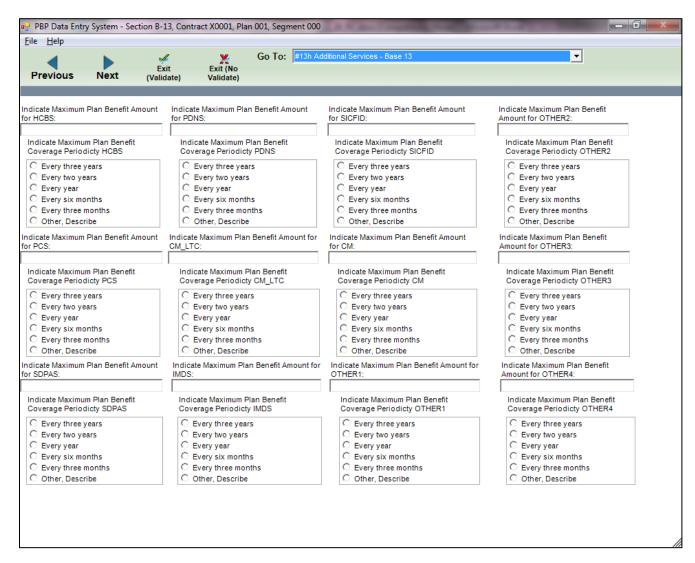
PBP Data Entr	v System - 9	ection B-13. Co	ntract X0001	Plan 001, Segment 000
jie <u>H</u> elp				
		4	v	Go To: #13h Additional Services - Base 10
	Next	Exit	Exit (No	
Previous	Next	(Validate)	Validate)	
Indicate units a I	imit will be pro	vided in for Oth	er 15:	Indicate units a limit will be provided in for Other 17:
C Sessions				C Sessions
O Visits				C Visits
C Hours C Points				C Hours C Points
C Points C Meals				O Points O Meals
O Other, Descr	ribe			O Other, Describe
Indicate numeric		services provide	d for Other 15:	Indicate numerical limit on the services provided for Other 17:
				Select limit on services periodicity for Other 17:
Select limit on se	ervices period	icity for Other 15		
C Every day				C Every day C Every week
C Every week C Every month				C Every week
C Every year				C Every year
C Every Sessio				C Every Session/Visit
C Every Pregn				C Every Pregnancy
C Every Lifetim				C Every Lifetime C Other, Describe
C Other, Descr	nde			
Indicate units a l	imit will be pro	wided in for Oth	er 16:	Indicate units a limit will be provided in for Other 18:
C Sessions				C Sessions
O Visits O Hours				O visits
C Points				C Hours C Points
O Meals				O Points O Meals
C Other, Desci	ribe			O Other, Describe
Indicate numeric	al limit on the	services provid	ed for Other 16:	Indicate numerical limit on the services provided for Other 18:
	an innin on and	Services provid		Indicate numerical limit on the services provided for Other 18:
Select limit on se	ervices period	icity for Other 16		Select limit on services periodicity for Other 18:
C Every day				C Every day
C Every week				C Every week
C Every month				C Every month
C Every year C Every Sessio	n A/isit			C Every year C Every Session/Visit
C Every Pregn	ancy			O Every Pregnancy
C Every Lifetim	e			C Every Lifetime
C Other, Descr	ribe			C Other, Describe

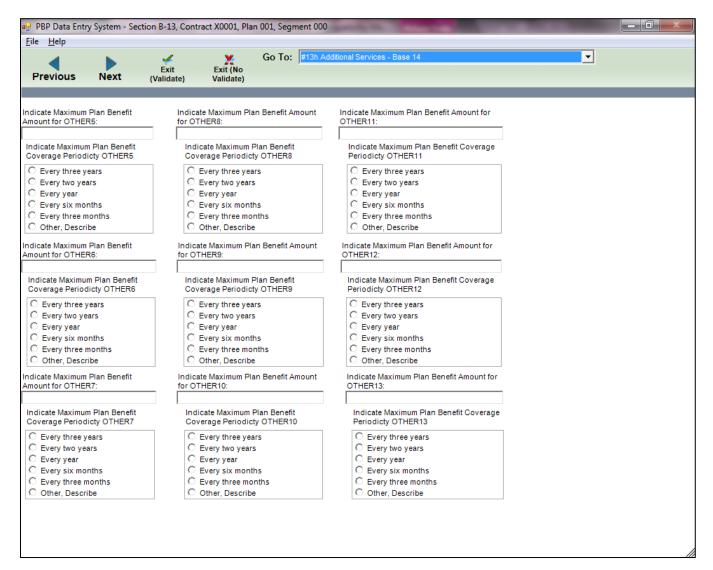
🔢 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment	t 000	
Ele Help		
Evit Evit No	Additional Services - Base 11	
Previous Next (Validate) Validate)		
Indicate units a limit will be provided in for Other 19:		
O Sessions	Indicate units a limit will be provided in for Other 21:	Indicate units a limit will be provided in for Other 23:
O Visits	C Sessions C Visits	C Sessions C Visits
C Hours	O Hours	C Visits C Hours
C Points	C Points	O Points
C Meals	C Meals	O Meals
C Other, Describe	C Other, Describe	C Other, Describe
Indicate numerical limit on the services provided for Other 19:	Indicate numerical limit on the services provided for Other 21:	Indicate numerical limit on the services provided for Other 23:
Select limit on services periodicity for Other 19: C Every day	Select limit on services periodicity for Other 21:	Select limit on services periodicity for Other 23:
C Every day	C Every day	C Every day
C Every week	C Every week	C Every week
O Every year	C Every month C Every year	O Every month
O Every Session/Visit	C Every year C Every Session/Visit	C Every year
C Every Pregnancy	C Every Session/Visit C Every Pregnancy	C Every Session/Visit C Every Pregnancy
C Every Lifetime	O Every Lifetime	O Every Pregnancy O Every Lifetime
C Other, Describe	O Other, Describe	C Other, Describe
Indicate units a limit will be provided in for Other 20:	Indicate units a limit will be provided in for Other 22:	
C Sessions	C Sessions	
C Visits	C Visits	
C Hours C Points	O Hours	
C Points C Meals	O Points	
C Other, Describe	O Meals	
Indicate numerical limit on the services provided for Other 20:	C Other, Describe	
	Indicate numerical limit on the services provided for Other 22:	
Select limit on services periodicity for Other 20:	Colorit limit an anni an iorr anni a fisite fan Othan 20.	
O Every day	Select limit on services periodicity for Other 22:	7
C Every week	C Every day	
C Every month	C Every week C Every month	
O Every year	C Every month C Every year	
C Every Session/Visit	C Every year C Every Session/Visit	
C Every Pregnancy	C Every Pregnancy	
C Every Lifetime	O Every Lifetime	
C Other, Describe	O Other, Describe	
	·	-

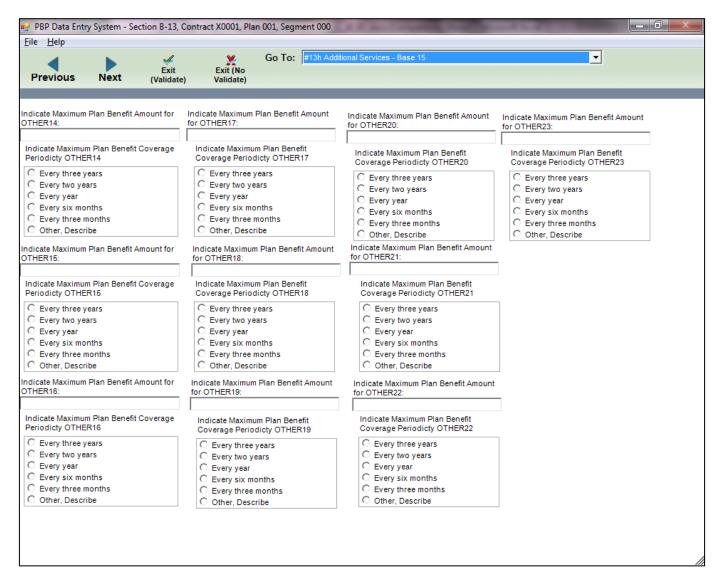
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🚆 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Seg	nent 000	
Ele Help	24 Additional Consideration Report 40	
Fxit Exit No	3h Additional Services - Base 12	
Previous Next (Validate) Validate)		
Is there a Maximum Plan Benefit Amount for Additional Services?	Indicate Maximum Plan Benefit Amount for EPSDT:	
C Yes		Indicate Maximum Plan Benefit Amount for RCS:
C No		1
Select which Additional Services have a Maximum Plan Benefit Coverage Amount (Select all that apply):	Indicate Maximum Plan Benefit Coverage Periodicty EPSDT	Indicate Maximum Plan Benefit Coverage Periodicty RCS
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	C Every three years	C Every three years
Tobacco Cessation Counseling for Pregnant Women Freestanding Birth Center Services	C Every two years	C Every two years
Respiratory Care Services	C Every year	C Every year
Family Planning Services Nursing Home Services	C Every six months	C Every six months C Every three months
Home and Community Based Services	C Every three months C Other, Describe	O Other, Describe
Personal Care Services Self-Directed Personal Assistance Services		
Private Duty Nursing Services	Indicate Maximum Plan Benefit Amount for TCCPW:	Indicate Maximum Plan Benefit Amount for FPS:
Case Management (Long Term Care)		I
Institution for Mental Disease Services for Individuals 65 or Older Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities	Indicate Maximum Plan Benefit Coverage Periodicty	Indicate Maximum Plan Benefit Coverage Periodicty
Case Management	TCCPW	FPS
Other 1 Other 2	C Every three years	C Every three years C Every two years
Other 3	C Every two years C Every year	C Every year
Other 4 Other 5	C Every six months	C Every six months
Other 6	C Every three months	C Every three months
Other 7 Other 8	C Other, Describe	O Other, Describe
Other 9	Indicate Maximum Plan Benefit Amount for FBCS:	Indicate Maximum Plan Benefit Amount for NHS:
Other 10 Other 11		
Other 12	Indicate Maximum Plan Benefit Coverage Periodicty	Indicate Maximum Plan Benefit Coverage Periodicty
Other 13 Other 14	FBCS	NHS
Other 15	C Every three years	C Every three years
Other 16 Other 17	C Every two years C Every year	C Every two years
Other 18	C Every year C Every six months	O Every year O Every six months
Other 19	C Every three months	C Every three months
Other 20 Other 21	C Other, Describe	C Other, Describe
Other 22		
Other 23		







ile <u>H</u> elp					
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: 📕	I3h Additional Services - Base 16
	soguiso qualifi	cation for and enro	allmantin a sta	to operated	Is a beneficiary receiving any benefit subject to a state-required monthly payment amount that is
aiver program?			onnent in a sta	le-operaleu	based on his or her financial resources (for example: a "patient pay amount")?
) Yes					O Yes
) No					C No
Select services waiver program		ualification for and	enrollmentin	a state-operated	Select benefits subject to a state-required monthly payment amount that is based on his or her financial resources (for example: a "patient pay amount"):
Early and Perio	dic Screening, I	Diagnostic, and Tre	atment (EPSDT)	Services	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
		for Pregnant Wom			Tobacco Cessation Counseling for Pregnant Women
Freestanding B	lirth Center Ser	/ices			Freestanding Birth Center Services
Respiratory Ca	re Services				Respiratory Care Services
Family Planning	Services				Family Planning Services
Nursing Home S	Services				Nursing Home Services
Home and Com		ervices			Home and Community Based Services
Personal Care \$	Services				Personal Care Services
Self-Directed P	ersonal Assista	nce Services			Self-Directed Personal Assistance Services
Private Duty Nu	Insing Services				Private Duty Nursing Services
Case Managem					Case Management (Long Term Care)
		ervices for Individu			Institution for Mental Disease Services for Individuals 65 or Older
		re Facility for Individ	duals with Intelle	ectual Disabilities	Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
Case Managem	nent				Case Management
Other 1					Other 1
Other 2					Other 2
Other 3					Other 3
Other 4					Other 4
Other 5					Other 5
Other 6					Other 6
Other 7					Other 7
Other 8					Other 8
Other 9					Other 9
Other 10					Other 10
Other 11					Other 11
Other 12					Other 12
Other 13					Other 13
Other 14					Other 14
Other 15					Other 15
Other 16					Other 16
Other 17					Other 17
Other 18					Other 18
Other 19					Other 19
Other 20					Other 20
Other 21					Other 21
Other 22					Other 22
Other 23					Other 23

PBP Data Entry System - Section B-13, Con	tract X0001, Plan 001, Segment 000						
Ele Help	Go To: <mark>≢13h Additional Ser</mark> Exit (No	vices - Base 17					
Previous Next (Validate)	Exit (No Validate)						
	Minimum Maximum	Minimum	Maximum				
	Patient Pay Patient Pay Amount Amount	Patient Pay Amount	Patient Pay Amount	0.000			
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		Other 3		Other 19			
Tobacco Cessation Counseling for Pregnant Women		Other 4		Other 20			
Freestanding Birth Center Services		Other 5		Other 21			
Respiratory Care Services		Other 6		Other 22			
Family Planning Services		Other 7		Other 23			
Nursing Home Services		Other 8					
Home and Community Based Services		Other 9					
Personal Care Services		Other 10					
Self-Directed Personal Assistance Services		Other 11					
Private Duty Nursing Services		Other 12					
Case Management (Long Term Care)		Other 13					
Institution for Mental Disease Services for Individuals 65 or Older		Other 14					
Services in an Intermediate Care Facility for	_	Other 15					
Individuals with Intellectual Disabilities Case Management		Other 16					
Other 1		Other 17					
Other 2		Other 18					
		1					
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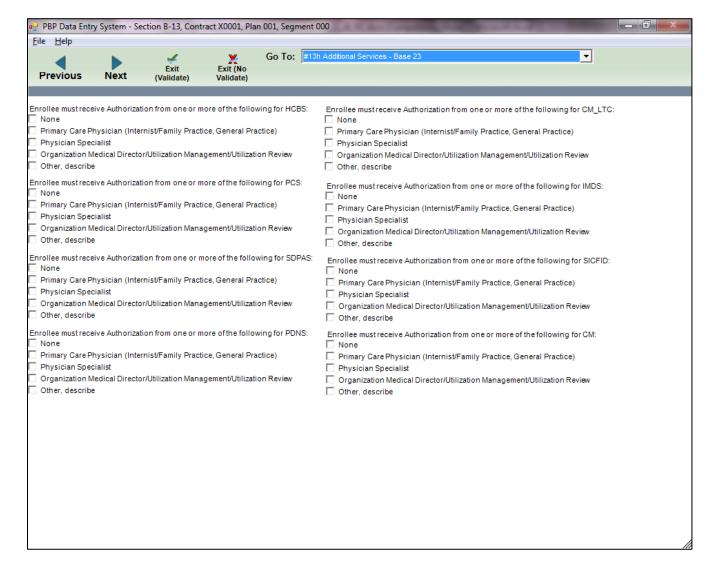
🖳 PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segm	ent 000	No. of Concession, name	
File Help			
	#13h Additional Services - Base 18		^
Previous Next (Validate) Validate)			
(
You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiar	following services.	Minimum Maximum Coinsuranc Coinsuranc	
may pay. Is there an enrollee Coinsurance?	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
C Yes C No	Tobacco Cessation Counseling for Pregnant Wome		
Select which Additional Services have a Coinsurance (Select all that apply):	Freestanding Birth Center Services		
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women	Respiratory Care Services		
Freestanding Birth Center Services Respiratory Care Services	Family Planning Services		
Family Planning Services Nursing Home Services	Nursing Home Services		
Home and Community Based Services Personal Care Services Self-Directed Personal Assistance Services	Home and Community Based Services		
Private Duty Nursing Services Case Management (Long Term Care)	Personal Care Services		
Institution for Mental Disease Services for Individuals 65 or Older Services in an Intermediate Care Facility for Individuals with Intellectual Disabilitie	Self-Directed Personal Assistance Services		=
Case Management Other 1	Private Duty Nursing Services		
Other 2 Other 3	Case Management (Long Term Care)		
Other 4 Other 5 Other 6	Institution for Mental Disease Services for Individuals 65 or Older		
Other 7 Other 8	Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities		
Other 9 Other 10	Case Management		
Other 11 Other 12	Other 1		
Other 13 Other 14	Other 2		
Other 15 Other 16	Other 3		
Other 17 Other 18			
Other 19			
Other 20			
Other 21			
Other 22			
Other 23			11

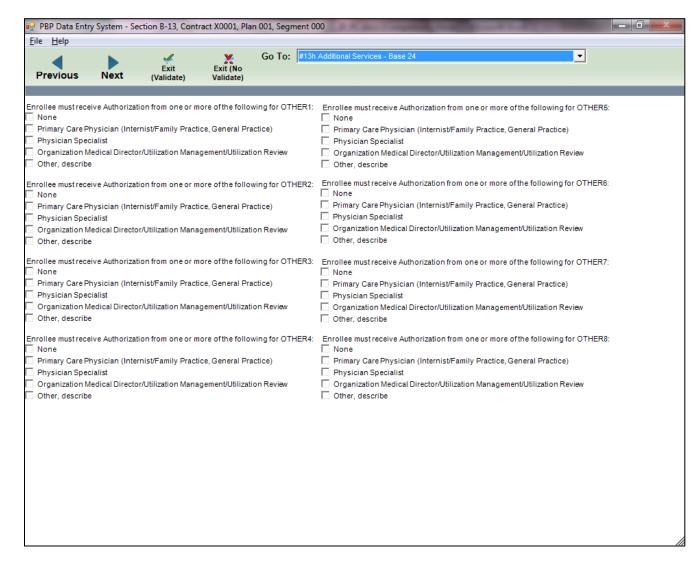
dicate Coinsurance for one or more of the following services Maximum Other 4 Other 19 Other 5 Other 20 Other 6 Other 21 Other 7 Other 22 Other 8 Other 23 Other 9 Other 23 Other 10 Other 12 Other 12 Other 13 Other 13 Other 14 Other 14 Other 15 Other 16 Other 14 Other 16 Other 14 Other 17 Other 14 Other 16 Other 14 Other 17 Other 14 Other 18 Other 14	File Help	Next	Exit (Validate)	Exit (No Validate)	Go To:	#13h Additional S	ervices - Base	19	_	
Other 5 Other 20 Other 6 Other 21 Other 7 Other 22 Other 8 Other 23 Other 9 Other 23 Other 10 Other 23 Other 11 Other 12 Other 12 Other 13 Other 14 Other 14 Other 15 Other 16 Other 17 Other 17	dicate Coinsura	nce for one o	r more of the follo	wing services.	Minimum Coinsurance	Maximum Coinsurance				
Other 6 Other 21 Other 7 Other 22 Other 8 Other 23 Other 9 Other 23 Other 10 Other 11 Other 12 Other 12 Other 13 Other 14 Other 16 Other 17				Other 4			Other 19			
Other 7 Other 72 Other 8 Other 23 Other 9 Other 23 Other 10 Other 10 Other 11 Other 11 Other 12 Other 13 Other 14 Other 14 Other 15 Other 16 Other 17 Other 17				Other 5		[]	Other 20	[
Other 8 Other 23 Other 9 Other 23 Other 10 Other 10 Other 11 Other 11 Other 12 Other 12 Other 13 Other 13 Other 14 Other 15 Other 16 Other 17				Other 6			Other 21			
Other 9				Other 7			Other 22			
Other 10				Other 8			Other 23			
Other 11				Other 9		<u> </u>				
Other 12				Other 10						
Other 13				Other 11						
Other 14				Other 12						
Other 15 Other 16 Other 17				Other 13						
Other 16				Other 14						
Other 17				Other 15						
				Other 16						
Other 18				Other 17						
				Other 18						

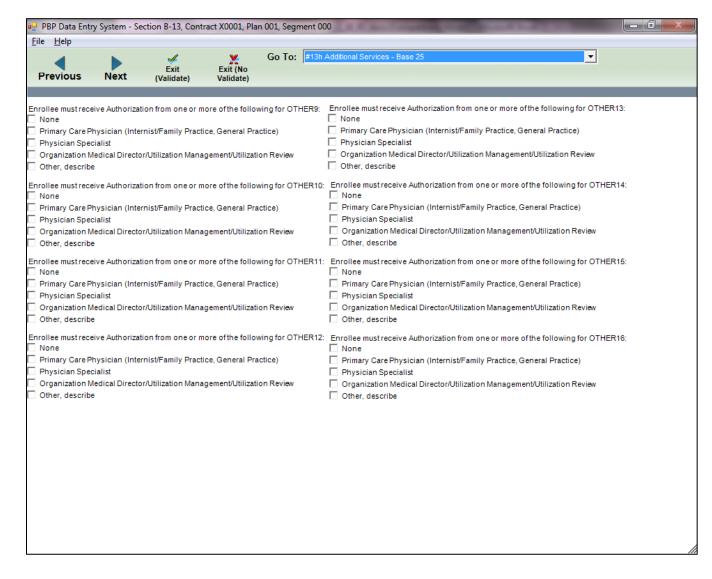
File Help Previous Next (Validate) Go To:	13h Additional Services - Base 20		•	
s there an enrollee Copayment?	Indicate Copayment for one or more of the	Minimum Copayment	Maximum Copayment	
C Yes C No	following services.	1.07 		
	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	ļ		
Select which Additional Services have a Copayment (Select all that apply): Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Tobacco Cessation Counseling for Pregnant Wom			
Tobacco Cessation Counseling for Pregnant Women Freestanding Birth Center Services Respiratory Care Services	Freestanding Birth Center Services	[
amily Planning Services Nursing Home Services	Respiratory Care Services			
Home and Community Based Services Personal Care Services	Family Planning Services			
Self-Directed Personal Assistance Services Private Duty Nursing Services	Nursing Home Services			
Case Management (Long Term Care) nstitution for Mental Disease Services for Individuals 65 or Older Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities	Home and Community Based Services			
Case Management Other 1	Personal Care Services			
Other 2 Other 3	Self-Directed Personal Assistance Services			
Other 4 Other 5	Private Duty Nursing Services	1	I	
Other 6 Other 7	Case Management (Long Term Care)			
Other 8 Other 9	Institution for Mental Disease Services for Individuals 65 or Older			
Other 10 Other 11 Other 12	Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities			
Other 13 Other 14	Case Management			
Utter 14 Other 15 Other 16	Other 1			
Other 17	Other 2	[
Other 18 Other 19	Other 2		1	
Other 20 Other 21	Other 3			
Other 22 Other 23				

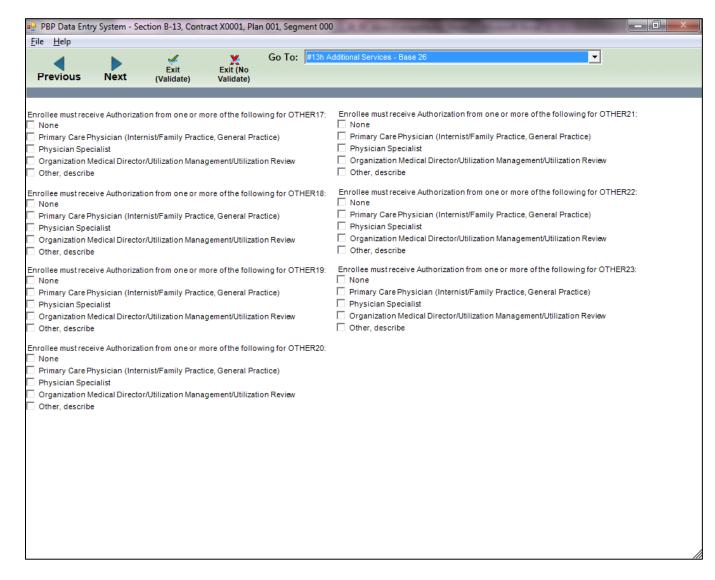
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #13h Additional Services - Base 21
dicate Copaymen lowing services.	nt for one or	(Validate)	Validate) Minimum Copayment	Maximum Copayment Other 19 Other 20 Other 21 Other 21 Other 22 Other 23
		Other 16 Other 17 Other 18		

🖳 PBP Data En	try System - S	Section B-13, Con	tract X0001, Pla	an 001, Segment 000		
<u>F</u> ile <u>H</u> elp						
•		exit	Exit (No	Go To: #13h A	dditional Services - Base 22	
Previous	Next	(Validate)	Validate)			
Is Authorization	equired for an	y Additional Servi	ces:			
C Yes						
C No						
Enrollee must	eceive Author	ization from one o	r more of the fol	llowing for EPSDT:	Enrollee must receive Authorization from one or more of the following for RCS:	
None	_				None	
Primary Car		nternist/Family Pra	actice, General I	Practice)	Primary Care Physician (Internist/Family Practice, General Practice)	
		ector/Utilization Ma	nagement/Utiliz	zation Review	Organization Medical Director/Utilization Management/Utilization Review	
C Other, desc	ribe		-		Other, describe	
	eceive Author	ization from one or	r more of the fol	lowing for TCCPW:	Enrollee must receive Authorization from one or more of the following for FPS:	
None	Dhusisian (l	nternist/Family Pra		Desetions	☐ None ☐ Primary Care Physician (Internist/Family Practice, General Practice)	
Primary Car		nternist/Family Pra	actice, General I	Practice)	Phinary Care Physician (Internist/Pamily Practice, General Practice)	
		ctor/Utilization Ma	nagement/Utiliz	ation Review	Organization Medical Director/Utilization Management/Utilization Review	
C Other, desc	ribe				Cther, describe	
Enrollee must	eceive Author	ization from one o	r more of the fol	llowing for FBCS:	Enrollee must receive Authorization from one or more of the following for NHS:	
	e Physician (I	nternist/Family Pra	actice. General I	Practice)	Primary Care Physician (Internist/Family Practice, General Practice)	
Physician S					Physician Specialist	
-		ector/Utilization Ma	inagement/Utiliz	zation Review	Organization Medical Director/Utilization Management/Utilization Review	
Other, desc	ribe				C Other, describe	
L						//









	13h Additional Services - Base 27
Previous Next (Validate) Exit Exit (No (Validate) Validate)	
s a referral required for one or more Additional Services? Yes No Select which Additional Services need a Referral (Select all that apply): Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women Freestanding Birth Center Services Respiratory Care Services Nursing Home Services Varsing Home Services Self-Directed Personal Assistance Services Personal Care Services Self-Directed Personal Assistance Services Case Management (Long Term Care) Institution for Mental Disease Services for Individuals 65 or Older Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities Case Management Dther 1 Dther 2 Dther 3 Dther 4 Dther 5 Dther 6 Dther 7 Dther 18 Dther 11 Dther 12 Dther 13 Dther 14 Dther 12 Dther 13 Dther 14 Dther 13 Dther 14 Dth	Additional Services Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes: Additional Notes: Additional Notes:

#14a Medicare-covered Preventive Services

	ry System - S	ection B-14, Cont	tract X0001, Pla	in 001, Segment 000	
File Help	Next	Exit (Validate)	Exit (No Validate)	Go To: #14a Med	dicare-covered Preventive Services
I attest that the Medicare prev Note: Plan may preventive serv Enrollee must re None Primary Care Physician Sp	d Preventive S re is no coinsu entive service not require an ices, for examp eceive Authoriz e Physician (In becialist n Medical Direct ibe	ervices Attestation urance, copaymer s that are offered a	it, or deductible at zero dollar co eferral for certai mmograms. more of the foll cctice, General F	st sharing. n \$0 cost sharing owing: Practice)	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:

#14b Annual Physical Exam – Base 1

e <u>H</u> elp			
Previous Next	Exit (Validate)	Exit (No Validate)	x #14b Annual Physical Exam - Base 1
CLICK FOR DESCRIPTION C	F BENEFIT		Is there a service-specific Maximum Plan Benefit Coverage amount?
er Medicare-covered preven vice category 14a.	tive services at \$0 cos	tsharing in PBP	C No
ishould only use these supp ims not covered by Original se Annual Physical Exams. N vices are always plan covere iropriate as a supplemental	Medicare. You may ch OTE: Medicare-cover d, and consequently t	arge copays for ed preventive	Indicate Maximum Plan Benefit Coverage amount:
es the plan provide the Annu ler Part C?		supplemental benefi	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes
Yes			C No
No Select type of benefit for th			Indicate Maximum Enrollee Out-of-Pocket Cost amount:
			·

#14b Annual Physical Exam – Base 2

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segme	ent 000 💼 💼 💼
File Help Previous Next (Validate) Go To: Validate)	#14b Annual Physical Exam - Base 2
s there an enrollee Coinsurance? 7 Yes 7 No	Is there an enrollee Copayment?
Indicate Minimum Coinsurance percentage for each Annual Physical Exam: Indicate Maximum Coinsurance percentage for each Annual Physical Exam: Indicate Deductible? Yes No Indicate Deductible Amount:	

#14b Annual Physical Exam – Base 3

	ry System - S	ection B-14, Cont	ract X0001, Pla	n 001, Segr	ment 000	1.16.16.16	State of Concession, Name		Contraction of the local division of the loc			
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#14b Anr	nual Physica	I Exam - Base	3		•	[
None Primary Care P Physician Spe	Physician (Inte cialist Medical Direct	tion from one or m ernist/Family Pract or/Utilization Mana	ice, General Pra	ctice)								
	red for the Ani	nual Physical Exar	n?									
⊖Yes ⊖No												
lote may include	additional inf	ormation to descri	be benefit in thi	service cat	tegory. Do I	not repeat ir	nformation ca	aptured in da	ta entry.			
otes:												
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Previous Next (Validate) Go To: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Select type of benefit for Nutritional/Dietary Select type of benefit for Enhanced Disease Des the plan provide Eligible Supplemental Benefits as Defined in Chapter 4 as a benefit under Part C? Mandatory Chandatory C Yes Select the number of visits for Nutritional/Dietary Select type of benefit for Telemonitoring Select yee of benefit for Telemonitoring Select yee of benefit for Telemonitoring Select yee of benefit for Remote Access Technology. Mandatory Minitable Select Yee of benefit for Select Yee of benefit for Telemonitoring Select yee of benefit for Remote Access Technology. Mandatory Mandatory Minitable Select Yee of benefit for Remote Access Technology. Mandatory Mandatory Mandatory Indicate number of visits for Nutritional/Dietary Benefit? Select type of benefit for Bathroom Safety Devices: Mandatory Counseling Services Indicate Duration for Nutritional/Dietary Benefit? Mandatory Mandatory Counseling Services Indicate number of visits of Nutritional/Dietary Benefit for Counseling Services: Mandatory Counseling Services Indicate number of visits of Nutritional/Dietary Benefit for Counseling Services: Select type of benefit for Counseling Services: Remote Access Technologies (including Web/Phone based technolog Indicate number of visits of Prevefiton Mandatory Potional<	

Eile Help Previous Next Exit (Validate) So To: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 2
Select type of benefit for Re-admission Prevention: Mandatory Optional Dayou offer Additional Sessions for Medicare-covered diseases? Yes No Indicate numerical limit will be provided in for Additional Sessions: O you offer Coverage for non-Medicare-covered diseases? Yes Indicate numerical limit will be provided for Additional Sessions: O you offer Coverage for non-Medicare-covered diseases? Describe that Coverage for non-Medicare-covered diseases? Indicate numerical limit will be provided for Coverage for non-Medicare-covered diseases: O yous Indicate numerical limit on the services provided for Coverage for non-Medicare-covered diseases: O yous Indicate numerical limit on the services provided for Coverage for non-Medicare-covered diseases: O yous Dayou offer Coverage for non-Medicare-covered diseases: O yous D yous differ Additional Sessions Select type of benefit for West discharge in-home Medication Reconciliation Readiatory O yous O yous Mandatory O potional Select type of benefit for Weight Management Programs: Mandatory <

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Chapter 4?		mental Benefits a	as Defined in	sessions of Smoking and Tobacco Cessation Counseling:	Access Technologies:
C Yes C No				Select Maximum Plan Benefit Coverage periodicity for Additi sessions of Smoking and Tobacco Cessation Counseling:	onal Select Maximum Plan Benefit Coverage periodicity for Remote Access Technologies:
Chapter 4 h (Select all t Health Educ Nutritional/E	have a Maximun that apply): cation Dietary Benefit*	lemental Benefit 1 Plan Benefit Co king and Tobacco	overage amount	t C Every two years C Every year C Every six months C Every three months	C Every three years C Every two years C Every year C Every six months C Every three months
Fitness Ber Enhanced E Telemonitor	nefit* Disease Manage ing Services*	ment		C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Fitnes: Benefit	C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Bathroom Safet/ Devices:
	Safety Devices*	es (including Web	/Phone based te	Select Maximum Plan Benefit Coverage periodicity for Fitner	
In-Home Sa Personal En	fety Assessmer	nse System (PER	S)	Benefit:	Select Maximum Pari Belenic Goverage periodicity for Balmoom Select Devices: C Every three years
Post discha Re-admissi	arge In-home Me on Prevention	INT) dication Reconcili to Chemotherapy		C Every two years C Every year	C Every two years C Every year
Weight Man	nagement Progra	ms		C Every six months O Every three months O Other, Describe	C Every six months C Every three months C Other, Describe
Education:	aximum Pian Be	nefit Coverage a	mount for Healt	Indicate Maximum Plan Benefit Coverage amount for Enhan Disease Management:	
		fit Coverage per	riodicity for Hea		
Education: C Every ti				Select Maximum Plan Benefit Coverage periodicity for Enha Disease Management:	ced Select Maximum Plan Benefit Coverage periodicity for Counseling Services:
C Every to C Every y C Every s	wo years /ear			C Every three years C Every two years C Every year C Every six months	C Every three years C Every two years C Every year C Every year
C Other, I	Describe			C Every three months C Other, Describe	C Every three months C Other, Describe
	Dietary Benefit:	nefit Coverage a	mount for	Indicate Maximum Plan Benefit Coverage amount for Telemonitoring Services:	Indicate Maximum Plan Benefit Coverage amount for In-Home Safety Assessment:
Nutritional/	Dietary Benefit:	fit Coverage per	iodicity for	Select Maximum Plan Benefit Coverage periodicity for Telemonitoring Services:	Select Maximum Plan Benefit Coverage periodicity for In-Home Safety Assessment:
C Every to C Every to C Every y	wo years (ear			C Every three years C Every two years	C Every three years C Every two years
C Every s C Every ti C Other, I	hree months			O Every year O Every six months O Every three months	C Every year C Every six months C Every three months
				C Other, Describe	C Other, Describe

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	6: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base		
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Indicate Maximum Plan Benefit Coverage amount for Personal	Indicate Maximum Plan Benefit Coverage amount for Re-	Indicate Maximum Plan Benefit Coverage amount for	
Emergency Response System (PERS):	admission Prevention:	Alternative Therapies:	
Select Maximum Plan Benefit Coverage periodicity for Personal	Select Maximum Plan Benefit Coverage periodicity for Re-	Select Maximum Plan Benefit Coverage periodicity for	
Emergency Response System (PERS):	admission Prevention:	Alternative Therapies:	
C Every three years	C Every three years	O Every three years	
C Every two years	C Every two years	C Every two years	
C Every year	C Every year	C Every year	
C Every six months	C Every six months	C Every six months	
C Every three months	C Every three months	C Every three months	
C Other, Describe	C Other, Describe	C Other, Describe	
Indicate Maximum Plan Benefit Coverage amount for Additional	Indicate Maximum Plan Benefit Coverage amount for Wigs for	Is there a service-specific Maximum Enrollee Out	
sessions of Medical Nutrition Therapy (MNT):	Hair Loss Related to Chemotherapy:	-of-Pocket Cost for Eligible Supplemental	
		Benefits as Defined in Chapter 4?	
Colorit Maximum Dise Des effi Osueres e este disi'. 1. 1.1111.	Colori Maximum Dira Darafi Osumana anti disi'i 1. 111. 1	C Yes	
Select Maximum Plan Benefit Coverage periodicity for Additional sessions of Medical Nutrition Therapy (MNT):	Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:	C No	
O Every three years	O Every three years	Indicate Maximum Enrollee Out-of-Pocket Cost	
C Every two years	C Every two years	amount:	
C Every year	C Every two years C Every year		
C Every six months	C Every six months		
C Every three months	C Every three months	Select the Maximum Enrollee Out-of-Pocket	
C Other, Describe	C Other, Describe	Cost periodicity:	
		C Every three years	
Indicate Maximum Plan Benefit Coverage amount for Post discharge In-home Medication Reconciliation:	Indicate Maximum Plan Benefit Coverage amount for Weight	C Every two years	
discharge in-nome Medication Reconciliation:	Management Programs:	O Every year	
		O Every six months	
Select Maximum Plan Benefit Coverage periodicity for Post	Select Maximum Plan Benefit Coverage periodicity for Weight	C Every three months	
discharge In-home Medication Reconciliation:	Management Programs:	C Other, Describe	
C Every three years	C Every three years		
C Every two years	C Every two years		
C Every year	C Every year		
C Every six months	C Every six months		
C Every three months	C Every three months		
C Other, Describe	C Other, Describe		
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Is there an enrollee	Coinsurance?			Indicate Minimum Coinsurance percentage for Fitness Benefit:	Indicate Minimum Coinsurance percentage for In-	Indicate Minimum Coinsurance percentage for Wigs	
C Yes					Home Safety Assessment:	Indicate minimum consistence processage to wrige for Hair Loss Related to Chemotherapy:	
C No							
Select which Eligit Chapter 4 have a C				Indicate Maximum Coinsurance percentage for Fitness Benefit:	Indicate Maximum Coinsurance percentage for In- Home Safety Assessment:	Indicate Maximum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy:	
Health Education Nutritional/Dietary E	Benefit*		<u> </u>				
Additional sessions		d Tobacco Cessa	tion Counseli	Indicate Minimum Coinsurance percentage for Enhanced Disease	Indicate Minimum Coinsurance percentage for	Indicate Minimum Coinsurance percentage for Weight	
Fitness Benefit* Enhanced Disease	Management			Management:	Personal Emergency Response System (PERS):	Management Programs:	
Telemonitoring Service Remote Access Telemonitoring Service Access		udiaa Wah/Dhaas	hanned to obs	Indicate Maximum Coinsurance percentage for Enhanced Disease	La dista Mariana Osiana ana sa ta sa fas		
Bathroom Safety D		luding web/Phone	based techn	Management:	Indicate Maximum Coinsurance percentage for Personal Emergency Response System (PERS):	Indicate Maximum Coinsurance percentage for Weight Management Programs:	
Counseling Service In-Home Safety As							
Personal Emergence	y Response Sy	vstem (PERS)		Indicate Minimum Coinsurance percentage for Telemonitoring Services:	Indicate Minimum Coinsurance percentage for Medical	Indicate Minimum Coinsurance percentage for	
Medical Nutrition Th Post discharge In-h		Peconciliation			Nutrition Therapy (MNT):	Alternative Therapies:	
Re-admission Prev	ention			Indicate Maximum Coinsurance percentage for Telemonitoring	Indicate Maximum Coinsurance percentage for Medical		
Wigs for Hair Loss	Related to Cher	motherapy	•	Services:	Nutrition Therapy (MNT):	Indicate Maximum Coinsurance percentage for Alternative Therapies:	
Indicate Minimun	Coinsurance	percentage for H	lealth Education				
				Technologies:	Indicate Minimum Coinsurance percentage for Post discharge In-home Medication Reconciliation:		
Indicate Maximur	n Coinsurance	nercentage for l	lealth Educatio			You must include total cost sharing to the beneficiary,	
	noomstance	percentage for	Iouni Euroano	Indicate Maximum Coinsurance percentage for Remote Access Technologies:	Indicate Maximum Coinsurance percentage for Post discharge In-home Medication Reconciliation:	including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and	
						maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.	
Indicate Minimum	Coinsurance	percentage for		Indicate Minimum Coinsurance percentage for Bathroom Safety Devices:	Indicate Minimum Coinsurance percentage for Re- admission Prevention;	anung init a concision may pay.	
Nutritional/Dietar	y Benefit:						
Indicate Maximur	n Coinsurance	percentage for		Indicate Maximum Coinsurance percentage for Bathroom Safety	Indicate Maximum Coinsurance percentage for Re-		
Nutritional/Dietar		,,		Devices:	admission Prevention:		
				Indicate Minimum Coinsurance percentage for Counseling Services			
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sessions of Smol	king and Tobac	co Cessation Co	unseling:				
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Previous Next (Validate) Validate)			
Is there an enrollee Deductible?			
O Yes	Indicate Minimum Copayment percentage for Additional sessions of Smoking and Tobacco Cessation Counseling:	Indicate Minimum Copayment amount for Counseling Services:	Indicate Minimum Copayment amount for Re- admission Prevention:
C No			
Indicate Deductible Amount:	Indicate Maximum Copayment percentage for Additional sessions of Smoking and Tobacco Cessation Counseling:	Indicate Maximum Copayment amount for Counseling	Indicate Maximum Copayment amount for Re-admission
	sessions of Smoking and Fobacco Cessation Counseling.	Services:	Prevention:
is there an enrollee Copayment?	Indicate Minimum Copayment percentage for Fitness Bene		Indicate Minimum Copayment amount for Wigs for Hair
O Yes		Safety Assessment:	Loss Related to Chemotherapy:
C No	Indicate Maximum Copayment percentage for Fitness Benefi	Indiaste Maximum Canaumant amount for In Hama	Indicate Maximum Copayment amount for Wigs for Hair
Select which Eligible Supplemental Benefits as Defined in Chapter 4 have a Copayment (Select all that apply):		Safety Assessment:	Loss Related to Chemotherapy:
Health Education	Indicate Minimum Copayment amount for Enhanced		
Nutritional/Dietary Benefit* Additional sessions of Smoking and Tobacco Cessation Counseling	Disease Management:	Indicate Minimum Copayment amount for Personal Emergency Response System (PERS):	Indicate Minimum Copayment amount for Weight Management Programs:
Fitness Benefit* Enhanced Disease Management			
Telemonitoring Services*	Indicate Maximum Copayment amount for Enhanced Disease Management:	Indicate Maximum Copayment amount for Personal	Indicate Maximum Copayment amount for Weight
Remote Access Technologies (including Web/Phone based technolo Bathroom Safety Devices*		Emergency Response System (PERS):	Management Programs:
Counseling Services In-Home Safety Assessment	Indicate Minimum Copayment percentage for Telemonitoring Services:	Indicate Minimum Copayment amount for Medical	Indicate Minimum Copayment amount for Alternative
Personal Emergency Response System (PERS)		Nutrition Therapy (MNT):	Therapies:
Medical Nutrition Therapy (MNT) Post discharge In-home Medication Reconciliation	Telemonitoring Services:	In dianta Maninerra Consumant annuat fao Madinal	
Re-admission Prevention Wigs for Hair Loss Related to Chemotherapy	Copayment percentage for Remote	Indicate Maximum Copayment amount for Medical Nutrition Therapy (MNT):	Indicate Maximum Copayment amount for Alternative Therapies:
Weight Management Programs	Access Technologies:		
Alternative Therapies* Indicate Minimum Copayment amount for Health Education:	Indicate Maximum Copayment percentage for Remote	Indicate Minimum Copayment amount for Post discharge In-home Medication Reconciliation:	
	Access Technologies:	dischargem-nome medication Reconcination.	
Indicate Maximum Copayment amount for Health Education:		Indicate Maximum Copayment amount for Post	
	Indicate Minimum Copayment amount for Bathroom Safety Devices:	discharge In-home Medication Reconciliation:	
Indicate Minimum Copayment percentage for Nutritional/Dietary Benefit:			
Copayment percentage for	Indicate Maximum Copayment amount for Bathroom Safety Devices:		
Nutritional/Dietary Benefit:			

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Enrollee must re	ceive Authoriza	ation from one or r	nore of the folio	wing:	Additional sessions of Smoking and Tobacco Cessation Cours	selina Notes:
None						
	Physician (Int	ernist/Family Prac	tice. General Pr	ractice)		
Physician Sp			and the production of	100.00		
		tor/Utilization Man	agement/Utiliza	tion Review		
Other, descri			agementeethea			
Curren, desen						
Is a referral requi	ired for Eligible	e Supplemental Be	enefits as Define	ed in Chapter 4?		
C Yes						-
C No						
V NO					Fitness Benefit Notes:	
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lisible Constant	antal Danafia	as Defined in Cha	ator d Materia			
suppremi	entai benents i	as Delined in Cha	pier 4 Notes.			
lata may in aluda	additional infe	umation to describ	se han afit in this			
Note may include	additional info	ormation to descrit	be benefit in this	s service category.		
Note may include Do not repeat info	additional info ormation captu	ormation to descrit ured in data entry.	be benefit in this	s service category.		
Note may include Do not repeat info Health Education	ormation captu	ormation to descril ired in data entry.	be ben efit in this	s service category.		
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Bathroom Safety Devices Notes:	
*	
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*	*
Counseling Services Notes: Post discharge In-home Medication Reconciliation Notes:	*
Counseling Services Notes: Post discharge In-home Medication Reconciliation Notes:	
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n-Home Safety Assessment Notes: Re-admission Prevention Notes:	E.c.
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Previous	Next	Exit (Validate)	Exit (No Validate)			
Wigs for Hair I	oss Related to	o Chemotherapy N	lotes:			
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/eight Manag	ment Notes:			150		
				~		
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ternative The	rapies Notes:					
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#14d Kidney Disease Education Services – Base 1

	try System - Si	ection B-14, Cont	tract X0001, Plan	n 001, Segn	nent 000	
Eile Help	Next	Exit (Validate)	Exit (No Validate)	Go To:	#14d - Kidney Disease Education Services Base 1	
Maximum Plan B Is there a service C Yes C No Indicate Maxin	its are not appl enefit Coverage -specific Maxi num Enrollee (aximum Enrolle ree years o years ar ar onoths ree months ree months	F BENEFIT icable for this Ser e is not applicable mum Enrollee Out Out-of-Pocket Cos	of-Pocket Cost	,	You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay. Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits Indicate Maximum Coinsurance percentage for Medicare-covered Benefit	

#14d Kidney Disease Education Services – Base 2

	ry System - S	ection B-14, Cont	ract X0001, Pla	n 001, Segment 000	
Eile Help	Next	Exit (Validate)	Exit (No Validate)	Go To: #14d - Kidney Disease Education Services Base 2	
Is there an enrol C Yes C No Indicate Deduc	ible Amount:			Enrollee must receive Authorization from one or more of the following: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe 	
Is there an enrol C Yes C No	ee Copaymen	t?		Is a referral required for Kidney Disease Education Services?	
Indicate Maxim	um Copaymen	amount for Medic	are-covered Ber	nefit	

#14d Kidney Disease Education Services – Base 3

revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#14d - Kidney D	sease Education S	Services Base 3		•	
ney Disease E	ducation Ser	vices Notes								
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	additionarini	offication to descri	be benefit in this	Service ca	tegory. Do notrep	eatimormation ca	aptoreo in data er	ury.		
es:									*	
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#14e Diabetes Self-management Training – Base 1

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Previous Next (Validate) Go To	o: #14e Diabetes Self-Management Training - Base 1
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?
Enhanced Benefits are not applicable for this Service Category.	C Yes C No
Maximum Plan Benefit Coverage is not applicable for this Service Categor Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits
C Yes C No	Indicate Maximum Coinsurancepercentage for Medicare-covered Benefit
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Is there an enrollee Deductible?
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	C Yes C No
C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	Indicate Deductible Amount:

#14e Diabetes Self-management Training – Base 2

e <u>H</u> elp		4	Exit (No	Go To: #14e Diabetes Self-Management Training - Base 2
Previous	Next	Exit (Validate)	Exit (No Validate)	
	ee Copayment	?		Enrollee must receive Authorization from one or more of the following:
Yes No				Primary Care Physician (Internist/Family Practice, General Practice)
icate Minimun	Copaymenta	mount for Medica	re-covered Bene	C Other, describe
icate Maximur	n Copayment a	mount for Medica	are-covered Bene	Is a referral required for Diabetes Self-Management Training? C Yes C No

#14e Diabetes Self-management Training – Base 3

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#14e Diabete	s Self-Manage	ment Training -	Base 3	•	
betes Self-Ma	nagement Trai	ning Notes								
te may include	additional info	ormation to descri	be benefit in this	service ca	itegory. Do not	repeat inform	ation captured	in data entry		
tes:									 *	
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#15 Medicare Part B Rx Drugs – Base 1

PBP Data Entry System - Section B-15, Contract X0001, Pla	n 001, Segment 000	
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CLICK FOR DESCRIPTION OF BENEFIT Is there a Maximum Enrollee Out-of-Pocket Cost? C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost Amount:	Is there an enrollee Coinsurance? Yes No Select which Medicare Part B Rx Drugs have a Coinsurance (Select all that apply): Medicare Part B Chemotherapy Drugs Other Medicare Part B Drugs Indicate the Minimum Coinsurance percentage	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity C Every three years C Every two years C Every year C Every year C Every six months Every three months C Every month C Other Describe	for Medicare Part B Chemotherapy Drugs: Indicate the Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs: Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs: Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:	
C Other, Describe		

#15 Medicare Part B Rx Drugs – Base 2

	ry System - S	ection B-15, Conti	ract X0001, Pla	lan 001, Segment 000	X
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Copayment (Sel Medicare Pau Other Medica Indicate Mini Medicare Par	ble Amount: ee Copaymen edicare Part B ect all that ap t B Chemothe are Part B Dru mum Copaym t B Chemothe	It? Rx Drugs have a ply): rrapy Drugs gs ent Amount for rapy Drugs: ent Amount for		Indicate Minimum Copayment Amount for other Medicare Part B Drugs: Indicate Maximum Copayment Amount for other Medicare Part B Drugs: Is Authorization Required? Yes No	

#15 Medicare Part B Rx Drugs – Notes

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revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#15 Medicare P	art B Rx Drugs - M	lotes		<u>-</u>]
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#15 Home Infusion Bundled Services

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Does the plan pro as a mandatory su			s as part of a bur	Idled service	Does the plan pay for Part D drug home infusion services and supplies as a Medicaid benefit?	
C Yes C No					C Yes C No	
If you select 'Yes't of a bundled servi specific medicatio Formulary Submis You must also ens drug, but any serv	ce as a suppl ons in a flat file sion Module sure that your	emental benefit?", which must be up by Friday, June 6, benefit includes no	you must indica loaded through 2014 at 12:00pr ot only the hom	te these the n Eastern Ti e infusion		
administration. If your organizatic supplemental bun sharing. As descr the application of provided under a	dled servicet ibed in the Ch zero cost sha	hen those service ⁄2010 Call Letter th ring for the bundle	s must be provid	ded at \$0 cost ditioned on		
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Previous Next (Validate)	Go To: #16a Preventive Dental - Ba Exit (No Validate)	se 1 👤	
CLICK FOR DESCRIPTION OF BENEFIT Oes the plan provide Preventive Dental Items as a upplemental benefit under Part C? Yes Oral Exams Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays Select type of benefit for Oral Exams: C Mandatory C 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 six 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 Cother, 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: Select the Fluoride Treatment periodicity: Every three years Every two years Every three months Other, Describe	

e <u>H</u> elp	Go To: #16a Preventive Dental - Base 2	
Previous Next (Validate)	Go To: #16a Preventive Dental - Base 2 Exit (No Validate)	
ect type of benefit for Dental X-Rays:	Is there a service-specific Maximum Plan Benefit Coverage amoun	
Mandatory	C Yes	
Optional	C No	
his benefit unlimited for Dental X-Rays?	Does the Maximum Plan Benefit Coverage amount apply to In-	
Yes	network services only OR does it apply to both In-network and Out-of-network services?	
No. indicate number	Out-of-network services?	
	C In-network services only	
dicate number of visits for Dental X-Rays:	C Both In-network and Out-of-network services	
	Indicate Manimum Dise Descript Conserve encount	
	Indicate Maximum Plan Benefit Coverage amount:	
Select the Dental X-Rays periodicity:		
C Every three years		
C Every two years	Select the Maximum Plan Benefit Coverage periodicity:	
C Every year	C Every three years	
C Every six months	C Every two years	
C Every three months	C Every year	
C Other, Describe	C Every six months	
	C Every three months	
	C Other, Describe	

Previous Next (Validate)	Go To: #16a Preventive Dental - Base 3	
a service-specific Maximum Enrollee Out-of-Pocket Cost Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	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 Data Entry System - Section B-16, Contract X0001, Pl	an 001, Segment 000
Eile Help Previous Next Exit Exit (No (Validate) Validate)	Go To: #16a Preventive Dental - Base 4
s there an enrollee Deductible? C Yes C No	Indicate Copayment amount for Office Visit:
Indicate Deductible Amount:	Indicate Minimum Copayment amount for Oral Exams:
Is there an enrollee Copayment?	Indicate Maximum Copayment amount for Oral Exams:
C Yes C No	Indicate Minimum Copayment amount for Prophylaxis (Cleaning):
Select which Preventive Dental Services have a Copayment (Select all that apply): Oral Exams	Indicate Maximum Copayment amount for Prophylaxis (Cleaning):
Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays	Indicate Minimum Copayment amount for Fluoride Treatment:
Is there a combination of services included in a single cost per Office Visit?	Indicate Maximum Copayment amount for Fluoride Treatment:
C Yes C No	Indicate Minimum Copayment amount for Dental X-Rays:
Select which combination of services are included in a single cost per Office Visit: Oral Exams Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays	I Indicate Maximum Copayment amount for Dental X-Rays:

	y System - Se	ection B-16, Cont	ract X0001, Plan	n 001, Segment 0	00	Statement of the local division in which the local division in the local division in the local division in the		10.0		
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None Primary Care Ph Physician Spec Organization M Other, describe	nysician (Inte ialist edical Directo	tion from one or m rnist/Family Pract pr/Utilization Mana tive Dental Service	ice, General Pra gement/Utilizati	ctice)						
	dditional info	ormation to descri	be benefit in this	service category. I	Do not repeat inforr	nation captured in	n data entry.	*		

Go To: #16b Comprehensive Dental - Base	e1 👻
Select type of benefit for Non-routine Services:	Select type of benefit for Diagnostic Services: C Mandatory
C Optional	C Optional
Is this benefit unlimited for Non-routine Services?	Is this benefit unlimited for Diagnostic Services?
C Yes	C Yes C No, indicate number
Indicate number of visits for Non- routine Services:	Indicate number of visits for Diagnostic Services:
Select the Non-routine Services periodicity:	Select the Diagnostic Services periodicity:
C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe
	Services: C 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 six months Every three months

Previous Next (Validate)	Go To: #16b Comprehensive D Exit (No Validate)	ental - Base 2	
Select type of benefit for Restorative Services: C Mandatory C Optional Is this benefit unlimited for Restorative Services C Yes No, indicate number Indicate number of visits for Restorative Services: Select the Restorative Services periodicity: C Every three years C Every three years C Every year C Every six months C Other, Describe	Select type of benefit for Endodontics/Periodontics/Extractions: C Mandatory O Optional Is this benefit unlimited for Endodontics/Periodontics/Extractions? C Yes No, indicate number Indicate number of visits for Endodontics/Periodontics/Extractions: Select the Endodontics/Periodontics/Extractions periodicit C Every three years C Every three years C Every two years C Every two years C Every three months C Other, Describe	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: C Mandatory Optional Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services? 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: C Every three years Every two years Every two years Every three months Other, Describe	

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segn	nent 000
ile Help Previous Next (Validate) Go To: Exit Exit (No Validate)	#16b Comprehensive Dental - Base 3
there a service-specific Maximum Plan Benefit Coverage amount? Yes No Select the Maximum Plan Benefit Coverage type: C 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:	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost C Yes C No Select the Maximum Enrollee Out-of-Pocket Cost type: C Covered under Preventive Dental Category 16a C Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every three years C Every two years C Every three months C Other, Describe
Select the Maximum Plan Benefit Coverage periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	

Yes Indicate Maximum Coinsurance percentage for Restorative Services: Indicate Minimum Coinsurance percentage for Restorative Services: Indicate Minimum Coinsurance percentage for Restorative Services: Indicate Minimum Coinsurance percentage for Cestive Services Indicate Minimum Coinsurance percentage for Restorative Services: Indicate Minimum Coinsurance percentage for Oral/Maxillofacial Surgery, Other Services Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Per	Previous Next Exit (Validate) Exit (No Validate) Indicate Minimum Coinsurance? Indicate Minimum Coinsurance percentage for Restorative Services: Yes Indicate Minimum Coinsurance percentage for Restorative Services: Yes Indicate Maximum Coinsurance percentage for Restorative Services: Indicate Maximum Coinsurance percentage for Restorative Services: Indicate Maximum Coinsurance percentage for Restorative Services: Indicate Maximum Coinsurance percentage for Cestorative Services Indicate Maximum Coinsurance percentage for Endodontics/Extradons: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum	ile <u>H</u> elp						
Yes Indicate Maximum Coinsurance percentage for Restorative Services: Indicate Minimum Coinsurance percentage for Restorative Services: Indicate Minimum Coinsurance percentage for Restorative Services: Indicate Minimum Coinsurance percentage for Restorative Services Indicate Minimum Coinsurance percentage for Restorative Services: Indicate Minimum Coinsurance percentage for Medicare-covered Benefits Indicate Minimum Coinsurance percentage for Endodontics/Extractions: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Indicate Minimum Coinsurance percentage for Redicare-covered Benefits Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits Indicate Minimum Coinsurance percentage for Nedicare-covered Benefits Indicate Minimum Coinsurance percentage for Nedicare-covered Benefits Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 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 Non-routine Services: Indicate Minimum Coinsurance percentage for Diagnostic Services: Indicate Maximum Coinsurance percentage for Diagnostic Services: Indicate Minimum Coi	C Yes Indicate Maximum Coinsurance percentage for Restorative Services: Belect which Comprehensive Dental Services have a Coinsurance (Select al hat apply): Indicate Maximum Coinsurance percentage for Restorative Services: Medicare-covered Benefits Indicate Minimum Coinsurance percentage for Restorative Services: Diagnostic Services Indicate Minimum Coinsurance percentage for Endodontics/Extractions: Description Endodontics/Periodontics/Extractions: Prosthodontics/Periodontics/Extractions Indicate Maximum Coinsurance percentage for Medicare-covered Benefits Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Non-routine Services: Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Minimum Coinsurance percentage for Diagnostic Services: Is there an enrollee Deductible?	Previous	Next	Exit		Go To:	#16b Comprehensive Dental - Base 4	
Select which Comprehensive Dental Services have a Coinsurance (Select all Medicare-covered Benefits Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions: Endodontics/Periodontics/Extractions: Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Minimum Coinsurance percentage for Diagnostic Services: Is there an enrollee Deductible?	No Indicate Maximum Coinsurance percentage for Restorative Services: Select which Comprehensive Dental Services have a Coinsurance (Select all hat apply): Indicate Maximum Coinsurance percentage for Restorative Services: Medicare-covered Benefits Indicate Minimum Coinsurance percentage for Restorative Services: Diagnostic Services Indicate Minimum Coinsurance percentage for Endodontics/Extractons Endodontics/Extractons: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Indicate Maximum Coinsurance percentage for Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits Indicate Minimum Coinsurance percentage for Nedicare-covered Benefits Indicate Minimum Coinsurance percentage for Nedicare-covered Benefits Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Maximum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Minimum Coinsurance percentage for Non-routine Services: Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: Indicate Minimum Coinsurance percentage for Diagnostic Services: Indicate Ma	s th <mark>ere an enrol</mark>	lee Coinsuran	ce?			Indicate Minimum Coinsurance percentage for Restorative Services:	
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Indicate Maximum Coinsurance percentage for Non-routine Services: Indicate Minimum Coinsurance percentage for Diagnostic Services: Indicate Minimum Coinsurance p	Indicate Maximum Coinsurance percentage for Non-routine Services: Indicate Minimum Coinsurance percentage for Diagnostic Services: Indicate Minimum Coinsurance p	ndicate Minimu	m Coinsuranc	e percentage for N	Non-routine Serv	vices:	Indicate Maximum Coinsurance percentage for Prosthodontics. Other	
Indicate Minimum Coinsurance percentage for Diagnostic Services:	Indicate Minimum Coinsurance percentage for Diagnostic Services:	indicate Maximu	m Coinsuranc	ce percentage for I	Non-routine Ser	vices:		
C No	C No							
Indicate Maximum Coinsurance percentage for Diagnostic Services:	Indicate Maximum Coinsurance percentage for Diagnostic Services:	ndicate Minimu	m Coinsuranc	e percentage for D	Diagnostic Servi	ces:		
		ndicate Maximu	m Coinsuranc	se percentage for I	Diagnostic Serv	ices:	Indicate Deductible Amount:	

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File Help	Next	Exit (Validate)	Exit (No Validate)	io To: #16b Com	prehensive Dental - Base 5		
Is there an enroll	ee Copaymei	nt?	Indicate M	aximum Copaymen	t amount for Diagnostic		
C Yes C No			Services:				
Select which Co have a Copaym Medicare-co Non-routine	ent (Select al vered Benefit		Indicate M Services:	linimum Copayment	t amount for Restorative		
Diagnostic S Restorative S Endodontics Prosthodont	Services s/Periodontic ics, Other Ori	And a state of the state	Indicate M Services:	aximum Copaymen	at amount for Restorative		
Surgery, Oth Indicate Minimu covered Benefit:	m Copaymen	t amount for Medica	Indicate M	linimum Copaymen ics/Periodontics/Ex			
Indicate Maximu covered Benefit		nt amount for Medic	Indicate M	laximum Copaymen ics/Periodontics/Ex			
Indicate Minimu Services:	m Copaymen 	tamountfor Non-ro	Indicate M	inimum Copayment I/Maxillofacial Surge	t amount for Prosthodontics, ery, Other Services:		
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None Primary Care I Physician Spe Organization Other, descrit	Physician (Int ecialist Medical Direc be	ation from one or i ternist/Family Prac tor/Utilization Man rehensive Dental S	tice, General Pr agement/Utilizat	actice)							
C No	additional inf	formation to descr	ibe benefit in this	service cate	egory. Do n	ot repeat info	ormation captu	ured in data e	entry.	*	
										Ŧ	

#17a Eye Exams – Base 1

Previous Next (Validate) Validate)	- Base 1
CLICK FOR DESCRIPTION OF BENEFIT Is there a service-specific Maximum P Coverage amount? Coverage amount? Does the plan provide Eye Exams as a supplemental benefit under Part C? C Yes C Yes Does the Maximum Plan Benefit Cov apply to In-network and Out-of-network services only OR Select enhanced benefit: Does the Maximum Plan Benefit Cov apply to In-network and Out-of-network services only C No Both In-network services only Select type of benefit for Routine Eye Exams/Other: C In-network and Out-of-network	or-Pocket Cost? C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: ork services Select the Maximum Enrollee Out-of-Pocket Cost periodicity: rrage amount: C Every three years C Every two years C Every year

#17a Eye Exams – Base 2

PBP Data Entry System - Section B-17, Contract X0001, Pla	in 001, Segment 000	X
File Help Previous Next (Validate)	Go To: #17a Eye Exams - Base 2	
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes C No	C Yes C No	
Select which Eye Exams have a Coinsurance (Select all that app Medicare-covered Benefits Routine Eye Exams/Other	Select which Eye Exams have a Copayment (Select all that apply): Medicare-covered Benefits Routine Eye Exams/Other	
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/Other:	Indicate Minimum Copayment amount per Routine Eye Exam/Other:	
Indicate Maximum Coinsurance percentage for Routine Eye Exams/Other:	Indicate Maximum Copayment amount per Routine Eye Exam/Other:	
Is there an enrollee Deductible?		
C Yes C No		
Indicate Deductible Amount:		
		3

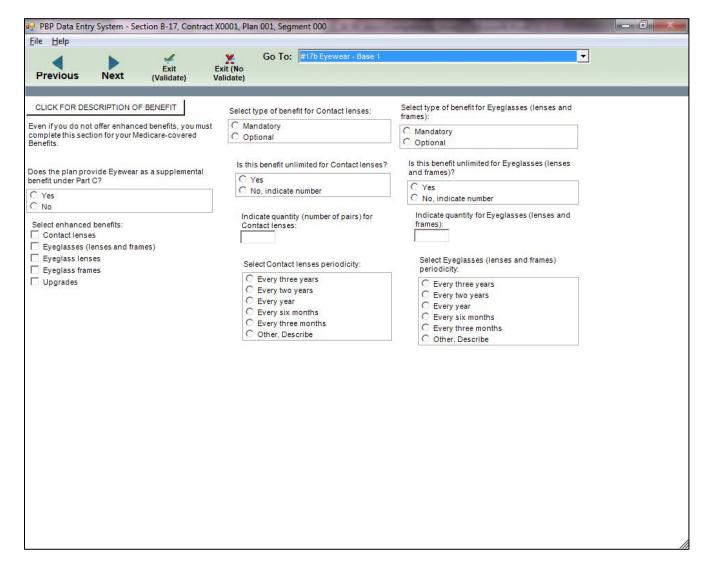
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#17a Eye Exams – Base 3

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<u>File H</u> elp					
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None Primary Care F Physician Spe	Physician (Inte cialist Medical Direct	tion from one or m ernist/Family Pract or/Utilization Mana	ice, General Pri	actice)	
s a referral requir	ed for Eye Exa	ams?			
C Yes					
C No				2	
lote may include ategory. Do not r	additional info repeat informa	ormation to descril ation captured in d	be benefit in this ata entry.	service	
lotes:					
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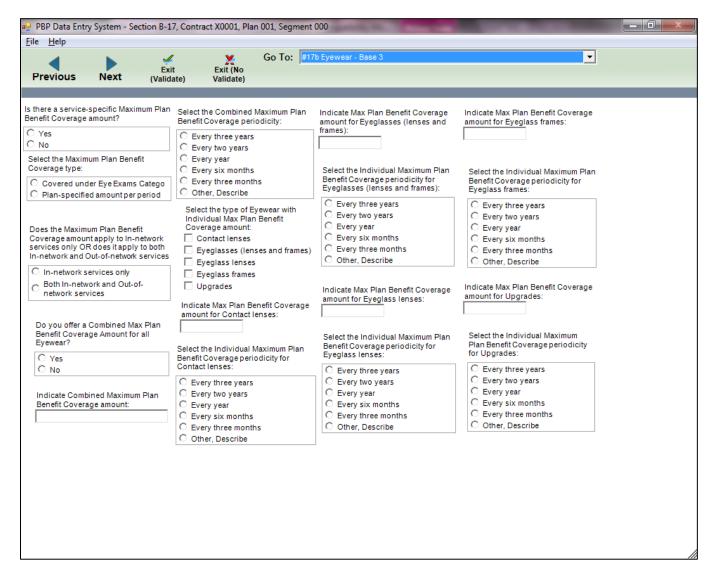
#17b Eyewear – Base 1



#17b Eyewear – Base 2

PBP Data Entry System - Section B-17, Contract X000	01, Plan 001, Segment 000
Eile Help Previous Next (Validate)	Go To: #17b Eyewear - Base 2 (No ate)
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?	Is this benefit unlimited for Eyeglass frames?
C Yes C No, indicate number	C No, indicate number
Indicate quantity (number of pairs) for Eyeglass lenses:	Indicate quantity for Eyeglass frames:
Select Eyeglass lenses periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	Select Eyeglass frames periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe
	Select type of benefit for Upgrades: C Mandatory C Optional

#17b Eyewear – Base 3



#17b Eyewear – Base 4

🔜 PBP Data Entry System - Section B-17, Contract X0001, Plan	001, Segment 000
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Gi	o To: #17b Eyewear-Base 4
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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Minimum Coinsurance percentagefor Medicare-covered Benef Indicate Minimum Coinsurance percentage for Eyeglass frames:
C Yes C No	
Select the Maximum Enrollee Out-of-Pocket Cost type: C Covered under Eye Exams Category 17a	Indicate Maximum Coinsurancepercentage for Medicare-covered Bene Indicate Maximum Coinsurance percentage for Eyeglass frames:
C Plan-specified amount per period	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
	Indicate Minimum Coinsurance percentage for Contact lenses: Indicate Minimum Coinsurance percentage for Upgrades:
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Maximum Coinsurance percentage for Contact lenses: Indicate Maximum Coinsurance percentage for Upgrades:
C Every three years	
C Every two years C Every year	
C Every six months	Indicate Minimum Coinsurance percentage for Eyeglasses (lenses and frames):
C Every three months C Other, Describe	
Is there an enrollee Coinsurance?	
C Yes C No	Indicate Maximum Coinsurance percentage for Eyeglasses (lenses and frames):
Select which Eyewear Benefits have a Coinsurance (Select all that	
apply):	Indicate Minimum Coinsurance percentage for Eyeglass lenses:
Contact lenses	
Eyeglasses (lenses and frames)	Indicate Maximum Coinsurance percentage for Eyeglass lenses:
Eyeglass lenses Eyeglass frames	
Upgrades	

#17b Eyewear – Base 5

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Is there an enrollee Deductible?	
G ves Indicate Minimum Copayment amount for Contact lenses: Indicate Minimum Copayment amount for Eyeglass frames:	
Indicate Deductible Amount: Indicate Maximum Copayment amount for Contact Lenses: Indicate Maximum Copayment amount for Eyeglass frames:	
Is there an enrollee Copayment? Indicate Minimum Copayment amount for EvenIsses (lenses and frames): Indicate Minimum Copayment amount for Upgrades:	
Is there an enrollee Copayment? Indicate Minimum Copayment amount for Eyeglasses (lenses and frames): Indicate Minimum Copayment amount for Upgrades:	
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appiy):	
Medicare-covered Benefits Contact lenses	
Contact lenses Indicate Minimum Copayment amount for Eyeglass lenses:	
Eyeglass frames	
Upgrades Indicate Maximum Copayment amount for Eyeglass lenses:	
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Indicate Maximum Coppayment amount for Medicars-covered	
Benefits:	
	//

#17b Eyewear – Base 6

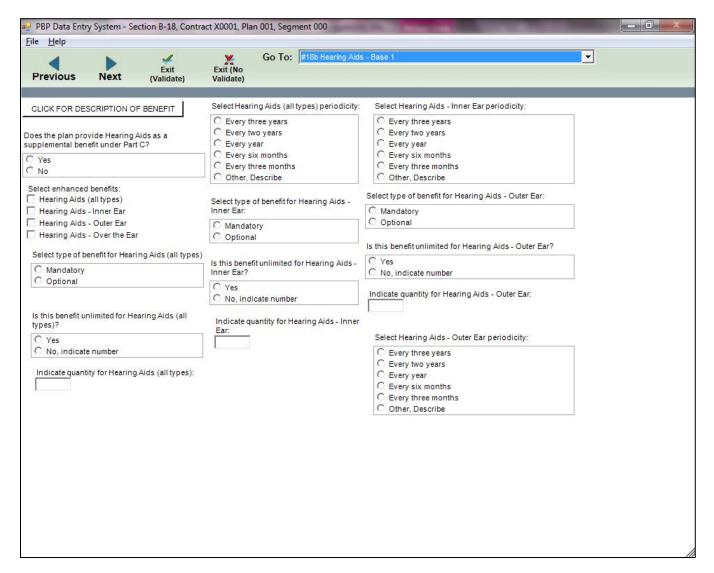
🖳 PBP Data Ent	ry System - Se	ection B-17, Cont	ract X0001, Pla	n 001, Segment	000	and in succession	1	Second St.	2) ×
<u>File</u> <u>H</u> elp											
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #17	'b Eyewear - Bas	e 6				•	
Enrollee must rec	eive Authoriza	tion <mark>f</mark> rom one or m	ore of the follow	ving:							
1770 B 1994 B 1997 B 20	hysician (Inte	rnist/Family Practi	ce, General Pra	ictice)							
Physician Spe											
		or/Utilization Mana	gement/Utilizati	on Review							
Other, describ	e										
ls a referral requi	ed for Eyewea	ır?									
C Yes											
C No											
Eyewear Notes											
R.					_						
Note may include	additional info	ormation to describ	be benefit in this	service category	. Do not repeat ir	nformation captu	ired in data er	ntry.			
Notes:											
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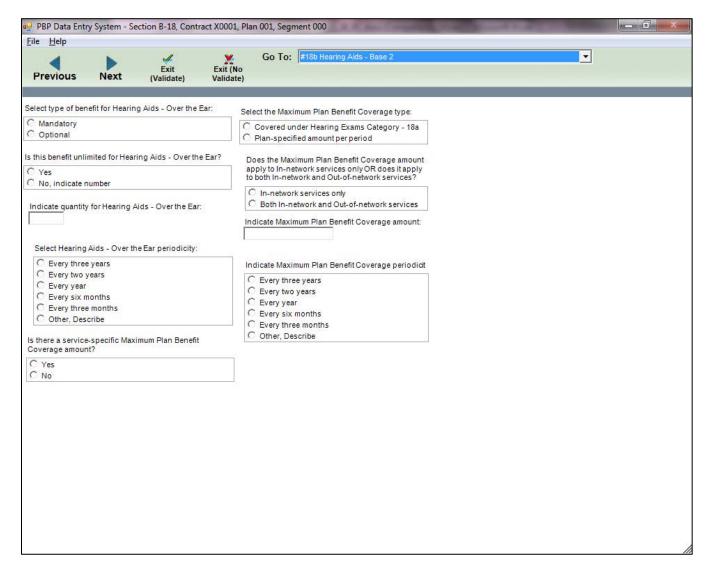
PBP Data Entry System - Section B-18, Contract X0001,	Plan 001, Segment 000
File Help Previous Next (Validate)	
CLICK FOR DESCRIPTION OF BENEFIT Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits. Does the plan provide Hearing Exams as a supplemental benefit under Part C? Yes No	C Every six months C Every three months C Other, Describe Select type of benefit for Fitting/Evaluation for Hearing Aid: C Mandatory
Select enhanced benefits: Routine Hearing Exams Fitting/Evaluation for Hearing Aid Select type of benefit for Routine Hearing Exams:	C Optional Is this benefit unlimited for Fitting/Evaluation for Hearing Aid? C Yes C No, indicate number
C Mandatory C Optional Is this benefit unlimited for Routine Hearing Exams?	Indicate number for Fitting/Evaluation for Hearing Ai
C Yes C No, indicate number Indicate number for Routine Hearing Exams:	Select Fitting/Evaluation for Hearing Aid periodicit C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe

stere a service-specific Maximum Plan Benefit Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	Previous Next (Validate)	Go To: #18a Hearing Exams - Exit (No Validate)	Base 2
Select the Maximum Plan Benefit Coverage periodicity. C Every three months Routine Hearing Exams: C Every three years Is there an enrollee Coinsurance? Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid: C Every three months No Select which Hearing Exam Benefits have a Coinsurance (Select all that apply): S there an enrollee Deductible? Medicare-covered Benefits Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid: C Yes Fitting/Evaluation for Hearing Aid Fitting/Evaluation for Hearing Aid:	Verage amount? Yes No Does the Maximum Plan Benefit Coverage amount pply 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 ndicate Maximum Plan Benefit Coverage amount:	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 three years Every two years Every two years Every year	Medicare-covered Benefits: Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits: Indicate Minimum Coinsurance percentage for Routine Hearing Exams:
C Every six months C No Fitting/Evaluation for Hearing Aid: C Every three months Select which Hearing Exam Benefits have a Coinsurance (Select all that apply): Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid: Is there an enrollee Deductible? Medicare-covered Benefits Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid: C Yes Fitting/Evaluation for Hearing Aid	C Every three years C Every two years	C Every three months C Other, Describe Is there an enrollee Coinsurance?	Routine Hearing Exams:
Is there an enrollee Deductible? Routine Hearing Exams Fitting/Evaluation for Hearing Aid: Yes Fitting/Evaluation for Hearing Aid	C Every three months	Select which Hearing Exam Benefits have a Coinsurance (Select all that apply):	
	C Yes	C Routine Hearing Exams	

	System - Se	ection B-18, Cont	tract X0001, Plan	in 001, Segment 000	
File Help Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #18a Hearing Exams - Base 3	
Previous Is there an enrollee C Yes No Select which Heari all that apply): Medicare-cover Routine Hearing Fitting/Evaluate Indicate Minimum Benefits: Indicate Maximum Benefits: Indicate Maximum Indicate Maximum	Copaymen ng Exam Be ed Benefits) Exams in for Hearir Copayment Copayment	inefits have a Cop ng Aid amount for Medic t amount for Medic	are-covered care-covered	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	

le <u>H</u> elp		ection B-18, Contr		10.00								
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To	: #18a Hea	ring Exams -	Base 4				•	
aring Exams N	otes											
ote may include	additional info	ormation to descri	be benefit in this	servicec	ategory. Do r	not repeat inf	ormation cap	tured in data	entry.			
tes:												
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🧧 PBP Data Entry System - S	Section B-18, Contract X00	01, Plan 001, Segment 000	
File Help Previous Next	Exit Exit (Validate) Valid	No	
Is there a service-specific Max Pocket Cost? Yes Select the Maximum Enrollee Covered under Hearing 1 Plan-specified amount per Indicate Maximum Enrollee Select Maximum Enrollee Every the years Every two years Every two years Every two years Every two years Every six months Other, Describe Is there an enrollee Coinsura Other, Describe Is there an enrollee Coinsura Select which Hearing Aids B (Select all that apply): Hearing Aids - Inner Ear Hearing Aids - Over the E	Out-of-Pocket Cost type: Exams Category - 18a er period Out-of-Pocket Cost amount Dut-of-Pocket Cost periodici	Hearing Aids - Inner Ear:	Indicate Minimum Coinsurance percentage for Hearing Aids - Over the Ear:

🧱 PBP Data Entry System - Section B-18, Contract X0001, P	lan 001, Segment 000
Ele Help	
Exit Exit (No	Go To: #18b Hearing Adds - Base 4
Previous Next (Validate) Validate)	
Is there an enrollee Copayment?	Indicate Minimum Copayment amount per Hearing Aid - Outer E Is there an enrollee Deductible?
C Yes C No	C Yes C No
Select which Hearing Aids Benefits have a Copayment (Select	Indicate Maximum Copayment amount per Hearing Aid - Outer E Indicate Deductible Amount:
all that apply): Hearing Aid - Inner Ear	
Hearing Aid - Outer Ear	Indicate Minimum Coppyment amount per two Hearing Aids -
Hearing Aids - Over the Ear	OuterEar:
Indicate Minimum Copayment amount per Hearing Aid (all types	Indicate Maximum Copayment amount per two Hearing Aids - Outer Ear:
Indicate Maximum Copayment amount per Hearing Aid (all types	Indicate Minimum Copayment amount per Hearing Ald -
	Over the Ear:
Indicate Minimum Copayment amount per Hearing Aid - Inner E	Indicate Maximum Copayment amount per Hearing Aid - Over the Ear:
Indicate Maximum Copayment amount per Hearing Aid - Inner E	Indicate Minimum Copayment amount per two Hearing Alds - Over the Ear:
Indicate Minimum Copayment amount per two Hearing Aids - Inner Ear:	Indicate Maximum Copayment amount per two Hearing Aids - Over the Ear:
Indicate Maximum Copayment amount per two Hearing Aids -	
Inner Ear:	

e <u>H</u> elp												
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#18b He	aring Aids - Base	:5			<u>-</u>	•	
None Primary Care P Physician Spe Organization N Other, describ	thysician (Inte cialist Aedical Directo e	tion from one or m rnist/Family Pract pr/Utilization Mana	ice, General Pra	ictice)								
referral requir	ed for Hearing	g Aids?										
Yes No												
	additional info	ormation to descri	be benefit in this	service ca	tegory Do	not repeat infor	mation capture	ed in data ent	rv.			
							and the second second					
es:												
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🖳 PBP Data Entry System - Section B-20, Cont	ract X0001, Plan 001, Segment 000	
Eile Help Previous Next (Validate)	Go To: <mark>#20 Outpatient D</mark> Exit (No Validate)	Drugs - Base 1
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Outpatient Drugs as a supplemental benefit under Part C? Yes No Select type of benefit: Mandatory Optional Indicate the number of drug groupings that are offered: 1 2 3 4 5	Is there a Maximum Plan Benefit Coverage amount for drugs? Yes No Indicate type of Maximum Plan Benefit Coverage: All drug groups covered by plan Combination of drug groups Individual drug groups Is the Maximum Plan Benefit Coverage net of the enrollee copay? Yes No Indicate Maximum Plan Benefit Coverage periodicity for drugs: Annually Guarterly Monthly Other, describe	Indicate Max Plan Benefit Coverage amount annually for dru Indicate Max Plan Benefit Coverage amount semi-annually for drugs: Indicate Max Plan Benefit Coverage amount quarterly for drug Indicate Max Plan Benefit Coverage amount monthly for drug Indicate Max Plan Benefit Coverage amount for Other for drug

🖳 PBP Data Entry System - S	ection B-20, Contr	act X0001, Plan	n 001, Segr	nent 000
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Previous Next	Exit (Validate)	Exit (No Validate)	Go To:	#20 Outpatient Drugs - Base 2
Can any unused amounts be contract period?	arried forward to the	e next period wit	thin the	Indicate Max Plan Benefit Coverage amount annually for combination of drug groups:
C Yes				
C No				
Select what combination of dru Benefit: Group 1 Group 2 Group 3 Group 4	ig groups are includ	ded in the Maxin	num Plan	Indicate Max Plan Benefit Coverage amount semi-annually for combination of drug groups: Indicate Max Plan Benefit Coverage amount quarterly for combination of drug groups:
Group 5				
Indicate Maximum Plan Benefit drug groups: Annually Semi-annually Quarterly Monthly Other, describe	Coverage periodici	ty for combinati	on of	Indicate Max Plan Benefit Coverage amount monthly for combination of drug groups:

PBP Data Entry System - Section B-20, Contract X0001, Plan 001	L, Segment 000	
Exit Exit No	o To: #20 Outpatient Drugs - Base 3	
Previous Next (Validate) Validate)		_
	Medicare Part B Chemotherapy Drugs Other Medicare Part B Drugs Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs: Indicate Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:	

Fu Associates, Ltd.

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Select what combination of drug groups applies for Deductible: Group 1 Group 2 Group 3 Group 4 Group 5 Medicare Covered Benefits Indicate Deductible amount: Indicate Maximum Copayment for other Medicare Part B Drugs: Indicate Minimum Copayment for other Medicare Part B Drugs: Indicate Maximum Copayment for other Medicare Part B Drugs:	<u>File H</u> elp					
Yes Chemotherapy Drugs: No Indicate Maximum Copayment amount for Medicare Part B Group 1 Chemotherapy Drugs: Group 2 Chemotherapy Drugs: Group 3 Chemotherapy Drugs: Group 4 Indicate Maximum Copayment for other Medicare Part B Drugs: Medicare Covered Benefits Indicate Minimum Copayment for other Medicare Part B Drugs: Indicate Deductible amount: Indicate Maximum Copayment for other Medicare Part B Drugs: Is there an enrollee Copayment for Medicare-covered Benefits? Enrollee must receive Authorization for drugs from one or more of the following: No None Primary Care Physician (Internist/Family Practice, General Practic Select which Medicare-covered Outpatient Drugs have a Copayment Primary Care Physician Specialist/Dentist Medicare Part B Chemotherapy Drugs Organization Medical Director/Utilization Management/Utilization	Previous	Next	Exit	Exit (No	Go To	#20 Outpatient Drugs - Base 4
No Select what combination of drug groups applies for Deductible: Group 1 Group 2 Group 3 Group 4 Group 5 Indicate Maximum Copayment for other Medicare Part B Drugs: Indicate Deductible amount: Indicate Deductible amount: Indicate Deductible amount: Is there an enrollee Copayment for Medicare-covered Benefits? C Yes No Select which Medicare-covered Outpatient Drugs have a Copayment Select which Medicare-covered Outpatient Drugs have a Copayment Primary Care Physician (Internist/Family Practice, General Practic Select which Medicare Part B Drugs Medicare Part B Drugs Other Medicare Part B Drugs		Deductible?	6			
Group 1 Indicate Maximum Copayment amount for Medicare Part B Group 2 Chemotherapy Drugs: Group 3 Indicate Maximum Copayment for other Medicare Part B Drugs: Group 5 Indicate Minimum Copayment for other Medicare Part B Drugs: Indicate Deductible amount: Indicate Maximum Copayment for other Medicare Part B Drugs: Indicate Deductible amount: Indicate Maximum Copayment for other Medicare Part B Drugs: Is there an enrollee Copayment for Medicare-covered Benefits? Enrollee must receive Authorization for drugs from one or more of the following: No None Select which Medicare-covered Outpatient Drugs have a Copayment Primary Care Physician (Internist/Family Practice, General Practic Select which Medicare Part B Chemotherapy Drugs Organization Medical Director/Utilization Management/Utilization Review	Ves No					
Group 5 Indicate Minimum Copayment for other Medicare Part B Drugs: Indicate Deductible amount: Indicate Minimum Copayment for other Medicare Part B Drugs: Indicate Deductible amount: Indicate Maximum Copayment for other Medicare Part B Drugs: Is there an enrollee Copayment for Medicare-covered Benefits? Indicate Maximum Copayment for other Medicare Part B Drugs: Is there an enrollee Copayment for Medicare-covered Benefits? Enrollee must receive Authorization for drugs from one or more of the following: No Primary Care Physician (Internist/Family Practice, General Practic (Select all that apply): Primary Care Physician Specialist/Dentist Medicare Part B Chemotherapy Drugs Organization Medical Director/Utilization Management/Utilization Organization Medical Director/Utilization Management/Utilization	Group 1 Group 2 Group 3	ination of dru	ug groups applies	for Deductible:		
Indicate Maximum Copayment for Medicare Part B Drugs: Is there an enrollee Copayment for Medicare-covered Benefits? C Yes C Yes C No Select which Medicare-covered Outpatient Drugs have a Copayment Select which Medicare-covered Outpatient Drugs have a Copayment C Select all that apply): C Medicare Part B Chemotherapy Drugs C Other Medicare Part B Drugs C Other Medi	Group 5	ered Benefits	0			Indicate Minimum Copayment for other Medicare Part B Drugs:
C Yes Enrollee must receive Authorization for drugs from one or more of the following: No Primary Care Physician (Internist/Family Practice, General Practic (Select all that apply): Medicare Part B Chemotherapy Drugs Organization Medical Director/Utilization Management/Utilization Review	Indicate Deductib	le amount:				Indicate Maximum Copayment for other Medicare Part B Drugs:
No following: None None Select which Medicare-covered Outpatient Drugs have a Copayment Primary Care Physician (Internist/Family Practice, General Practic (Select all that apply): Primary Care Physician Specialist/Dentist Medicare Part B Chemotherapy Drugs Organization Medical Director/Utilization Management/Utilization Review	Is there an enrolle	ee Copaymer	nt for Medicare-co	vered Benefits?		
Select which Medicare-covered Outpatient Drugs have a Copayment (Select all that apply): Primary Care Physician (Internist/Family Practice, General Practic Physician Specialist/Dentist Medicare Part B Chemotherapy Drugs Organization Medical Director/Utilization Management/Utilization Review	C Yes C No					following:
Extension and the second sec	(Select all that a Medicare Par	pply): t B Chemoth	erapy Drugs	ıgs have a Copay	A. S. 620	Physician Specialist/Dentist Organization Medical Director/Utilization Management/Utilization
		no ran o bu	.9.			

#20 Outpatient Drugs – Notes (Optional)

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revious	Next	Exit (Validate)	Exit (No Validate)	Go To	#20 Outp	atient Drugs	- Notes (Opti	onal)		-	
patient Drugs	Notes										
	additional info	ormation to descri	be benefit in this	service ca	ategory. Do r	not repeat in	formation ca	ptured in da	ta entry.		
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#20 Outpatient Drugs – Group 1 – Base 1

PBP Data Entr	y System - Se	ection B-20, Cont	tract X0001, Plan	1001, Segment 000
File Help	Next	Exit (Validate)	Exit (No Validate)	Go To: #20 Outpatient Drugs - Group 1 - Base 1
Select a label f	or Group 1:			Indicate Maximum Plan Benefit Coverage annual amount for Group 1:
Select the dru Generic Preferred I Brand		ered for Group 1:		Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1: Indicate Maximum Plan Benefit Coverage quarterly amount
Is there a Maxim C Yes C No	u <mark>m Plan Bene</mark>	efit Coverage amo	unt for Group 1	for Group 1:
Indicate Maximu Annually Semi-annual Quarterly Monthly Per Prescrip Other, descr	ly lion	fit Coverage for G	roup 1 periodicit	Group 1: Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:
				Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:

#20 Outpatient Drugs – Group 1 – Base 2

<u>File H</u> elp						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #20 Outpatient Drugs - Group 1 - B	lase 2 🔽	
Select from wher Designated R HMO-Owned Mail Order Other, descrit	etail Pharmacy Pharmacy	gs can be acquire	d:			
s there an enroll	e Coinsuranc	e for Group 1?		is there an enrollee Copayment for Group 1'	?	
C Yes				C Yes		
C No				C No		
Indicate Coinsu Pharmacy:	rance percenti	age for Group 1 De	esignated Retail	Indicate Copayment amount for Group 1 Designated Retail Pharmacy:	Up to a day supply covered for Group 1 Designated Retail Pharmacy:	
Indicate Coinsu Pharmacy:	ance percents	ngeforGroup1HN	NO-Owned	Indicate Copayment amount for Group 1 HMO-Owned Pharmacy:	Up to a day supply covered for Group 1 HMO-Owned Pharmacy:	
Indicate Coinsu	ance percenta	ige for Group 1 Ma	ail Order:	Indicate Copayment amount for Group 1 M Order:	aii Up to a day supply covered for Group 1 Mail Order:	
Indicate Coinsu	ance percenta	age for Group 1 Ot	her:	Indicate Copayment amount for Group 1 Ot	the Up to a day supply covered for Group 1 Other:	

#20 Outpatient Drugs – Group 2 – Base 1

<u>File</u> <u>H</u> elp				
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #20 Outpatient Drugs - Group 2 - Base 1
Select a label for Gr	oup 2:			Indicate Maximum Plan Benefit Coverage annual amount for
			<u> </u>	Group 2:
Select the drug type	(s) covere	d for Group 2:		Indicate Maximum Plan Benefit Coverage semi-annual amount
Preferred Brand				for Group 2:
Brand				
Is there a Maximum	Plan Benef	it Coverage amou	nt for Group 2	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:
C No				
Indicate Maximum P	lan Benefit	Coverage for Gro	up 2 periodicit	Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:
Semi-annually				
Monthly Per Prescription				Indicate Maximum Plan Benefit Coverage amount per
Other, describe				prescription for Group 2:
				Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:

#20 Outpatient Drugs – Group 2 – Base 2

<u>Eile H</u> elp						
Previous	Next	Exit (Validate)	Go To: #20 Outpa Exit (No Validate)	tient Drugs - Group 2 -	Base 2	
Designated Ro HMO-Owned I Mail Order Other, describ sthere an enrolle	etail Pharmac Pharmacy e		Is there an enrollee Copayment	for Group 2?		
C Yes C No			C Yes C No			
		tage for Group 2 for	Indicate Copayment amount fi Designated Retail Pharmacy:		Ip to a day supply covered for Group 2 lesignated Retail Pharmacy:	
Indicate Coinsu HMO-Owned Pt		age for Group 2 for	Indicate Copayment amount fr HMO-Owned Pharmacy:		Ip to a day supply covered for Group 2 IMO-Owned Pharmacy:	
Indicate Coinsu Mail Order:	rance percent	age for Group 2 for	Indicate Copayment amount fo Order:		Ip to a day supply covered for Group 2 Iail Order:	
Indicate Coinsu Other:	ance percent	age for Group 2 for	Indicate Copayment amount fo		Ip to a day supply covered for Group 2 <u> ther:</u>	

#20 Outpatient Drugs – Group 3 – Base 1

<u>File</u> <u>H</u> elp				
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #20 Outpatient Drugs - Group 3 - Base 1
Select a label for G	iroup 3:			Indicate Maximum Plan Benefit Coverage annual amount for
			•	Group 3:
Select the drug typ Generic Preferred Branc Brand		d for Group 3:		Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 3:
Is there a Maximun	n Plan Bene	fit Coverage amour	nt for Group	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3:
C Yes C No				
Indicate Maximum Annually Semi-annually Quarterly	Plan Benefit	Coverage Group 3	3 periodicity:	Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:
Monthly Per Prescription Other, describe				Indicate Maximum Plan Benefit Coverage amount per prescription for Group 3:
				Indicate Maximum Plan Benefit Coverage amount for Otherfor Group 3:

#20 Outpatient Drugs – Group 3 – Base 2

le <u>H</u> elp				
Previous Next (Exit Exit (M Validate) Validat	lo	Base 2	•
elect from where Group 3 Drugs ca Designated Retail Pharmacy HMO-Owned Pharmacy Mail Order Other, describe	in be acquired:			
there an enrollee Coinsurance for	Group 3?	Is there an enrollee Copayment for Group 3?		
Yes No		C Yes C No		
ndicate Coinsurance percentage fo letail Pharmacy:	or Group 3 Designated	Indicate Copayment amount for Group 3 Designated Retail Pharmacy:	Up to a day supply covered for Group 3 Designated Retail Pharmacy:	
ndicate Coinsurance percentage fo Pharmacy:	or Group 3 HMO-Owned	Indicate Copayment amount for Group 3 HMC -Owned Pharmacy:	Up to a day supply covered for Group 3 HMO-Owned Pharmacy:	
ndicate Coinsurance percentage fo	or Group 3 Mail Order:	Indicate Copayment amount for Group 3 Mail Order:	Up to a day supply covered for Group 3 Mail Order:	
ndicate Coinsurance percentage fo	or Group 3 Other:	Indicate Copayment amount for Group 3 Othe	Up to a day supply covered for Group 3 Other:	

#20 Outpatient Drugs – Group 4 – Base 1

🖳 PBP Data Entry System - Section B-20, Contract X0001, P	lan 001, Segment 000
Eile Help Previous Next (Validate) Exit (No (Validate)	Go To: #20 Outpatient Drugs - Group 4 - Base 1
Select a label for Group 4:	Indicate Maximum Plan Benefit Coverage annual amount for Group 4:
Select the drug type(s) covered for Group 4: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 4:
Is there a Maximum Plan Benefit Coverage amount for Group C Yes C No	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4:
Indicate Maximum Plan Benefit Coverage Group 4: Annually Semi-annually Quarterly	Indicate Maximum Plan Benefit Coverage monthly amount for Group 4:
Monthly Per Prescription Other, describe	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 4:
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 4:

#20 Outpatient Drugs – Group 4 – Base 2

Eile <u>H</u> elp						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #20 Outpatient Drugs - (roup 4 - Base 2	•
Designated Re HMO-Owned F Mail Order Other, describe there an enrolle Yes No Indicate Coinsur Retail Pharmacy:	tail Pharmacy Pharmacy e e Coinsuranc ance percent ance percent		signated 10-Owned	Is there an enrollee Copayment for Gr Yes No Indicate Copayment amount for Grou Designated Retail Pharmacy: Indicate Copayment amount for Grou HMO-Owned Pharmacy: Indicate Copayment amount for Grou Order:	p 4 Up to a day supply covered fr Group 4 Designated Retail Pharmac p 4 Up to a day supply covered fr Group 4 HMO-Owned Pharmacy:	sy: Dr
Indicate Coinsur	ance percent	age for Group 4 Ot	her:	Indicate Copayment amount for Grou	4 Other Up to a day supply covered fo Group 4 Other:	Dr

#20 Outpatient Drugs – Group 5 – Base 1

PBP Data Entry System - Section B-20, Contract X0001 File Help	, Plan 001, Segment 000
Previous Next (Validate)	Go To: #20 Outpatient Drugs - Group 5 - Base 1
Select a label for Group 5:	■ Indicate Maximum Plan Benefit Coverage annual amount for Group 5:
Select the drug type(s) covered for Group 5: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 5:
Is there a Maximum Plan Benefit Coverage amount for Grou C Yes C No	5 Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:
Indicate Maximum Plan Benefit Coverage for Group 5 period Annually Semi-annually Quarterly Monthly	licit Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:
Per Prescription Other, describe	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 5:
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 5:

#20 Outpatient Drugs – Group 5 – Base 2

Previous Next Exit (No Validate) Go To: #20 Outpatient Drugs - Group 5 - Base 2 Select from where Group 5 Drugs can be acquired:	Tevious Next Exit (Validate) Exit (No Validate) Select from where Group 5 Drugs can be acquired: Designated Retail Pharmacy HMO-Owned Pharmacy Mail Order Designated Retail Pharmacy HMO-Owned Pharmacy Mail Order Other, describe sthere an enrollee Coinsurance for Group 57 Is there an enrollee Copayment for Group 57 C Yes Yes No No Indicate Coinsurance percentage for Group 5 Indicate Copayment amount for Group 5 Designated Retail Pharmacy: Indicate Copayment amount for Group 5 Indicate Coinsurance percentage for Group 5 HMO- Owned Pharmacy: Indicate Copayment amount for Group 5 HMO -Owned Pharmacy: Indicate Coinsurance percentage for Group 5 Mail Ord Indicate Copayment amount for Group 5 Mail Order: Up to a	Help			
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#20 Home Infusion Bundled Services

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