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fyou do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D. WA Organizations are not permitted to tier deductibles. Indicate Deductible? Yes No Indicate Deductible Amount for Tier 1: Indicate Deductible Amount for Tier 2: Indicate Deductible Amount for Tier 3: Indicate Deductible Amount for Tier 3: Indicate Deductible Amount for Tier 3: Indicate Deductible Amount for Tier 3: Yes No	Medicare-covered Copayment Cost Sharing for Tier1: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.) Prove Indicate Copayment amount for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay: C one C nore C Three Indicate the copayment amount and day interval(s) for the Medicare-covered stay (a) (b) (b) (b) (b) (for more information on cost share limitations plass view the valuable the. Copayment Amt Interval Begin Day Interval 2: Copayment Amt Interval Begin Day Interval 3: C interval Begin Day Interval 3: C interval Begin Day Interval 3: C interval Begin Day Interval 3: C interval C interval	

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Additional Days Coinsurance Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days: C 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., 91 to 999); Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: Coinsurance % Interval 4: Coinsurance % I	Is the Coinsurance structure for the Non-Medicare-covered stay? Yes Indicate Coinsurance percentage for the Non-Medicare-covered stay: Indicate the number of day intervals for the Non-Medicare-covered stay: Zero (No Coinsurance per Day) One Three Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay: One or two Three Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter '999' if unlimited days are offered; e.g.; 11999); Coinsurance % interval 1 Begin Day Interval 2: Coinsurance % interval 2 Begin Day Interval 2: Coinsurance % Interval 3 Begin Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3:	

PBP Data Entry System - Section B-1, Con	ntract X0001, Plan 001, Segment 000	- 8
Eile Help Add Variable Previous Next (Validate)	Go To: #1b Inpatient Hospital Psychiatric - Base 7	
you do not have a service-specific deductible for this benefit but iffer a jan-specific deductible, then enter the plan deductible in lection D. A Organizations are not permitted to tier deductibles. Is there an enrollee Deductible? ☐ Yes ☐ No Indicate Deductible Amount for Tier 1: ☐ Indicate Deductible Amount for Tier 2: ☐ Indicate Deductible Amount for Tier 3: ☐ Is there an enrollee Copayment? ☐ Yes ☐ No	Medicare-covered Copayment Cost Sharing for Tier 1: Do you charge the Medicare-defined costs hares? (These are the total charges for all services provided to the enrolleein the impatient facility.) Provide the comparison of the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay: Cone	

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📰 PBP Data Entry System - Section B-1, Contract	X0001, Plan 001, Segment 000
Eile Help Add Variable	o: ≢1b inpatient Hospital Psychiatric - Base 8
Previous Next (Validate) Go T	
Medicare-covered Copayment Cost Sharing for Tier 2:	Medicare-covered Copayment Cost Sharing for Tier 3:
Do you charge the Medicare-defined cost shares? (These are the total	Do you charge the Medicare-defined cost shares? (These are the total charges
charges for all services provided to the enrollee in the inpatient facility.) C Yes	for all services provided to the enrollee in the inpatient facility.) C Yes
C No	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:	Indicate the number of day intervals for the Medicare-covered stay:
C Zero (No Copayment per Day) C One C Two	C Zero (No Copayment per Day) C One C Two
C Three	C Three
Indicate the copayment amount and day interval(s) for the Medicare- covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.	Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30, 31 to 90). For more information on cost share limitations please view the variable help.
Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:
Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:
Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:

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Previous Next (Validate) Vali	Go To: #1b Inpatient Hospital Psychiatric - Base t (No date)	9 v
edicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3
dicate the number of day intervals for the Medicare- vered 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:
Zero (No Copaymentper Day) One Two Three	C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copayment per Day) C One C Two C Three
dicate the copayment amount and day interval(s) the 60 Medicare-covered Lifetime Reserve Days 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 Days	Interval Days
Copay Amount Begin Day End Day	Copay Amount Begin Day End Day	Copay Amount Begin Day End Day
erval 1:	Interval 1:	Interval 1:
erval 2:	Interval 2:	Interval 2:
erval 3:	Interval 3:	Interval 3:

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PBP Data Entry System - Section B-1, Contract X le <u>H</u> elp Add Variable	(0001, Plan 001, Segment 000	- 8
🖌 🖌 🌿 Go To:	: #1b Inpatient Hospital Psychiatric - Base 10	
Previous Next (Validate) Validate)		
ditional Days Copayment Cost Sharing for Tier 1:	Additional Days Copayment Cost Sharing for Tier 2:	
ditional bays Copayment Cost Snaring for The T.	Indicate the number of day intervals for Additional Days:	
Zero (No Copayment per Day)	C Zero (No Copayment per Day)	
) One) Two	C One C Two	
Three	C Three	
dicate the copayment amount and day interval(s) for Additional Days nter "999" if unlimited days are offered; e.g., 91 to 999):	Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):	
opayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	
opayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
opayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	

PBP Data Entry System - Section B-1, Contract XC	0001, Plan 001, Segment 000	- 8 ×
Eile Help Add Variable	: #1b Inpatient Hospital Psychiatric - Base 11	
Additional Days Copayment Cost Sharing for Tier3: Indicate the number of day intervals for Additional Days: Care (No Copayment per Day) Three Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999): Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1: Copayment Amt Interval2 Begin Day Interval 2: End Day Interval 2: Copayment Amt Interval3 Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval3 Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval3 Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval3 Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval3 Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval3 Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval3 Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval3 Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval3 Begin Day Interval3: End Day Interval3: Copayment Amt Interval3 Begin Day Interval3: End Day Interval3: Copayment Amt Interval3 Begin Day Interval3: End Day Interval3: Copayment Amt Interval3: End Day Interval3: End Day Interval3: Copayment Amt Interval4: End Day Interval4: End Day Interval4: End Day Interval5: End Day Interval	Is the Copayment Structure for the Non-Medicare-covered stay?	

PBP Data Entry System - Section B-1, Contract X000	1, Plan 001, Segment 000
Eile Help Add Variable Go To: Exit Exit Exit No	Inpatient Hospital Psychiatric - Base 12
Previous Next (Validate) Validate)	
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	Inpatient Hospital Psychiatric Notes:

🔡 PBP Data Entry System - Section B-1, Contrac	t X0001, Plan 001, Segment 000	<u>- 8 ×</u>
	To: #1b Inpatient Hospital Psychiatric (B Only) - Base 1	
Previous Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT Do you offer Inpatient Psychiatric Hospital Services as a benefit? Yes No Select type of benefit for Inpatient Psychiatric Hospital Services: Mandatory Optional Does this benefit have unlimited days? Yes No, indicate number Indicate number of days per period: Select the days periodicity:	Is there a service-specific Maximum Plan Benefit Coverage amount? Yes No Select the Maximum Plan Benefit Coverage type: C Covered under Inpatient Hospital Services Category 1a Plan-specified amount per period Indicate Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage periodicity: C Every three years C Every three years C Every three months C Every thr	
C Every three years C Every two years C Every year C Every six months C Every three months C Every three months C Every Stay C Other, Describe	C Every Stay C Other, Describe	

were volus	PBP Data Entry System - Section B-1, Co	ntract X0001, Plan 001, Segment 000	
ire a service-specific Maximum Enrollee Out-of-Pocket Cost? es to to tot the Maximum Enrollee Out-of-Pocket Cost type: Covered under the Inpatient Hospital Services Category 1a Plan-specified amount per period licate Maximum Enrollee Out-of-Pocket Cost amount: elect the Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every three years Every three years Every three months Every three months Every Benefit Period Every Stay	Help Add Variable	Go To: #1b Inpatient Hospital Psychiatric (8 Only) - Base 2	
tes bookstand bo	ere a service-specific Maximum Enrollee Out-of-Pocket Co		
Covered under the Inpatient Hospital Services Category 1a Plan-specified amount per period dicate Maximum Enrollee Out-of-Pocket Cost amount: elect the Maximum Enrollee Out-of-Pocket Cost periodicity: Cevery three years Every three years Every three months Eve	/es lo		
Covered under the Inpatient Hospital Services Category 1a Plan-specified amount per period dicate Maximum Enrollee Out-of-Pocket Cost amount: elect the Maximum Enrollee Out-of-Pocket Cost periodicity: Cevery three years Every three years Every three months Eve	ect the Maximum Enrollee Out-of-Pocket Cost type:		
elect the Maximum Enrollee Out-of-Pocket Cost periodicity: Every two years Every year Every year Every six months Every three months Every Breefit Period Every Bay		•	
Every three years Every two years Every six months Every six months Every three months Every three months Every six Every six Every six	dicate Maximum Enrollee Out-of-Pocket Cost amount:		
Every two years Every year Every time months Every timee months Every Benefit Period Every Stay	elect the Maximum Enrollee Out-of-Pocket Cost periodicity	:	
D Every Benefit Period D Every Stay	C Every three years C Every two years C Every year C Every yix months		
	C Every three months C Every Benefit Period C Every Stay		

BP Data Entry System - Section B-1, Con	ntract X0001, Plan 001, Segment 000
Elle Help Add Variable Previous Next (Validate) Validate)	Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 3
Previous Next (validate) Validate) s there an enrollee Coinsurance? Yes	Indicate the coinsurance percentage and day interval (s) for the stay center: "99 Finding days and effects (g), 116 990; coinsurance % interval 2 egin Day Interval 2: coinsurance % interval 3 egin Day Interval 3: coinsurance % interval 4 effects (c)

ile <u>H</u> elp Add Variable		
Exit Exit (N	Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 4	
Previous Next (Validate) Validate	a)	
there an enrollee Deductible?	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:	
ndicate Deductible Amount:		
	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
here an enrollee Copayment?		
Yes	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	
No		
dicate Copayment amount per stay:	Enrollee must receive Authorization from one or more of the following:	
	None	
dicate the number of day intervals for the stay:	Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist	
Zero (No Copayment per Day)	Organization Medical Director/Utilization Management/Utilization Review	
One Two	C Other, describe	
Three	Is a referral required for Inpatient Psychiatric Hospital Services?	
	C Yes C No	

le <u>H</u> elp Ad	d Variable	Exit (Validate)	Exit (No Validate)	Go To: #1b Inpatient Hospit	Il Psychiatric (B Only) - Base 5			
itient Hospital I								
may include a	dditional info	mation to descri	be bene <mark>fit in this</mark>	service category. Do not repeat i	nformation captured in data en	try.		
6						<u>^</u>		
						*		

#2 SNF – Base 1

😸 PBP Data Entry System - Section B-2, Contract X00	001, Plan 001, Segment 000	_ 8 ×
<u>F</u> ile <u>H</u> elp Add Variable		
Go To:	#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?	
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	C Yes C No	
O Yes O No	Indicate the Number of Hospital Days Required Prior to SNF	
Select enhanced benefits:	Admission (0-2):	
Additional days beyond Medicare-covered	C Zero	
Non-Medicare-covered stay (MMP Only)	C Two	
Select type of benefit for Additional Days beyond Medicare-covered:	Maximum Plan Benefit Coverage is not applicable for this Service	
O Mandatory	Category.	
C Optional	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Is this benefit unlimited for Additional Days?	C Yes	
O Yes	C No	
O No, indicate number	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 periodicity:	
	C Every three years	
Select type of benefit for the Non-Medicare-covered stay:	O Every two years O Every year	
○ Mandatory ○ Optional	C Every six months	
	C Every three months	
	O Every Stay O Other, Describe	
	O Other, Describe	
		//

#2 SNF – Base 2

😸 PBP Data Entry System - Section B-2, Contract X(0001, Plan 001, Segment 000	- 8 ×
Eile Help Add Variable Previous Next Exit Exit Exit (No Validate) Control Control Co	≠2 SNF - Base 2	
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care? Yes How many cost sharing tiers do you offer? Tier 1 Tier 2 Tier 3 What is your lowest cost tier? Original Medicare Annual Per Admission Other, describe If "Other, Describe" is selected enter description below: Do you charge cost sharing on the day of discharge? Original Medicare No	Is there an enrollee Coinsurance?	

#2 SNF – Base 3

PBP Data Entry System - Section B-2, Contract X00	01, Plan 001, Segment 000	- 8 >
Eile Help Add Variable Go To:	#2 SNF - Base 3	
Previous Next (Validate) Go To:		
Medicare-covered Coinsurance Cost Sharing for Tier 2:	Medicare-covered Coinsurance Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the	Do you charge the Medicare-defined cost shares? (These are the	
total charges for all services provided to the enrollee in the SNF.) C Yes	total charges for all services provided to the enrollee in the SNF.) O Yes	
C No Indicate Coinsurance percentage for the Medicare-covered stay:	O No Indicate Coinsurance percentage for the Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Coinsurance per Day)	Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Coinsurance per Day)	
C One C Two	C Zero (No Coinsurance per Day) C One C Two	
O Three	C Three	
Indicate the coinsurance percentage and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100):	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: 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: End Day Interval 2: End Day Interval 2:	
	Coloniano Materia da Decisiona da Endormada	
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	Coinsurance % Interval 3: Begin Day Interval 3:	

If is provided If is an impact of the same structure of the same
Additional Days Coinsurance Cost Sharing for Tier 3: Is the Coinsurance shuckure for the Non-Medicare-covered stay the same as the Coinsurance per Covered stay? Indicate the number of day intervals for Additional Days: C Yes Core (No Coinsurance per Day) Indicate Coinsurance per Covered stay? Core (No Coinsurance per Covered at a start the number of day interval (s) for Additional Days (enter '999' if unlimited days are offered; e.g., 101 to 999): Indicate the number of day intervals for the Non-Medicare-covered stay: Coinsurance % Interval 2: End Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3: Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3: Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3: Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3: Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3:

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revious Next (Validate	Exit (No Validate)	Go To: #2 SNF - Base 6	
do not have a service-specific deductib	le for this benefit bu	ut is there an enrollee Copayment?	
a plan-specific deductible, then enter the on D. Irganizations are not permitted to tier de		C Yes C No	
there an enrollee Deductible?	uucibies.	Medicare-covered Copayment Cost Sharing for Tier 1:	
O Yes O No		Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	
Indicate Deductible Amount Tier 1:		C Yes C No	
Indicate Deductible Amount Tier 2:		Indicate Copayment amount for Medicare-covered stay:	
		Indicate the number of day intervals for the Medicare-covered stay:	
Indicate Deductible Amount Tier 3:		C Zero (No Copayment per Day) C One C Two C Two C Three	
		Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): For more information on cost share limitations please view the variable help.	
		Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
		Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
		Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	

PBP Data Entry System - Section B-2, Contract X0	0001, Plan 001, Segment 000	_ 8
	#2 SNF - Base 7	
Previous Next (Validate) Validate)		
edicare-covered Copayment Cost Sharing for Tier 2:	Medicare-covered Copayment Cost Sharing for Tier 3:	
o you charge the Medicare-defined cost shares? (These are the total arges for all services provided to the enrollee in the SNF.)	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	C Yes C No	
dicate Copayment amount for Medicare-covered stay:	Indicate Copsyment amount for Medicare-covered stay:	
dicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
) Zero (No Copayment per Day)) One) Two	C Zero (No Copayment per Day) C One C Two	
D Three dicate the copayment amount and day interval(s) for Medicare-covered ay (e.g., 1 to 20; 21 to 100): For more information on cost share	C Three Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g., 1 to 20, 21 to 100): For more information on cost share	
nitations please view the variable help. opayment Amt Interval 1:Begin Day Interval 1:End Day Interval 1:	limitations please view the variable help. <u>Copayment Amt Interval 1:</u> <u>Begin Day</u> Interval 1: <u>End Day</u> Interval 1:	
ppayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2: End Day Interval 2:	
opayment Amt Interval 3:Begin Day Interval 3:Interval 3:	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	

Eile Help Add Variable Previous Next Exit (No Validate) Go To: #2 SNF - Base 9 Additional Days Copayment Cost Sharing for Tier 3: Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?
Additional Davs Copayment Cost Sharing for Tier 3: Is the Copayment structure for the Non-Medicare-covered stay the same as
Additional Days Copayment Cost Sharing for Tier 3: Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?
Indicate the copyment amount of day intervals for Additional Days C rec (IV Copyment famount for Non-Medicane-covered stay: C Two C Two

PBP Data Entry System - Section B-2, Contract X000	01, Plan 001, Segment 000	- 8
Eile Help Add Variable 🖉 🖌 🖉 Go To: 📴	2 SNF - Base 10	
Previous Next (Validate) Go To:		
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 referal required for SNF Services? C Yes No	SNF Notes Note may include a diditional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	

PBP Data Entry System - Section B-2, Co	ntract X0001, Plan 001, Segment 000	
Help Add Variable	Go To: #2 SNF (B Only) - Base 1	
CLICK 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: Mandatory	Is there a service-specific Maximum Plan Benefit	
Optional	Coverage amount?	
7 Yes 7 No, indicate number	C No	
Indicate number of days per period:	Indicate Maximum Plan Benefit Coverage amoun	
Select the days periodicity:	Select Maximum Plan Benefit Coverage periodicity:	
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 six months	
C Every three months C Every Stay C Other, Describe	C Every three months C Every Stay C Other, Describe	

PBP Data Entry System - Section B-2, Cont	ract X0001, Plan 001, Segment 000	
ile <u>H</u> elp Add Variable	Go To: ⊭2 SNF (B Only) - Base 2	
Exit Exit (No	Go To: #2 SNr (b Omly) - base 2	
Previous Next (Validate) Validate)		
there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the number of day intervals for the stay:	
Yes No	C Zero (No Coinsurance per Day) C One	
dicate amount for Maximum Enrollee Out-of-Pocket Cost:	C Two C Three	
	Indicate the coinsurance percentage and day interval(s) for the stay	
elect the Maximum Enrollee Out-of-Pocket Cost periodicity:	(enter "999" if unlimited days are offered; e.g.; 1 to 999):	
Every three years	Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
Every two years Every year		
Every six months Every three months	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
Every Stay		
Other, Describe ere an enrollee Coinsurance?	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
/es		
lo		
cate Coinsurance percentage:		
cale constraince percentage.		

ile <u>H</u> elp Add Variable		
Previous Next (Validate)	Go To: #2 SNF (B Only) - Base 3	
there an enrollee Deductible? Yes No Indicate Deductible Amount: there an enrollee Copayment? Yes No ndicate 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 '99' 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 Begin Day Interval 3: Copayment Amt Interval 4: Copayment	

😸 PBP Data Entry System - S	ection B-2, Co	ntract X0001, Plan	001, Segment 00	0			- 8
Eile Help Add Variable Previous Next (Validat	Exit (No e) Validate)	Go To: #2 SNF (B On	ly) - Base 4				
Enrollee must receive Authorization from or None Primary Care Physician (Internist/Family Physician Specialist Organization Medical Director/Utilization Other, describe Is a referral required for SNF Services?	Practice, General Pr	actice)					
C No							
Skilled Nursing Facility (B-Only) Notes							
Note may include additional information to	describe benefit in thi	s service category. Do not r	epeat information captured	in data entry.			
Notes:					A.		
					×		

🔡 PBP Data Entry System - Section B-3, Contract X0	001, Plan 001, Segment 000	_ 8 ×
Elle Help Add Variable Previous Next Exit (Validate) Validate	#3 Cardiac and Pulmonary Rehabilitation Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C? Yes Additional Cardiac Rehabilitation Services Additional Cardiac Rehabilitation Services Select type of benefit for Additional Cardiac Rehabilitation Services? C Yes No Select the Additional Cardiac Rehabilitation Services? C Yes No, indicate number Indicate number of visits for Additional Cardiac Rehabilitation Services: Select the Additional Cardiac Rehabilitation Services? Select the Additional Cardiac Rehabilitation Services: C Yes No, indicate number Indicate number of visits for Additional Cardiac Rehabilitation Services: C Every wars C Every year C Every year C Every year C Every six months C Other, Describe Selecttype of benefit for Additional Intensive Cardiac Rehabilitation Services: C Mandatory C Optional	C Optional Is this benefit unlimited for Additional Pulmonary Rehabilitation Services? C Yes No, indicate number Indicate number of visits for Additional Pulmonary Rehabilitation Services: Select the Additional Pulmonary Rehabilitation Services periodicity:	

🔡 PBP Data Entry System - Section B-3, Contract X(0001, Plan 001, Segment 000			- 8 >
Eile Help Add Variable	#3 Cardiac and Pulmonary Rehabilitation Services - Ba	2		
Exit Exit (No	#3 Cardiac and Pulmonary Rehabilitation Services - Ba	se z		
Previous Next (Validate) Validate)		_		
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Select which Cardiac and Pulmonary Rehabilitation Coinsurance (Select all that apply):	Services have a	ea	
s there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Medicare-covered Cardiac Rehabilitation Service	s		
Yes	Medicare-covered Intensive Cardiac Rehabilitation			
O No	Medicare-covered Pulmonary Rehabilitation Serv Additional Cardiac Rehabilitation Services	vices		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Additional Intensive Cardiac Rehabilitation Services	ces		
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Select Maximum Enrollee Out-of-Pocket Cost periodicity:		Minimum Coinsurance	Maximum 2e Coinsurance	
C Every three years	Indicate Coinsurance percentage for Medicare- covered Cardiac Rehabilitation Services:			
C Every year C Every year C Every six months	Indicate Coinsurance percentage for Medicare- covered Intensive Cardiac Rehabilitation Services:			
C Every three months	Indicate Coinsurance percentage for Medicare-			
C Other, Describe You must include total cost sharing to the beneficiary, including any	covered Pulmonary Rehabilitation Services:			
facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.	Indicate Coinsurance percentage for Additional Cardiac Rehabilitation Services:			
Is there an enrollee Coinsurance?	Indicate Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:			
C Yes	Indicate Coinsurance percentage for Additional			

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	tional Pulmonary Renabilitation Services				

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<u>Eile H</u> elp Ac	dd Variable	4	x	Go To: \Bigg	Cardiac and Pulm	onary Rehabilitation	Services - Base	4	-			
Previous	Next	Exit (Validate)	Exit (No Validate)									
Primary Care Physician Sp	Physician (Int ecialist Medical Direc	ation from one or ernist/Family Pra tor/Utilization Mar	ctice, General F	Practice)								
ardiac and Pulr	monary Rehab	ilitation Services	Notes									
ote may include otes:	e additional inf	ormation to desc	ribe benefit in th	is service catego	ry. Do not repeat	information capture	ed in data entry.					
								4				

#4a Emergency Care – Base 1

	iable		Go To: #4a Emergency Care - Base 1	
evious N	ext (Validate	Exit (No Validate)		
Sectors 1000	TION OF BENEFIT	J	Cost sharing cannot be greater than the amount established by CMS in the Final Call Letter for Medicare-covered Emergency Care.	
	not applicable for thi		Is there an enrollee Coinsurance?	
re a service-speci es	ic Maximum Enrollee	Out-of-Pocket Cos	□ O Yes	
0			C No	
dicate Maximum E	nrollee Out-of-Pock	t Cost amount:	Indicate Minimum Coinsurance percentage for Medicare- covered Benefits:	
lect Maximum Enr	ollee Out-of-Pocket (ost periodicity:	Indicate Maximum Coinsurance percentage for Medicare-	
Every three year	s		covered Benefits:	
Every two years Every year				
Every six month Every three mon			Indicate the maximum per visit amount:	
Other, Describe	uns			
			Is the Coinsurance for Medicare-covered Benefits waived if	
			admitted to hospital?	
			C No	
			Select either Days or Hours within which admission must occur	
			for waiver: C Days	
			C Hours	
			Enter number of Days or Hours:	

#4a Emergency Care – Base 2

PBP Data Entry System - Section B-4, Cont <u>File</u> <u>Help</u> Add Variable	tract X0001, Plan 001, Segment 000	- 8)
	Go To: #4a Emergency Care - Base 2	
s there an enrollee Copayment? Yes No Indicate Minimum Copayment amount for Medicare-covered Benefits: Indicate Maximum Copayment amount for Medicare-covered Benefits: Is the Copayment for Medicare-covered Benefits waived if admitted to hospital? Select either Days or Hours within which admission must occur for waiver: Days Hours Enter number of Days or Hours: Yes No No	Authorization is not applicable for this Service Category. Emergency Care Notes 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

Previous Next Children Verlieten	Go To: #4b Urgently Needed Services - Bas	se 1	
CLICK FOR DESCRIPTION OF BENEFIT Aximum Plan Benefit Coverage is not applicable for this ervice Category. there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No select the Maximum Enrollee Out-of-Pocket Cost type: C Covered under Emergency Care Service Category 4a Plan-specified amount per period	Go To: #4b Urgently Needed Services - Eas Indicate Maximum Enrollee Out-of- Pocket Cost amount: Select Maximum Enrollee Out-of- Pocket Cost periodicity: C Every three years C Every two years C Every year C Every year C Every six months C Other, Describe Cost sharing cannot be greater than the amour established by CMS in the Final Call Letter for Medicare-covered Digently Needed Services. Is there an enrollee Coinsurance percentage for Medicare-covered Benefits: Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits: Indicate the maximum per visit amount:	Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital? C Yes C No Select either Days or Hours within which admission must occur for waiver: C Days C Hours Enter number of Days or Hours:	

#4b Urgently Needed Services – Base 2

PBP Data Entry System - Section B File Help Add Variable	-4, Contract X0001, Plan 001, Segment 000	_ 8
Exit E	Go To: #4b Urgently Needed Services - Base 2	
Previous Next (Validate) V:	xit No	

#4b Urgently Needed Services – Base 3

		stem - Sectio	on B-4, Co	ntract X0001, Plan 001	, Segment 000		
Eile Help Ad	d Variable	Exit (Validate)	Exit (No Validate)	Go To: #4b Urgently Needed	Services - Base 3	•	
Authorization is no Referral is not app							
Irgently Needed S							
ote may include a	dditional info	mation to describ	e benefit in this	s service category. Do not repeat			
nformation captur lotes:	ed in data enti	у.					
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Fu Associates, Ltd.

#4c Worldwide Emergency/Urgent Coverage – Base 1

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Previous Next (Validate) Valid	No		
CLICK FOR DESCRIPTION OF BENEFIT	Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/UrgentCoverage?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
pes the plan provide Worldwide Emergency/Urgent overage as a supplemental benefit under Part C?	C Yes C No	C Yes O No	
Yes No	Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	Indicate Maximum Enrollee Out-of- Pocket Cost amount:	
elect type of benefit for Worldwide Emergency/Urgent	C Yes	Focket Cost amount.	
overage:	C No Indicate Maximum Plan Benefit Coverage	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Optional	amount:	C Every three years	
es this benefit include emergency transportation? If yes, scribe the benefit in the notes.		C Every two years C Every year C Every six months	
Yes No		C Every star literation of the control of the contr	
NU	Ê.		

#4c Worldwide Emergency/Urgent Coverage – Base 2

PBP Data Entry System - Section B-4, Con	tract X0001, Plan 001, Segment 000	_
le Help Add Variable	Go To: #4c Worldwide Emergency/Urgent Coverage - Base 2	
Previous Next (Validate) Validate)		
here an enrollee Coinsurance?	Is there an enrollee Copayment?	
Yes No	C Yes C No	
ndicate Minimum Coinsurance percentage for Worldwide Emergency/Urgent Coverage:	Indicate Minimum Copayment amount for Worldwide Emergency/Urgent Coverage:	
ndicate Maximum Coinsurance percentage for Worldwide imergency/Urgent Coverage:	Indicate Maximum Copayment amount for Worldwide Emergency/Urgent Coverage:	
s this Coinsurance waived for Worldwide Emergency/Urgent Coverage if admitted to hospital?	Is this Copayment waived for Worldwide Emergency/Urgent Coverage if admitted to hospital?	
O Yes O No	C Yes C No	
ere an enrollee Deductible?	time new second s	
rés No		

#4c Worldwide Emergency/Urgent Coverage – Base 3

e <u>H</u> elp Add	l Variable						
		Exit	Exit (No Validate)	Go To: #4c World	wide Emergency/Urgent Coverage - Base 3		
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horization is no	tapplicablefo	r this Service Cat	egory.				
erral is not app	icable for this	Service Category	γ.				
rldwide Emerge	ncy/Urgent C	overage Notes					
e may include a	dditional info	mation to descrit	be benefit in thi	is service category. Do no	otrepeat		
rmation capture	ed in data ent	y.					
15.					A		
					-		

#5 Partial Hospitalization – Base 1

📕 PBP Data Entry System - Section B-5, Contract X	0001, Plan 001, Segment 000	- 8 ×
Eile Help Add Variable Previous Next Exit Exit Exit (No (Validate) Validate	#5 Partial Hospitalization - Base 1	
Previous Next Exit (Validate) 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 Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years C Every three years C Every three months C Every three months C Other, Describe	Is there an enrollee Coinsurance Procentage for Medicare-covered Beneficiar	

#5 Partial Hospitalization – Base 2

PBP Data Entry System - Section B-5, Contract X	X0001, Plan 001, Segment 000	- 8
Eile <u>H</u> elp Add Variable 🖌 🖌 🖌 Go To	o: #5 Partial Hospitalization - Base 2	
Previous Next (Validate) Go To Exit Exit (No Validate)		
s there an enrollee Copayment?	Partial Hospitalization Notes	
O Yes	Note may include additional information to describe benefit in this service	
O No	category. Do not repeat information captured in data entry.	
ndicate Minimum Copayment amount for Medicare-covered Benefits per day:	Notes:	
	<u>×</u>	
Indicate Maximum Copayment amount for Medicare-covered Benefits per	6	
lay:		
nrollee must receive Authorization from one or more of the following: None		
Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist		
Organization Medical Director/Utilization Management/Utilization Review	W	
Other, describe		
a referral required for Partial Hospitalization?	-	
i ves i No		
	<u>z</u>	

#6 Home Health Services – Base 1

	n B-6, Contract X0001, Plan 001, Se	egment 000	- 8 ×
<u>File</u> <u>H</u> elp Add Variable	Go To: #6 Home Health Services	- Base 1	
Previous Next (Validate)	Go To: #6 Home Health Services Exit (No Validate)		
(summer)	- Chouchy		
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?	
Enhanced Benefits are not applicable for this Service Category, except for MMPs.	C Yes C No	C Yes C No	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe		
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#6 Home Health Services – Base 2

		on B-6, Contra	act X0001, Plan 00	1, Segment 000		_ 8
ile <u>H</u> elp Add Varia		Exit (No	Go To: #6 Home Health Ser	rvices - Base 2	_	
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there an enrollee Dedu	ctible?					
) Yes) No						
ndicate Deductible Amo	unt:					
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No						
Torcate Minimum Copa	yment amount per visit fo	n wedicare-covere	u perellts:			
dicate Maximum Copa	yment amount per visit fo	or Medicare-covere	ed Benefits:			

#6 Home Health Services – Base 3

📕 PBP Data I		tem - Sectio	on B-6, Co	ntract X00	01, Plan 00	01, Segmer	nt 000						- 8
Eile <u>H</u> elp Add	Variable Next	Exit (Validate)	Exit (No Validate)	Go To: 📕	Home Health S	ervices - Base 3	3	_	_	•			
nrollee must receir None Primary Care Ph Physician Speci Organization Me Other, describe s a referral requirer	ysician (Intern alist edical Director/	ist/Family Pract Utilization Mana	tice, General P	ractice)									
O Yes O No													
lome Health Servic Note may include ac		nation to descri	be benefit in thi	is service catego	y. Do notrepe	at information c	aptured in data	entry.					
lotes:									*				

#6 Home Health Services – MMP – Base 1

PBP Data Entry System - Section B-6, Contract X(0001, Plan 001, Segment 000		- 8
revious Next (Validate)	#6 Home Health Services - MMP - Base 1		
CLICK FOR DESCRIPTION OF BENEFIT es this plan provide Non-Medicare Home Health Services? Yes No Select Non-Medicare Home Health Services: Additional Hours of Care Additional Hours of Care Other 1 Other 2 Enter name of Other 1 Service: Enter name of Other 2 Service:	Is there a limit on the services provided? Yes No Select Non-Medicare Home Health Service Additional Hours of Care Other 1 Other 2 Indicateunits a limit will be provided in for Additional Hours of Care. Sessions Visits Hours Ho	s where limit applies: Indicate units a limit will be provided in for Personal Care Services: Sessions Visits Hours Points Meals Items/other, Describe	
Is there a service-specific Maximum Plan Benefit Coverage Amount? Yes No Indicate Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage periodicity: Every three years Every three years Every three years Every three months Every three months C Other, Describe	Indicate numerical limit on the services provided for Additional Hours of Care: Select limit on services periodicity for Additional Hours of Care: © Every day © Every week © Every week © Every went © Every year © Other, Describe	C Items/Other, Describe Indicate numerical limit on the services provided for Personal Care Services: Select limit on services periodicity for Personal Care Services: C Every day C Every week C Every week C Every week C Every week C Other, Describe	

#6 Home Health Services – MMP – Base 2

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dicate units a limit will be provided in for ther 1: Indicate units a limit will be provided in for Other 2: Is there an enrollee Coinsurance? 2 Sessions C Visits C Visits 3 Sessions C Visits 4 Ours C Points 6 Hours C Points 7 Points C No 9 Points C Points 6 Meals C Items/Other, Describe 1 Indicate numerical limit on the services ovided for Other 1: 1 Indicate numerical limit on the services provided for Other 2: 1 Select limit on services periodicity for her 1: 2 Every day 2 Every week 2 Every week 2 Every week 2 Every month 2 Every week	revious Next (Validate)	Exit (No Validate)	
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Hours Chours Consume (select all that apply): Points Points Additional Hours of Care Meals Personal Care Services Other 1 indicate numerical limit on the services Other 2 Other 2 provided for Other 1: Indicate numerical limit on services periodicity for Main services periodicity for ietertlimit on services periodicity for Select limit on services periodicity for Main services ietertlimit on services periodicity for Select limit on services periodicity for Main services ietertlimit on services periodicity for Select limit on services periodicity for Main services ietertlimit on services periodicity for Select limit on services periodicity for Cerving services: ietery week Every week Other 1: Image services ietery sear Cerving week Other 1: Image services ietery week Cerving week Other 1: Image services			Select which Neo Medicare Home Health Services have a
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Heet limit on services periodicity for Other 2: Select limit on services periodicity for Other 2: Additional Hours of Care Perent Hert : C Every day Personal Care Services Every week C Every week Other 1: Every war C Every year Other 2:			or more of the
her 1: Other 2: Additional Hours of Care Every day C Every day Every week C Every week Every month C Every month Every year C Every year	lect limit on services periodicity for	Select limit on services periodicity for	
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			Other 2:
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#6 Home Health Services – MMP – Base 3

PBP Data Entry System - Section B-6, Contract X00	001, Plan 001, Segment 000	_ 8
Elle Help Add Variable File Help Add Variable Sector Exit Exit Exit (No Validate) Validate)	#S Home Health Services - MMP - Base 3	
s there an enrollee Copayment? Yes No lelect which Non-Medicare Home Health Services have a Copayment(select II that apply): Additional Hours of Care Personal Care Services Other 1 Other 2 micate copayment mount for one or core of the following s Copayment copayment <	Does any service require qualification for and enrollment in a state-operated waiver program: Select Which Services qualification for and enrollment in a state-operated waiver program: Other 2 Conter 2	

#7a Primary Care Physician Services – Base 1

📕 PBP Data Entry System - Section B-7, Contr	act X0001, Plan 001, Segment 000	- 8 ×
Eile Help Add Variable	Go To: #7a Primary Care Physician Services - Base 1	
Previous Next (Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
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 Yes Indicate Maximum Enrollee Out-of-Pocket Cost amount:	No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits: Is there an enrollee Deductible?	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every two years C Every year C Every six months C Every six months C Every three months C Other, Describe	Indicate Deductible Amount:	

#7a Primary Care Physician Services – Base 2

PBP Data Entry System - Sec File Help Add Variable	ction B-7, Contract X0001, Plan 00	01, Segment 000		_ 5
Previous Next (Validate)	Go To: #7a Primary Care Exit (No Validate)	Physician Services - Base 2		
authorization is not applicable for this Service	e Category.			
Primary Care Physician Services Notes				
	scribe benefit in this service category. Do not repe	t information captured in data entry.		
lotes:				
			×	

#7b Chiropractic Services – Base 1

	n B-7, Contract X0001, Plan 001, Segm	ent 000	- 8 ×
<u>F</u> ile <u>H</u> elp Add Variable			
Exit	Go To: #7b Chiropractic Services - Bas Exit (No	e 1 🗸 🗸	
Previous Next (Validate)	Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Select Routine Care/Other periodicity:	Is there a service-specific Maximum Enrollee Out-of-	
CLICK FOR DESCRIPTION OF BENEFIT	C Every three years	Pocket Cost?	
Does the plan provide Chiropractic Services as a	C Every two years C Every year	O Yes O No	
supplemental benefit under Part C?	C Every six months	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
O No	C Every three months C Other, Describe		
Select enhanced benefit: Routine Care/Other	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select the Maximum Enrollee Out-of-Pocket Cost	
Select type of benefit for Routine Care/Other:	O Yes	periodicity: O Every three years	
O Mandatory		C Every two years	
C Optional	Indicate Maximum Plan Benefit Coverage amount:	C Every year C Every six months	
	,	C Every three months	
Is this benefit unlimited for Routine Care/Other?	Select Maximum Plan Benefit Coverage periodicity:	O Other, Describe	
C Yes	C Every three years C Every two years		
C No, indicate number	C Every year		
Indicate number of visits for Routine	C Every six months C Every three months		
Care/Other:	O Other, Describe		
Do you offer a combined Acupuncture and			
Chiropractor Services benefit?			
O Yes O No			

#7b Chiropractic Services – Base 2

PBP Data Entry System - Section B-7, Cont <u>Help</u> Add Variable	tract X0001, Plan 001, Segment 000	- 1
Exit Exit (No	Go To: #7b Chiropractic Services - Base 2	
revious Next (Validate) Validate)		
here an enrollee Coinsurance?		
Yes No		
viect which Chiropractic Services have a Coinsurance (Select that apply): Medicare-covered Chiropractic Services Routine Care/Other		
dicate Minimum Coinsurance percentage per visit for Idicare-covered Benefits:		
licate Maximum Coinsurance percentage per visit for dicare-covered Benefits:		
icate the Minimum Coinsurance percentage per visit for time Care/Other:		
icate the Maximum Coinsurance percentage per visit for utime Care/Other:		

#7b Chiropractic Services – Base 3

🔜 PBP Data Entry System - Section B-7, Contract X(0001, Plan 001, Segment 000	_ 8 >
<u>F</u> ile <u>H</u> elp Add Variable		
	#7b Chiropractic Services - Base 3	
Previous Next Exit Exit (No (Validate) Validate)		
(Fundace) Fundace)		
Is there an enrollee Deductible?	Indicate Minimum Copayment amount per visit for Routine Care/Other:	
O Yes		
C No		
Indicate Deductible Amount:	Indicate Maximum Copayment amount per visit for Routine Care/Other.	
	Enrollee must receive Authorization from one or more of the following:	
Is there an enrollee Copayment?		
C Yes	Primary Care Physician (Internist/Family Practice, General Practice)	
C No	Physician Specialist Organization Medical Director/Utilization Management/Utilization Review	
Select which Chiropractic Services have a Copayment (Select all that apply):		
Medicare-covered Chiropractic Services		
Routine Care/Other	Is a referral required for Chiropractic Services?	
Indicate Minimum Copayment amount for Medicare-covered Benefits:	C Yes C No	

#7b Chiropractic Services – Base 4

e <u>H</u> elp Ado		stelli - Secu	on 6-7, Co	tract X0001, Plan 001, Segment 000	
•		Exit (Validate)	Exit (No Validate)	Go To: #7b Chiropractic Services - Base 4	
evious	Next	(Validate)	Validate)		
practic Servi	ces Notes				
may include a	dditional info	ormation to describ	be benefit in this	service category. Do not repeat information captured in data entry.	
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#7c Occupational Therapy Services – Base 1

	tion B-7, Contract X0001, Plan 001, S	Segment 000	- 8
le <u>H</u> elp Add Variable	Go To: #7c Occupational Thera		
Previous Next (Validate)	Exit (No		
Previous Next (Validate)	Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	
hanced Benefits are not applicable for this rvice Category, except for MMPs.	C Every three years C Every two years C Every year	C Yes C No Indicate Deductible Amount:	
ximum Plan Benefit Coverage is not plicable for this Service Category. there a service-specific Maximum Enrollee	C Every six months C Every three months C Other, Describe	Is there an enrollee Copayment?	
it-of-Pocket Cost?	You must include total cost sharing to the beneficiary, including any facility cost sharing.	C Yes	
No	Is there an enrollee Coinsurance?	C No	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	O No	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
	Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
	Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:		

#7c Occupational Therapy Services – Base 2

		stem - Secti	on B-7, Co	ntract X000	1, Plan 001,	, Segment 00	0				- 8
Eile <u>H</u> elp Ad	Id Variable Next	Exit (Validate)	Exit (No Validate)	Go To: \Bigg #70	Occupational The	rapy Services - Bas	se 2				
None Primary Care P Physician Spe	Physician (Inte cialist Aedical Directo	ion from one or m rnist/Family Pract pr/Utilization Mana	tice, General Pr	actice)							
a referral require Yes	ed for Occupat	tional Therapy Se	rvices?								
O No											
ccupational The	erapy Services	Notes									
ote may include	additional info	rmation to descri	be benefit in thi	s service categor	. Do not repeat in	nformation captured	d in data entry.				
otes:								*			
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#7c Occupational Therapy Services – MMP – Base 1

PBP Data Entry System - Section B-7, Contract	K0001, Plan 001, Segment 000	
Eile Help Add Variable	t #7c Occupational Therapy Services - MMP - Base 1 ▼	
Previous Next (Validate) Go To		
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
Does this plan provide Non-Medicare Occupational Therapy Services?	C No	
C Yes C No	Indicate Minimum Coinsurance percentage:	
Enter name of Non-Medicare Occupational Therapy Service:		
	Indicate Maximum Coinsurance percentage:	
i there a service-specific Maximum Plan Benefit Coverage amount?		
) Yes) No	Is there an enrollee Copayment?	
Indicate Maximum Plan Benefit Coverage amount:	C Yes C No	
	Indicate Minimum Copayment amount:	
Select Maximum Plan Benefit Coverage periodicity:		
C Every three years C Every two years	Indicate Maximum Copayment amount:	
C Every six months		
C Every three months		
C Other, Describe		

#7c Occupational Therapy Services – MMP – Base 2

PBP Data Entry System - Section B-7, Contract X	0001, Plan 001, Segment 000
Eile Help Add Variable 🖉 🖌 Go To:	#7C Occupational Therapy Services - MMP - Base 2
Previous Next (Validate) Go To: Exit Exit (No Validate)	
nrollee must receive Authorization from one or more of the following:	Occupational Therapy Services MMP Notes
Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
Organization Medical Director/Utilization Management/Utilization Review	Notes:
a referral required for Services?	
Yes No	
NO	
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#7d Physician Specialist Services – Base 1

	B-7, Contract X0001, Plan 001, S	egment 000	_ 8 ×
Eile Help Add Variable			
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Previous Next (Validate) V	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 Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes Indicate Maximum Enrollee Out-of-Pocket Cost Indicate Maximum Enrollee Out-of-Pocket Indicate Maximum Enrollee	Co To: Jerd Hysical Specials terms in the special state of the Maximum Enrollee Out-of-Pocket Cost indicity. Every three years Every set Every set Every set Every set Every set Every the enoths Other, Describe here an enrollee Coinsurance percentage for edicate Minimum Coinsurance percentage for edicate-covered Benefits: dicate Maximum Coinsurance percentage for edicate-covered Benefits:	Scruces - case 1	

#7d Physician Specialist Services – Base 2

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le <u>H</u> elp Ad	ld Variable	Exit (Validate)	Exit (No Validate)	Go To: 🖅	l Physician Specialist S	ervices - Base 2		•			
None Primary Care P Physician Spe Organization N Other, describ	Yhysician (Inte cialist Aedical Directo e	ion from one or m nist/Family Pract r/Utilization Mana	tice, General Pr agement/Utiliza	ractice)							
referral require Yes No	ed for Physicia	n Specialist Servi	ices?								
ysician Special te may include			be benefit in thi	is service categor	y. Do notrepeat inform	ation captured in data	entry.				
tes:								X			

#7e Mental Health Specialty Services – Base 1

e <u>H</u> elp Ad	ld Variable					
revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	7e Mental Health Specialty Services - Base 1	
LICK FOR DE	SCRIPTION O	BENEFIT				
nanced Benefit	ts are not appl	cable for this Ser	vice Category.			
		is not applicabl				
Yes No	Specific Maxin		-orr ocaci oosi			
	m Enrollee Ou	t-of-Pocket Cost	amount:			
elect Maximum	n Enrollee Out	of-Pocket Cost p	eriodicity:			
Every three Every two y	years	011 001010031	introdicity.			
C Every year C Every six m C Every three	ionths					
O Other, Desc	cribe					

#7e Mental Health Specialty Services – Base 2

Previous Previous Previous Previous	🔡 PBP Data Entry System - Section B-7, Cor	ntract X0001, Plan 001, Segment 000	_ 8 ×
Previous Exit	<u>F</u> ile <u>H</u> elp Add Variable		
Previous Vext (Validate) there an enrollee Coinsurance? Iter an enrollee Coinsurance? Is there an enrollee Copayment? Yes Yes Select which Mental Health Specialty Services have a Copayment (Select all that apply): Select which Mental Health Specialty Services have a Copayment (Select all that apply): Medicare-covered findividual Sessions Medicare-covered Individual Sessions Indicate Maximum Coinsurance percentage for Medicare-covered Individual Sessions: Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions: Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions: Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions: Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions: Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions: Indicate Minimum Copayment amount for Medicare-covered Group Sessions: Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions: Indicate Minimum Copayment amount for Medicare-covered Group Sessions: Indicate Minimum Coinsurance percentage for Medicare-covered Group Sessions: Indicate	Exit Exit (No	Go 10: #/e Mental Health Specialty Services - base 2	
Ves Yes No Select which Mental Health Specialty Services have a Copayment (Select all that apply): Select which Mental Health Specialty Services have a Copayment (Select all that apply): Medicare-covered Individual Sessions Medicare-covered Individual Sessions Medicare-covered Group Sessions Indicate Minimum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum 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: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum Copayment amount for Medicare-covered Group Sessions: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum Copayment amount	Previous Next (Validate) Validate)		
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Coinsurance (Select all that apply): (Select all that apply): Medicare-covered Individual Sessions Medicare-covered Group Sessions Indicate Minimum Coinsurance percentage for Medicare-covered Group 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 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 Maximum Copayment amount for Medicare-covered Individual Sessions: Indicate Minimum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum 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: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum 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: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	C No	C No	
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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 Minimum Copayment amount for Medicare-covered Group Sessions: Indicate Maximum 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: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum 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: Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum Copayment amount for Medicare-covered Group Sessions: Indicate Deductible? Indicate Maximum Copayment amount for Medicare-covered Group Sessions: Indicate Deductible? Indicate Maximum Compare Percentage Group Ses	Medicare-covered Individual Sessions	Medicare-covered Individual Sessions	
covered Individual Sessions: Individual Sessions: Individual Sessions: Indideate Maximum Copayment amount for Medicare-covered			
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covered Group Sessions: Indicate Maximum Copayment amount for Medicare-covered Group Sessions: Group Sessions: Types No	covered Group Sessions:	Group Sessions:	
Group Sessions: there an enrollee Deductible?			
Yes No		Group Sessions:	
No	s there an enrollee Deductible?		
Indicate Deductible Amount	O Yes O No		
	Indicate Deductible Amount:		
			//

#7e Mental Health Specialty Services – Base 3

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Eile <u>H</u> elp Add		Exit	Exit (No	Go To:	7e Mental Heath Specialty Services - Base 3	
Previous	Next	(Validate)	Validate)	_		
nrollee must rece None Primary Care Ph Physician Spec Organization M Other, describe a areferral require Yes No tental Health Spec Iote may include a	nysician (Inte ialist edical Directo d for Mental H	rnist/Family Pract pr/Utilization Mana Health Specialty Si Health Specialty Si	ice, General Pr Igement/Utiliza ervices <mark>-</mark> Non-F	ractice) tion Review Physician?	ory. Do not repeat information captured in data entry.	
ites:					100	

#7f Podiatry Services – Base 1

le <u>H</u> elp Add Variable	on B-7, Contract X0001, Plan 001, Segm		
Exit	Go To: #7f Podiatry Services - Base 1 Exit (No		
Previous Next (Validate)	Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Select the Routine Foot Care periodicity:	Is there a service-specific Maximum Enrollee Out -of-Pocket Cost?	
es the plan provide Podiatry Services as a oplemental benefit under Part C?	C Every two years C Every year C Every six months	C Yes C No	
Yes No	C Every three months C Other, Describe	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Routine Foot Care	Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
Select type of benefit for Routine Foot Care: O Mandatory O Optional	C No Indicate Maximum Plan Benefit Coverage amount:	C Every three years C Every two years	
s this benefit unlimited for Routine Foot Care?		C Every year C Every six months C Every three months	
O Yes O No	Select Maximum Plan Benefit Coverage periodicity: C Every three years C Every two years	C Other, Describe	
Indicate number of Routine Foot Care visits:	C Every years C Every year C Every six months C Every three months C Other, Describe		
	O Other, Describe		

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#7f Podiatry Services – Base 2

🔡 PBP Data Entry System - Section B-7, Contract X0	001, Plan 001, Segment 000	- 8 :
Eile Help Add Variable	#7f Podiatry Services - Base 2	
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(valuate) valuate)		
is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
O Yes O No	C Yes C No	
Select which Podiatry Services have a Coinsurance (Select all that apply): Medicare-covered Podiatry Services Routine Foot Care	Select which Podiatry Services have a Copayment (Select all that apply): Medicare-covered Podiatry Services Routine Foot Care	
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Minimum Coinsurance percentage for Routine Foot Care:	Indicate Minimum Copayment amount per visit for Routine Foot Care:	
Indicate Maximum Coinsurance percentage for Routine Foot Care:	Indicate Maximum Copayment amount per visit for Routine Foot Care:	
is there an enrollee Deductible?		
O Yes O No		
Indicate Deductible Amount:		

#7f Podiatry Services – Base 3

Bile Help Add Variable	ystem - Sectio	n B-7, Cor	ntract X000	L, Plan 001,	, Segment 0	00					- 8
Previous Next	Exit (Validate)	Exit (No Validate)	Go To: #71	Podiatry Services	- Base 3		-				
Enrollee must receive Authoriz None Primary Care Physician (Int Physician Specialist Organization Medical Direc Other, describe s a referral required for Podiat Yes No	ternist/Family Practic tor/Utilization Manag	ce, General Pra	actice)								
odiatry Services Notes											
lote may include additional inf	formation to describe	e benefit in this	service category	Do not repeat in	formation capture	d in data entry.					
lotes:								*			
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#7g Other Health Care Professional – Base 1

😸 PBP Data Entry System - Sectio	n B-7, Contract X0001, Plan 001, Se	gment 000	<u>_</u>
Eile Help Add Variable 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. Aaximum Plan Benefit Coverage is not applicable or this Service Category. Indicate Maximum Enrollee Out-of-Pocket Cost Indicate Maximum Enrollee Out-of-Pocket Cost	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every year C Every year C Every year C Every three months C 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: D Second Benefits: D Second Benefits: Second Benefi	Is there an enrollee Deductible?	

#7g Other Health Care Professional – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000 Elle Help Add Variable	_ _ _ _
Previous Next Exit Exit No Validate) Go To: #7g Other Health Care Professional - Base 2	
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 Health Care Professional Services? C Yes C No	
Other Health Care Professional Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
	1

#7h Psychiatric Services – Base 1

		on B-7, Cor	ntract X00	01, Plan 001, Segment 000	- 8
Eile Help Add Varia	1	Exit (No	Go To: 📕	7h Psychiatric Services - Base 1	
Previous Nex	t (Validate)	Exit (No Validate)			
CLICK FOR DESCRIPTI					
nhanced Benefits are no		vice Category.			
faximum Plan Benefit Co	verage is not applicable	e for this Service	Category.		
there a service-specific	Maximum Enrollee Out	-of-Pocket Cost	2		
) Yes) No					
Indicate Maximum Enroll	ee Out-of-Pocket Cost	amount:			
Select the Maximum En	ollee 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					
			đ.		

#7h Psychiatric Services – Base 2

🧱 PBP Data Entry System - Section B-7, Contract X00	01, Plan 001, Segment 000	<u>- ㅋ×</u>
Eile Help Add Variable		
Go To:	7h Psychiatric Services - Base 2	
Previous Next (Validate) Validate)		
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
O Yes O No	O Yes O No	
Select which Psychiatric Services have a Coinsurance (Select all that apply): Medicare-covered Group Sessions Medicare-covered Individual Sessions Indicate Maximum Coinsurance percentage for Medicare-covered Individual Sessions: Indicate Minimum Coinsurance percentage for Medicare-covered Group Sessions: Indicate Maximum Sessions: Indicate Deductible Amount: Indicate Deductible Amount: Indicate Deductible Amount: Indicate Maximum Sessions: Indicate Deductible Amount: Indic	Select which Psychiatric Services have a Copayment (Select all that apply): Medicare-covered Group Sessions Indicate Minimum Copayment amount for Medicare-covered Indicate Miximum Copayment amount for Medicare-covered Group Sessions: Indicate Miximum Copayment amount for Medicare-covered Group Sessions: Indicate Miximum Copayment amount for Medicare-covered Group Sessions:	

#7h Psychiatric Services – Base 3

📕 PBP Data	Entry Sy	stem - Sectio	on B-7, Co	ntract X0	001, Plan 001, Segment 000	Ð×
<u>F</u> ile <u>H</u> elp						
• • • • • • • • • • • • • • • • • • •		Exit	Exit (No	Go To:	#7h Psychiatric Services - Base 3	
Previous	Next	(Validate)	Validate)			
		-				
Enrollee must rece						
Primary Care P	hysician (Inte	rnist/Family Pract	tice, General Pr	actice)		
Physician Spec Organization N		or/Utilization Mana	agement/Litiliza	tion Review		
Other, describe		on oun zaron mane	rgemente otinza			
Is a referral require	ed for Psychia	tric Services?				
C Yes						
C No						
Occupational The	apy Services	Notes				
Note may include a	dditional info	mation to descril	be benefit in thi	s service cate	ory. Do not repeat information captured in data entry.	
Notes:						
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						1

#7i PT and SP Services – Base 1

	tion B-7, Contract X0001, Plan 001, S	Segment 000	_ 8 ×
<u>File</u> <u>H</u> elp Add Variable			
A D Exit	Go To: #7i PT and SP Services Exit (No	Base 1	
Previous Next (Validate)	Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Is there an enrollee Deductible?	
Enhanced Benefits are not applicable for this	C Every three years	C No	
Service Category, except for MMPs.	C Every two years C Every year	Indicate Deductible Amount:	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	C Every six months C Every three months		
	C Other, Describe		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	You must include total cost sharing to the beneficiary, including any facility cost sharing.	Is there an enrollee Copayment?	
C Yes	Is there an enrollee Coinsurance?	O No	
C No	C Yes	Indicate Minimum Copayment amount per visit for	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	C No	Medicare-covered Benefits:	
	Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
	Indicate Maximum Coinsurance percentage per		
	visit for Medicare-covered Benefits:		

#7i PT and SP Services – Base 2

<mark>H PBP Data Entr</mark> <u>F</u> ile <u>H</u> elp Add Vari	y System - Section	on B-7, Cor	ntract X0001,	Plan 001, Segi	ment 000					- 8
Previous Ne	Exit	Exit (No Validate)	Go To: #7iPT a	ind SP Services - Bas	e 2		T			
None Primary Care Physicia Physician Specialist	horization from one or m In (Internist/Family Pract Director/Utilization Mana	tice, General Pri	actice)							
a referral required for P Yes No	hysical Therapy and Spe	eech-Language	Pathology Services	•						
T and SP Services Note	s nal information to descril	be benefit in this	service category. Do	not repeat informati	on captured in data er	ntry.				
lotes:			Service category. De				*			
							×			

#7i PT and ST – MMP – Base 1

e Help Add Variable	0: #7i PT and ST - MMP - Base 1	
Exit Exit (No	0: #/1Pl and Sl - MMP- base 1	
Previous Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
es this plan provide Non-Medicare Physical and/orSpeech erapy services?	C Yes C No	
Yes No	Select which Non-Medicare Physical and/or Speech Therapy services have a Coinsurance (select all that apply): □ Other 1	
elect Non-Medicare Physical and/or Speech Therapy Service	Other 2	
Other 2 Enter name of Other 1 Service:	Indicate coinsurance Minimum Maximum percentage for one Coinsurance Coinsurance or more of the	
Enter name of Other 2 Service:	following services: Other 1:	
Enter hame of other 2 service.	Other 2:	
there a service-specific Maximum Plan Benefit Coverage amount		
Yes No		
Indicate Maximum Plan Benefit Coverage amount:		
I Select 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		

#7i PT and ST – MMP – Base 2

	, Contract X0001, Plan 001, Segment 000
e <u>H</u> elp Add Variable	Go To: #7i PT and ST - MMP - Base 2
Previous Next (Validate) Valid	No
Previous Next (Validate) Valida	
there an enrollee Copayment?	Enrollee must receive Authorization from one or more of the following:
Yes	☐ None ☐ Primary Care Physician (Internist/Family Practice, General Practice)
No	Primary Care Physician (internisor amily Practice, General Practice) Physician Specialist
ect which Non-Medicare Physical and/or Speech	Organization Medical Director/Utilization Management/Utilization Review
erapy services have a Copayment (select all that oly):	C Other, describe
Other 1 Other 2	Is a referral required for Services?
	C Yes C No
licate copayment Minimum Maximum ount for one or Copayment Copayment re of the following	U No
vices:	
ner 1:	PT and SP Services MMP Notes
ier 2:	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
101 2.	Notes:
	*

ile <u>H</u> elp Ad		Stelli Secu	on b of Col	and ce XO	001, Plan 001, Segment 000	_ (t
 <u>n</u>eip //u 		Exit	Exit (No	Go To:	#8a Outpatient Diag Procs/Tests/Lab Services - Base 1	
revious	Next	Exit (Validate)	Exit (No Validate)			
		1				
LICK FOR DES						
nanced Benefit	s are not appl	icable for this Ser	vice Category.			
kimum Plan Ber	nefit Coverag	e is not applicable	e for this Service	Category.		
	specific Maxi	num Enrollee Out	of-Pocket Cost	?		
Yes No						
	n Enrollee Ou	it-of-Pocket Cost	amount:			
Select Maximum	Enrollee Out	-of-Pocket Cost p	eriodicity:			
Every three	years			9		
C Every two y Every year						
C Every six m C Every three	onths					
Other, Desc	ribe					

ile <u>H</u> elp Add	and the second	stem - Sectio			001, Plan 001, Segment 000
4	•	4	Exit (No	Go To:	#8a Outpatient Diag Procs/Tests/Lab Services - Base 2
Previous	Next	Exit (Validate)	Exit (No Validate)		
ou must include to	otal cost shari	ng to the beneficia	ary, including a	ny facility cost	t Indicate Minimum Coinsurance percentage for Medicare-covered Lab
aximum fields to r	reflect the low	cost sharing, plea rest and highest c	ost sharing the	at a beneficiary	Services:
ay pay. there an enrollee	Coinsurance	2			
Yes	. oomsuranet	in the second se			Indicate Maximum Coinsurance percentage for Medicare-covered Lab Services:
No					
Select which Out	tpatient Diag	Procs/Tests/Lab S	ervices have a	Coinsurance	
Select all that ap	oply):	stic Procedures/T			
Medicare-cov			5515		
Indicate Minir	mum Coinsur	ance percentage f	or Medicare-co	overed	
Diagnostic Pr	rocedures/Te	STS:			
Indicate Maxi	mum Coinsur	ance percentage	for Medicare-c	overed	
Diagnostic Pr	rocedures/Te	sts:			
22					

ile <u>H</u> elp Add	l Variable					
-		eit Evi	🧙 Go it (No	o: #8a Outpatient Diag Procs/Tests/Lab Services - Ba	Base 3	
revious	Next (Vali	date) Val	idate)			
iere an enrollee	Deductible?					
Yes						
No						
icate Deductible	e Amount:					
nere an enrollee	Copayment?					
Yes No						
lect which Outp	atient Diag Procs/Tes	ts/Lab Services	have a			
payment (Selec	t all that apply): red Diagnostic Procei					
	red Lab Services	1010571050				
dicate Minimum (agnostic Proced	Copayment amount fo	r Medicare-cov	ered			
licate Maximum	Copayment amount f	or Medicare-cov	ered			
agnostic Proced	lures/Tests:					
dicate Minimum (Copayment amount fo	r Medicare-cove	ered Lab			
rvices:						
dicate Maximum	Copayment amount fo	or Medicare-cov	ered Lab			
ervices:						
a member receivo e same dav. doe	es multiple services a s only the maximum c	t the same locat	ion on			
Yes						
No						

Fu Associates, Ltd.

e <u>H</u> elp Add Variable	, Contract X0001, Plan 001, Segment 000	
	g Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 4 (No ate)	
ollee must receive Authorization from one or more of t None Primary Care Physician (Internist/Family Practice, Ger Physician Specialist Organization Medical Director/Utilization Managemen Other, describe Areferral required for Outpatient Diagnostic Procedure	tal Practice) Jtilization Review	×.
vices? Yes No		*1
paitent Diag/Procs/Tests/Lab Services Notes:		
e may include additional information to describe bene egory. Do not repeat information captured in data entr gnostic Procedures/Tests Notes:	in this service	
	*	
	*	

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

🔡 PBP Data Entry System - Section B-8, Contrac	ct X0001, Plan 001, Segment 000	- 8 ×
Eile Help Add Variable Previous Next Exit (Validate) Go Validate)	To: ≢8b Outpatient Diag/Therapeutic Rad Services - 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: Every three years Every two years Every year Every six months Every six months Every six months Every three months 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 may pay. Is there an enrollee Coinsurance? Yes No	Select which Outpatient Diagrotic Radiological Services Medicare-covered Diagnostic Radiological Services Medicare-covered Aragy Services Indicate Minimum Consume percentage for Medicare-covered Indicate Minimum Consume percentage for other Medicare-covered Indicate Minimum Consume percentage for Medicare-covered Indicate Minimum Consume percentage for Medicare-covered X-Ray Services Indicate Minimum Consume percentage for Medicare-covered X-Ray Indicate Minimum Consume percentage for Medicare-covered X-Ray	

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

the second s		stem - Sectio	on B-8, Co	ntract X0	001, Plan 001, Segment 000	- 8
ile <u>H</u> elp A	dd Variable	Exit	Exit (No	Go To:	#8b Outpatient Diag/Therapeutic Rad Services - Base 2	
Previous	Next	(Validate)	Validate)			
there an enroll	ee Deductible?					
Yes No						
Indicate Deduct	tible Amount:					
]					
there an enroll	ee Copayment	? <				
) No						
Select all that ap	ply):	eapeutic Rad Serv		opayment		
		c Radiological Ser tic Radiological Se				
Medicare-cov		vices tamount for other	Medicare-cove	ered		
Diagnostic Ra	diological Serv	rices (e.g., CT, MRI	I, etc):			
Indicate Maxim Diagnostic Ra	num Copaymen diological Serv	it amount for other rices (e.g., CT, MRI	Medicare-cov I. etc):	ered		
Indicate Minim Radiological S	ium Copaymen Services:	tamountfor Medic	are-covered T	herapeutic		
Indicate Maxin	num Copaymen	t amount for Medic	care-covered T	herapeutic		
Radiological S	Services:					
Indicate Minim Services:	um Copaymen	t amount for Medic	are-covered X	-Ray		
Indicate Maxin	num Copaymer	amount for Media	care-covered 3	-Ray		
Services:						
f a member recei	ves multiple se	rvices at the same	location on			
he same day, do OYes	es only the ma	ximum copay appl	ly?	ĩ		
O No						

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

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 00	0
ile <u>H</u> elp Add Variable Go To: #8b Outpatient Disg/Therapeutic Rad Ser	vices - Base 3
Previous Next (Validate)	
(Vanuaro) Vanuaro)	
rollee must receive Authorization from one or more of the following: Therapeutic Radiological Services Note None	
Primary Care Physician (Internist/Family Practice, General Practice)	×
Physician Specialist Organization Medical Director/Utilization Management/Utilization Review	
Organization Medical Director/Otilization Managemen/Otilization Review Other, describe	
a referral required for Outpatient Diagnostic/Therapeutic Radiological, and	
Ray Services? Yes	
No	
tpatient Diag/Therapeutic Rad Services Notes X-Ray Services Notes:	Y
te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry.	*
agnostic Radiological Services (e.g., CT, MRI, etc.) Notes:	

#9a Outpatient Hospital Services – Base 1

PBP Data Entry System - Section B-9, Contract X0	(0001, Plan 001, Segment 000	_ 8 ×
Elle Help Add Variable Previous Next Exit Exit Exit No (Validate) Validate)	: #9a Outpatient Hospital Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT inhanced Benefits are not applicable for this Service Category. Aaximum Plan Benefit Coverage is not applicable for this Service Category as 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 two years Every two years Every two gens 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 may pay. Is there an enrollee Coinsurance? You cost and maximum fields to clinsurance percentage for Medicare-covered Beneficiary Inclicate Minimum Coinsurance percentage for Medicare-covered Beneficiary Inclicate Minimum Coinsurance percentage for Medicare-covered Beneficiary Inclicate Maximum Coinsurance percentage for Medicare-covered Beneficiary Inclicate Maximum Coinsurance percentage for Medicare-covered Beneficiary Inclicate Maximum Coinsurance percentage for Medicare-covered Beneficiary	

#9a Outpatient Hospital Services – Base 2

🔡 PBP Data Entry System - Section B-9, Contract X0	001, Plan 001, Segment 000	_ 8 ×
Eile Help Add Variable		
Exit Exit (No	#9a Outpatient Hospital Services - Base 2	
Previous Next (Validate) Validate)		_
s there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:	
C Yes	None	
C No	Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist	
Indicate Deductible Amount:	Organization Medical Director/Utilization Management/Utilization Review Other, describe	
s there an enrollee Copayment?	Is a referral required for Outpatient Hospital Services?	
C Yes C No	C Yes C No	
Indicate Minimum Copayment amount per visit for Medicare-covered Benefit	5:	
Indicate Maximum Copayment amount per visit for Medicare-covered Benefi	ts:	

#9a Outpatient Hospital Services – Base 3

Help Ad				Go To:	Outpatient Hospital	Services Base 2		•				
evious	Next	Exit	Exit (No Validate)	GO TO: 1	routpatient nospital	Services - Dase 3						
evious	Heat	(Validate)	validate)	_	_	_	_	_	_	_	_	_
atient Hospita	al Services No	ites										
may include a	dditional info	rmation to descri	ibe benefit in thi	s service categor	. Do not repeat info	ormation captured in	data entry.					
5:								٠				
								x				

#9b ASC Services – Base 1

PBP Data Entry System - Section B-9, Contract X0 File Help Add Variable	0001, Plan 001, Segment 000	8
	#9b ASC Services - Base 1	
Previous Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize	
laximum Plan Benefit Coverage is not applicable for this Service Category.	the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay. Is there an enrollee Coinsurance?	
there a service-specific Maximum Enrollee Out-of-Pocket Cost?	C Yes C No	
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 C Plan-specified amount per period		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years Every year Every six months C Every three months Other, Describe		

#9b ASC Services – Base 2

PBP Data Entry System - Section B-9, Contract X(- 8 :
Eile Help Add Variable	#9b ASC Services - Base 2	
Exit Exit (No	HAD ASC SERVICES - Dase 2	
(Validate) Validate)		_
s there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following: Primary Care Physician (internist/Family Practice, General Practice) Prysician Specialist '' organization Medical Director/Utilization Management/Utilization Review '' Other, describe ''s a referral required for Ambulatory Surgical Center Services? '' Yes '' No ''	

#9b ASC Services – Base 3

revious	d Variable	Exit (Validate)	Exit (No Validate)	Go To: #9b ASC Se	rvices - Base 3		•		
Services Note	15								
nay include a	dditional info	rmation to descril	be benefit in this	s service category. Do no	repeat information captur	ed in data entry.			
				CORPORT.					
							~		

#9c Outpatient Substance Abuse – Base 1

Image: Next Image: Next Image: Next Image: Next <th>🧱 PBP Data Entry System - Section B-9, Contract ></th> <th>X0001, Plan 001, Segment 000</th>	🧱 PBP Data Entry System - Section B-9, Contract >	X0001, Plan 001, Segment 000
Next Exit Exit No LICK FOR DESCRIPTION OF BENEFIT anced Benefits are not applicable for this Service Category. imum Plan Benefit Coverage is not applicable for this Service Category. imum Plan Benefit Coverage is not applicable for this Service Category. iere a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Covered under Out-of-Pocket Cost type: Covered under Out-of-Pocket Cost amount:	Eile Help Add Variable	
LICK FOR DESCRIPTION OF BENEFIT anced Benefits are not applicable for this Service Category. imum Plan Benefit Coverage is not applicable for this Service Category. iere a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period idicate Maximum Enrollee Out-of-Pocket Cost periodicity: CEVERY hree years CEVERY here here here here here here here her	Exit Exit (No	1 H9C Outpatient Substance Abuse - Base 1
anced Benefits are not applicable for this Service Category. imum Plan Benefit Coverage is not applicable for this Service Category. iere a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Iete the Maximum Enrollee Out-of-Pocket Cost type: Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period Idicate 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 Ev	Previous Next (Validate) Validate)	
imum Plan Benefit Coverage is not applicable for this Service Category. iere a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Iete the Maximum Enrollee Out-of-Pocket Cost type: Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period Idicate 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	CLICK FOR DESCRIPTION OF BENEFIT	
ere a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Iect the Maximum Enrollee Out-of-Pocket Cost type: Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period Idicate 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 year C Every year C Every three months C Every	Enhanced Benefits are not applicable for this Service Category.	
Yes No lect the Maximum Enrollee Out-of-Pocket Cost type: Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period dicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: © Every three years © Every three years © Every three years © Every three months	Maximum Plan Benefit Coverage is not applicable for this Service Category	ý.
No lect the Maximum Enrollee Out-of-Pocket Cost type: Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period dicate 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 years C Every three months C Every three months	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Covered under Outpatient Hospital Services Category 9a Plan-specified amount per period dicate 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 years C Every three months C Every three months C Every three months	C Yes C No	
Plan-specified amount per period idicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every three months C Every three months	Select the Maximum Enrollee Out-of-Pocket Cost type:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every they years C Every they year C Every three months C Every three months	C Covered under Outpatient Hospital Services Category 9a C Plan-specified amount per period	
C Every three years C Every two years C Every year C Every six months C Every three months	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
C Every two years C C Every year C C Every tix months C C Every three months C	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Every year C Every six months C Every three months	C Every three years	
C Every three months	C Every year	

#9c Outpatient Substance Abuse – Base 2

🔜 PBP Data Entry System - Section B-9, Contract X	X0001, Plan 001, Segment 000	_ 8 ×
Eile Help Add Variable File Met Exit Section	p: #9c Outpatient Substance Abuse - Base 2	
You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay. Is there an enrollee Coinsurance?	Is there an enrollee Deductible?	

#9c Outpatient Substance Abuse – Base 3

Eile Help Add Variable
Previous Next (Validate) Validate)
Previous Next (Validate) Validate)
Evolute multi-roticial miting frame or an or of the billowing: Private Care Physician (Internalization Resetted) Private Care Physician (Internalization Resetted) Projectian Specialial Organization Resetted Interdet

#9d Outpatient Blood Services – Base 1

📓 PBP Data Entry System - Section B-9, Contract X0	0001, Plan 001, Segment 000	_ 8 ×
Eile Help Add Variable	#9d Outpatient Blood Services - Base 1	
Previous Next (Validate) Go To:		
CLICK FOR DESCRIPTION OF BENEFIT	Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years	
If blood is given as a part of an inpatient hospital stay, the cost sharing for the blood should be included in the inpatient hospital cost sharing. Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	C Every two years C Every year C Every six months C Every three months	
C Yes	C Other, Describe	
C No	Is there an enrollee Coinsurance? O Yes	
Select enhanced benefit: Three (3) pint deductible waived	Č No	
Select type of benefit for Three (3) Pint Deductible Waived:	Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits:	
C Mandatory C Optional		
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits:	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
C Yes C No		

#9d Outpatient Blood Services – Base 2

PBP Data Entry System - Section B-9, Contract X(<u>File Help</u> Add Variable	0001, Plan 001, Segment 000	<u>_ 8 ;</u>
	#9d Outpatient Blood Services - Base 2	
s there an enrollee Deductible? No Indicate Deductible Amount: s there an enrollee Copayment? Yes No Indicate Minimum Copayment amount per unit for Medicare-covered Benefits: Indicate Maximum Copayment amount per unit for Medicare-covered Benefits: Indicate Maximum Copayment amount per unit for Medicare-covered Benefits: Indicate Maximum Copayment amount per unit for Medicare-covered Benefits: Indicate Maximum Copayment amount per unit for Medicare-covered Benefits: Indicate Maximum Copayment amount per unit for Medicare-covered Benefits: Indicate Maximum Copayment amount per unit for Medicare-covered Benefits: Organization Matical Director/Utilization form one or more of the following: None Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe s a referral required for Outpatient Blood Services? Yes No	<text></text>	

#10a Ambulance Services – Base 1

	B-10, Contract X0001, Plan 001, Seg	gment 000	 7 ×
Elle Help Add Variable Previous Next Exit (Validate)	Go To: #10a Ambulance Services - B Exit (No Validate)	iase 1	
Exit	Exit (No Validate)	Is there an enrollee Copayment? C Yes No Indicate the Minimum Copayment amount for Medicare-covered Benefits: Indicate the Maximum Copayment amount for Medicare-covered Benefits:	

#10a Ambulance Services – Base 2

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000	- 8 ×
Eile Help Add Variable	
Previous Next (Validate) Validate)	
Enrollee must receive Authorization for non-emergency Medicare services from one or more of the following: Primary Care Physician (InternistFamily Practice, General Practice) Prhysician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Referral is not applicable for this Service Category. Ambulance Services Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	
	1

#10b Transportation Services – Base 1

	B-10, Contract X0001, Plan 001,	Segment 000	_ [
e <u>H</u> elp Add Variable	Go To: #10b Transportation Serv	ces - Base 1	
revious Next (Validate)	Go To: #10b Transportation Serv Exit (No Validate)		
(validato)	Vandatoj		
LICK FOR DESCRIPTION OF BENEFIT	Select Type of Transportation for Plan-approved Location:	Indicate number of trips for Any Location:	
es the plan provide Transportation Services as a plemental benefit under Part C?	O One-way O Round Trip O Days	Select Any Location Trips periodicity:	
Yes No	O Days O Other, describe	C Every three years	
lect enhanced benefit:	Indicate number of days for Plan-approved Location:	C Every years C Every year C Every six months	
Plan-approved Location Any Location		C Every six months C Every three months C Other, Describe	
lect type of benefit for Plan-approved Location: Mandatory	Select Mode of Transportation for Plan- approved Location: Taxi	Select Type of Transportation for Any Location:	
Optional	Bus/Subway Van	O One-way O Round Trip	
his benefit unlimited for number of trips for Plan proved Location?	Medical Transport	C Days C Other, describe	
Yes No	Select type of benefit for Any Location:	Indicate number of days for Any Location:	
dicate number of trips for Plan-approved	C Mandatory C Optional		
Select Plan-approved Location Trips periodicity:	Is this benefit unlimited for number of trips for Any Location?	Select Mode of Transportation for Any Location: Taxi Bus/Subway	
C Every three years	O Yes O No	☐ Van ☐ Medical Transport	
○ Every two years ○ Every year ○ Every six months		Other, describe	
C Every three months C Other, Describe			

#10b Transportation Services – Base 2

PBP Data Entry System - Section	B-10, Contract X0001, Plan (001, Segment 000	
e <u>H</u> elp Add Variable			
A D Exit	Go To: #10b Transportation	on Services - Base 2	
revious Next (Validate)	Validate)		
ere a service-specific Maximum Plan Benefit	Is there a service-specific Maximum	Is there an enrollee Coinsurance?	
erage amount?	Enrollee Out-of-Pocket Cost?	C Yes	
Yes No	C Yes	C No	
lo	C No	Indicate Minimum Coinsurance percentage:	
licate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of- Pocket Cost amount:		
	1	Indicate Maximum Coinsurance percentage:	
ect Maximum Plan Benefit Coverage periodicity:	Select Maximum Enrollee Out-of-		
Every three years	Pocket Cost periodicity:		
Every two years	C Every three years	Is there an enrollee Deductible?	
Every year	C Every two years	C Yes	
Every six months Every three months	C Every year	C No	
Every three months Other, Describe	C Every six months		
other, beschoe	C Every three months	Indicate Deductible Amount:	
	C Other, Describe		

#10b Transportation Services – Base 3

PBP Data Entry System - Section B-10, Contrac	t X0001, Plan 001, Segment 000
Elle Help Add Variable	o: #10b Transportation Services - Base 3
Previous Next (Validate) Go T	
there an enrollee Copayment?	Transportation Services Notes
) Yes D No	
ndicate Minimum Copayment amount per trip:	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
	Notes:
ndicate Maximum Copayment amount per trip:	
nrollee must receive Authorization from one or more of the following: None	
Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist	
Organization Medical Director/Utilization Management/Utilization Revie	w
Other, describe a referral required for Transportation Services?	
Yes	
No	
	<u>×</u>

#11a DME – Base 1

	n B-11, Contract X0001, Plan 001, Segme	ent 000	×
Eile Help Add Variable Previous Next Exit (Validate)	Go To: ≢11a DME - Base 1 Exit (No Validate)	x	
Previous Next LAR CLICK FOR DESCRIPTION OF BENEFIT	Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every two years C Every six months C Every six months C Other, Describe Is there an enrollee Coinsurance? Ves No Indicate Minimum Coinsurance percentage for Medicare- covered Benefits: Indicate Maximum Coinsurance percentage for Medicare- covered Benefits: Indicate Maximum Coinsurance percentage for Medicare- covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-	Is there an enrollee Deductible? C Yes No Indicate Deductible Amount: Is there an enrollee Copayment? C Yes No Indicate Minimum Copayment amount per item for Medicare-covered Benefits: Indicate Maximum Copayment amount per item for Medicare-covered Benefits:	

#11a DME – Base 2

🧱 PBP Data Entry System - Section B-11, Contract 🕽	X0001, Plan 001, Segment 000	- 8 ×
Exit Exit (No	#11a DME - Base 2	
Previous Next (Validate) Validate)		
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)? Ores No 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 Referral is not applicable for this Service Category.	Durable Medical Equipment Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	

#11a DME – MMP – Base 1

PBP Data Entry System - Section B-11, Contract		
Previous Next (Validate) Go To:	#11a DME - MMP - Base 1	
LICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
es this plan provide Non-Medicare Durable Medical Equipment?	C Yes C No	
Yes No	Select which Non-Medicare Durable Medical Equipment(s) (select all that apply):	
ect Non-Medicare Durable Medical Equipment: Durable Medical Equipment for use outside the home Other 1	Durable Medical Equipment for use outside the home Other 1 Other 2	
Other 2 hter name of Other 1 Service:	Indicate coinsurance percentage for one Minimum Maximum or more of the Coinsurance Coinsurance following services	
ter name of Other 2 Service:	Durable Medical Equipment for use	
nere a service-specific Maximum Plan Benefit Coverage amount?	Other 1:	
Yes No	Other 2:	
C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe		

#11a DME – MMP – Base 2

PBP Data Entry System - Section B-11, Contract X0001	, Plan 001, Segment 000	- 8
Eile Help Add Variable Go To: #11a D	ME - MMP - Base 2	
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Previous Next (Validate) Validate)	Image: Authorization from one or more of the following: Primary Care Physician (Internist/Family Practice, General Practice) Organization Medical Director/Utilization Management/Utilization Review Other, describe International Medical Director/Utilization Management/Utilization Review Dracted Medical Equipment MMP Notes Note may include additional Information to describe benefit in this service actegory. Do not repeat Information captured in data entry: Note:	

#11b Prosthetics/Medical Supplies – Base 1

PBP Data Entry System - Section B-11, Contract	X0001, Plan 001, Segment 000	<u></u>
Eile Help Add Variable Go To Exit Exit (No	#11b Prosthetics/Medical Supplies - Base 1	
Previous Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
CLICK FOR DESCRIPTION OF BENEFIT Sinanced 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 No Select Maximum Enrollee Out-of-Pocket Cost type: C Covered under DME Category 11a Plan-specified amountper 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 three years C Every six months C Every three months C Other, Describe	C Yes C No	

#11b Prosthetics/Medical Supplies – Base 2

PBP Data Entry System - Section B-11, Contrac	ct XUUU1, Plan UU1, Segment UUU	
e <u>H</u> elp Add Variable 🖌 🖌 Go 1	To: #11b Prosthetics/Medical Supplies - Base 2	
Previous Next (Validate) Go T		
nere an enrollee Deductible? Yes	Indicate Minimum Copayment amount per item for Medicare- covered Prosthetic Devices:	
Yes No		
dicate Deductible Amount:	Indicate Maximum Copayment amount per item for Medicare-	
	covered Prosthetic Devices:	
nere an enrollee Copayment?	Indicate Minimum Copayment amount per item for Medicare-	
Yes	covered Medical Supplies	
No		
Select which Prosthetics/Medical Supplies have a Copayment Select all that apply):	Indicate Maximum Copayment amount per item for Medicare- covered Medical Supplies:	
Medicare-covered Prosthetic Devices Medicare-covered Medical Supplies		

#11b Prosthetics/Medical Supplies – Base 3

PBP Data Entry System - Section B-11, Contract X00	001, Plan 001, Segment 000
Eile Help Add Variable	1b Prosthetics/Medical Supplies - Base 3
Enrollee must receive Authorization from one or more of the following: Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Referral is not applicable for this Service Category.	Prosthetics/Medical Supplies Notes Nate may include additional information captured in data entry: Note: Image: I

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

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Perform Net East Validate CLICK FOR DESCRIPTION OF BENEFIT Is there an enrollee Coinsurance? Orst in jup provide Non-Medicare Prosthetics/Medical Supplies? Indicate Coinsurance Percentage: Orst in jup provide Non-Medicare Service. Indicate Coinsurance Percentage: Indicate Coinsurance Percentage: Is there an enrollee Coinsurance Percentage: Indicate Service Is there an enrollee Coinsurance Percentage: Indicate Coinsurance Percentage: Is there an enrollee Coinsurance Percentage: Indicate Coinsurance Percentage: Is there an enrollee Coinsurance Percentage: Indicate Coinsurance Percentage: Indicate Coinsurance Percentage: Indicate Maximum Plan Benefit Coverage amount? Indicate Coparyment Amount: Indicate Maximum Plan Benefit Coverage amount? Indicate Coparyment Amount: Indicate Services Organization Medical Director/Utilization Management/Utilization Review Derey three years Creary Six for Services? Every three months Prostetics/Medical Supples MMP Notes Notemy include additional Information describe banefit in this service category. Do not repeat Information captured in data entry. Notemy include additional Information describe banefit in this service category. Do not repeat Information captured in data entry.		Htth Dealkalian Mulian Evention IND Dean t	
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Cubcle for Ox	Previous Next (Validate) Validate)		_
Does this plan provide Non-Medicare Prosthetics/Medical Supplies? C Yes C No Enter name of Non-Medicare Service: Indicate Coinsurance Percentage: Is there a service-specific Maximum Plan Benefit Coverage amount: No Indicate Copayment Amount: Vas Indicate Copayment Amount: No Indicate Copayment Amount: No Indicate Copayment Amount: No Select Maximum Plan Benefit Coverage amount: C Yery three years C Every two years C Yes No ther, Describe Prosthetics/Medical Supplies MMP Notes Notes: Notes:	CLICK FOR DESCRIPTION OF BENEFIT		
Joes mis juin provide von-Medicare Prosthetics/Medical supplies/ Yes Is there a service-specific Maximum Plan Benefit Coverage amount? Yes No Select Maximum Plan Benefit Coverage amount: Indicate Copayment Amount: Prosterior Coverage periodicity: Prysician (internistFamily Practice, General Practice) Prysician Specialist Prostection Medicar Director/Utilization Review Prysician Specialist Prosthetics/Medical Supplies MMP Notes Note may include additional information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information to describe benefit in this service category. Do not repeat information captured in data entry. Note:			
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Is there a service-specific Maximum Plan Benefit Coverage amount? Is there a service-specific Maximum Plan Benefit Coverage amount? Indicate Copayment Amount: Indicate Maximum Plan Benefit Coverage amount: Indicate Copayment Amount: Indicate Maximum Plan Benefit Coverage periodicity: Indicate Copayment Amount: Select Maximum Plan Benefit Coverage periodicity: Indicate Copayment Amount: Every three years Coparation Medical Director/Utilization Management/Utilization Review Other, Describe Is a referral required for Services? Very types No Other, Describe Prosthetics/Medical Supplies MMP Notes Note may include additional information captured in data entry. Notes: Notes: Information captured in data entry.	nter name of Non-Medicare Service:		
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Indicate Maximum Plan Benefit Coverage amount: Encrollee must receive Authorization from one or more of the following: Select Maximum Plan Benefit Coverage periodicity: Primary Care Physician (Internist/Family Practice, General Practice) Every three years Primary Care Physician Official Director/Utilization Management/Utilization Review Every three months Other, Describe Other, Describe Prosthetics/Medical Supplies MMP Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes: Image: Care Physician Service Phy		Indicate Copayment Amount:	
Select Maximum Plan Benefit Coverage periodicity: Propriodicity: Every three years Every thore years Every year Every survements Other, describe Is a referral required for Services? Yes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes: Notes: Is a referral information in the service category. Do not repeat information to describe benefit in this service category. Do not repeat information captured in data entry. 			
Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	None	
○ Every two years ○ Every year ○ Every three months ○ Other, Describe ○ Other, Describe □ Prosthetics/Medical Supplies MMP Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes: Image: Control of the service information in the service information information in the service information in the service information information in the service information in the service information information in the service information information information in the service information information information in the service information information information information information in the service information informatio	Select Maximum Plan Benefit Coverage periodicity:		
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© Every three months © Yes © Other, Describe Prosthetics/Medical Supplies MMP Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	C Every year		
Prosthetics/Medical Supplies MMP Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	C Every three months	O Yes	
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	U Other, Describe	C No	
category. Do not repeat information captured in data entry. Notes:			
		Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
		Y	

#11c Diabetic Supplies and Services – Base 1

🔡 PBP Data Entry System - Section B-11, Contract	ct X0001, Plan 001, Segment 000	- 8 ×
Eile Help Add Variable	To: #11c Diabetic Supplies and Services - Base 1	
Previous Next (Validate) Go To		
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 Select Maximum Enrollee Out-of-Pocket Cost type: Covered under DME Category 11a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Every two years Every two years Every two years Every two years Other, Describe Is there an enrollee Coinsurance? Yes No	Select which Diabetic Supplies Imadicate-covered Diabetic Supplies Indicate Minimum Coinsurance percentage for Medicate-covered Diabetic Supplies: Imdicate Minimum Coinsurance percentage for Medicate-covered Diabetic Supplies: Indicate Minimum Coinsurance percentage for Medicate-covered Diabetic Supplies: Indicate Maximum Coinsurance percentage for Medicate-covered Diabetic Supplies: Indicate Deductible? Yes No Indicate Deductible Amount:	

#11c Diabetic Supplies and Services – Base 2

🔜 PBP Data Entry System - Section B-11, Cont	ract X0001, Plan 001, Segment 000	_ 8 ×
<u>File</u> <u>H</u> elp Add Variable		
Exit Exit No	io To: #11c Diabetic Supplies and Services - Base 2	
Previous Next (Validate) Validate)		
Is there an enrollee Copayment?	Do you limit Diabetic Supplies and Services to those from specified manufacturers?	
O Yes O No	C Yes C No	
Select which Diabetic Supplies and Services have a Copayment (Select all that apply):	Enrollee must receive Authorization from one or more of the following:	
Medicare-covered Diabetes Supplies Medicare-covered Diabetic Therapeutic Shoes or Inserts	☐ None ☐ Primary Care Physician (Internist/Family Practice, General Practice) ☐ Physician Specialist	
Indicate Minimum Copayment amount per item for Medicare- covered Diabetes Supplies:	Organization Medical Director/Utilization Management/Utilization Review Other, describe	
	Referral is not applicable for this Service Category.	
Indicate Maximum Copayment amount per item for Medicare- covered Diabetes Supplies:	Diabelic Supplies and Services Notes	
Indicate Minimum Copayment amount per item for Medicare-	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
covered Diabetic Therapeutic Shoes or Inserts:	Notes:	
Indicate Maximum Copayment amount per item for Medicare- covered Diabetic Therapeutic Shoes or Inserts:		

#12 Dialysis Services – Base 1

	ion B-12, Contract X0001, Plan 001, S	Segment 000	_ 8 ×
<u>File</u> <u>H</u> elp Add Variable			
Exit	Go To: #12 Dialysis Services - Ba Exit (No	se 1	
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	Onland Maximum Francisco Oct of Depicted Cont		
CLICK FOR DESCRIPTION OF BENEFIT	Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years	Is there an enrollee Deductible?	
Enhanced Benefits are not applicable for this Service Category.	O Every two years O Every year	C No Indicate Deductible Amount:	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	C Every six months C Every three months		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	C Other, Describe You must include total cost sharing to the	Is there an enrollee Copayment?	
C Yes C No	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	C No	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	and highest cost sharing that a beneficiary may pay. Is there an enrollee Coinsurance?	Indicate Minimum Copayment amount per session for Medicare-covered Benefits:	
	O Yes O No	Indicate Maximum Copayment amount per	
	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	session for Medicare-covered Benefits:	
	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Reminder: Dialysis received from an Out-of- Network provider will be covered at the In- Network cost.	

#12 Dialysis Services – Base 2

Previous Previous Previous Previous <th>PBP Data Entry System - Section B-12, Contract X0001, Plan 001, Segment 000</th> <th>8 ></th>	PBP Data Entry System - Section B-12, Contract X0001, Plan 001, Segment 000	8 >
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 Dialysis Services? Yes One Dialysis Services Notes Notemay include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes:	Go To: #12 Dialysis Services - Base 2	
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#13a Acupuncture – Base 1

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Previous Ext.	
Dees the plan provide Acupuncture as a supplemental benefit under Part C? Indicate Number of Treatments periodicity: Is thre a service-specific Maximum Enrollee Out-of-Pocket Cost? O Yes Every two years Yes No Every three months Indicate Maximum Enrollee Out-of-Pocket Cost Select enhanced benefit: Every three months Indicate Maximum Enrollee Out-of-Pocket Cost Number of Treatments O ther, Describe Indicate Maximum Plan Benefit Coverage amount? Select type of benefit on Number of Treatments: Indicate Maximum Plan Benefit Coverage amount? Indicate Maximum Plan Benefit Coverage amount? Is this benefit unlimited for Number of Treatments: Indicate Maximum Plan Benefit Coverage amount? Indicate Maximum Plan Benefit Coverage amount? Indicate limit for Number of Treatments: Indicate Maximum Plan Benefit Coverage amount? Every three years Indicate limit for Number of Treatments: Indicate Maximum Plan Benefit Coverage amount? Every three years Indicate limit for Number of Treatments: O Every three years O Every three years Indicate limit for Number of Treatments: O Every three years O Every three years Indicate limit for Number of Treatments: O Every three years O Every three years Do you offer a combined Acupuncture and Chiropractor Ser	
Dees the plan provide Acupuncture as a supplemental benefit under Part C? Indicate Number of Treatments periodicity: Is thre a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes Every two years Yes Number of Treatments Every three months Indicate Maximum Plan Select type of benefit tor Number of Treatments: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost amount! Select type of benefit tor Number of Treatments: Indicate Maximum Plan Benefit Coverage amount? Is this benefit unlimited for Number of Treatments: Indicate Maximum Plan Benefit Coverage amount? Is this benefit unlimited for Number of Treatments: Indicate Maximum Plan Benefit Coverage amount? Indicate Imit for Number of Treatments: Indicate Maximum Plan Benefit Coverage amount? Indicate Imit for Number of Treatments: Indicate Maximum Plan Benefit Coverage amount? Indicate Imit for Number of Treatments: Every three years C Yes Indicate Maximum Plan Benefit Coverage amount? Indicate Imit for Number of Treatments: Every three years C Yes Indicate Maximum Plan Benefit Coverage amount? Indicate Imit for Number of Treatments: Every three years C Yes Indicate Maximum Plan Benefit Coverage amount? Do you offer a combined Acupuncture and Chirop	
supplemental benefit under Part C? C Yes of-Pocket Cost? C Yes C Yery three years Yes C No C Every three months Indicate Maximum Plan Select type of benefit for Number of Treatments: O ther, Describe Indicate Maximum Plan Benefit Coverage amount? C Yes No Indicate Maximum Plan Benefit Coverage amount? Indicate Maximum Plan Benefit Coverage amount? Indicate Imit for Number of Treatments: C Every three years C Every three years C Yes Indicate Maximum Plan Benefit Coverage amount: Indicate Maximum Plan Benefit Coverage amount: Indicate Imit for Number of Treatments: Indicate Maximum Plan Benefit Coverage amount: C Every three years C Yes Indicate Maximum Plan Benefit Coverage amount: C Every three years C Every three years C Yes Indicate Maximum Plan Benefit Coverage amount: Indicate Maximum Plan Benefit Coverage amount: C Every three years Indicate Imit for Number of Treatments: C Every three years C Every three years C Every three months Do you offer a combined Acupuncture and Chiropractor Services benefit? C Wery six months C Every three months C Yes C Other, Describe C Every three months C Every three months	
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Do you offer a combined Acupuncture and C Every six months Dripopractor Services benefit? C Every three months C Yes C Other Describe	

#13a Acupuncture – Base 2

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ere an enrollee Coinsurance? Is there an enrollee Copayment? res C Yes icate Minimum Coinsurance percentage: Indicate Minimum Copayment amount per treatment: icate Maximum Coinsurance percentage: Indicate Maximum Copayment amount per treatment: icate Maximum Coinsurance percentage: Indicate Maximum Copayment amount per treatment: icate Maximum Coinsurance percentage: Indicate Maximum Copayment amount per treatment: icate Maximum Coinsurance percentage: Indicate Maximum Copayment amount per treatment: icate Maximum Coinsurance percentage: Indicate Maximum Copayment amount per treatment: icate Maximum Coinsurance percentage: Indicate Maximum Copayment amount per treatment: icate Deductible? Enrollee must receive Authorization from one or more of the following: res None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review is a referral required for Acupuncture? C C Yes	
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Indicate Maximum Coinsurance percentage: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment Amount: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment Amount: Indicate Maximum Copayment amount per treatment: Indicate Maximum Copayment Amount: Indicate Maximum Copayment amount per treatment; Indicat	
re an enrollee Deductible? Enrollee must receive Authorization from one or more of the following: ss None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist ate Deductible Amount: Organization Medical Director/Utilization Management/Utilization Review Organization Medical Director/Utilization Management/Utilization Review Is a referral required for Acupuncture? C Yes	
es Indice indice for a conversion of the online of the forther of	
o Primary Care Physician (Internist/Family Practice, General Practice) Ate Deductible Amount: Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for Acupuncture? C Yes	
ate Deductible Amount: Organization Medical Director/Utilization Management/Utilization Review Other, describe Is a referral required for Acupuncture? Yes Yes	
C Yes	

#13a Acupuncture – Base 3

e <u>H</u> elp Add				ntract X0001, Plan 001, Segment 000	-
4		Exit	Exit (No Validate)	Go To: #13a Acupuncture - Base 3	
evious	Next	(Validate)	Validate)		
uncture Notes					
may include a	dditional info	mation to describ	be benefit in this	ervice category. Do not repeat information captured in data entry.	
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#13b OTC Items – Base 1

🔡 PBP Data Entry System - Section B-13, Contra	ct X0001, Plan 001, Segment 000	- 8
<u>Fi</u> le <u>H</u> elp Add Variable	To: #13b OTC items - Base 1	
Exit Exit (No	TO: #130 OTC rems - base 1	
Previous Next (Validate) Validate)		_
CLICK FOR DESCRIPTION OF BENEFIT Medicare-Medicaid plans may not use this section to provide benefit information about any OTC items that are submitted under the integrated formulary. Information about those benefits will be entered in the RX section of three PBP. This section should only be used to provide benefit information about OTC items that are covered as a supplemental benefit. Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit on OTC Items:	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C 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 year C Every three months C Every month C Every month	
Indicate Maximum Plan Benefit Coverage amount:		
Joes your Maximum Plan Benefit Coverage amount carry forward to he next period if it is unused? ○ Yes ○ No		

#13b OTC Items – Base 2

	n B-13, Contract X0001, Plan 001, Segment 000	_ 8 ×
Eile Help Add Variable	Go To: #13b OTC tems - Base 2	
Previous Next (Validate)	Go To: #13b OTC Items - Base 2	
(vandate)	valuale)	
Is 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 Coinsurance percentage:	Indicate Maximum Copayment amount:	
is there an enrollee Deductible?	Does this cover all of the OTC list which may befound in Chapter 4 of the Medicare Managed Care Manual?	
C No	C Yes C No	
Indicate Deductible Amount:	Authorization is not applicable for this service category.	
	Referral is not applicable for this service category.	
		1.

#13b OTC Items – Base 3

	le <u>H</u> elp Ad	d Variable	Exit	×	Go To: #13b OTC tems - Base 3	
may include additional information to describe benefit in this service category. Do not repeat information captured in data entry:	revious	Next	Exit (Validate)	Exit (No Validate)		
may include additional information to describe benefit in this service category. Do not repeat information captured in data entry:	Items Notes					
		dditional info	rmation to descri	be benefit in thi	ervice category. Do not repeat information captured in data entry	
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#13c Meal Benefit – Base 1

PBP Data Entry System - Section B-13, Contrac Help Add Variable		
revious Next (Validate) Go T	o: #13c Meal Benefit - Base 1	
ICK FOR DESCRIPTION OF BENEFIT		
the plan provide a Meal Benefit as a supplemental benefit	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
r Part C? res lo	C Yes C No	
ect type of benefit:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Mandatory Optional		
How many days does your Meal Benefit last?	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years	
What is the maximum number of meals the benefit provides?	C Every two years C Every year	
ere a service-specific Maximum Plan Benefit Coverage amount Yes	C Every six months C Every three months C Other, Describe	
No		
Indicate Maximum Plan Benefit Coverage amount:		
iicate Maximum Plan Benefit Coverage periodicity:		
Every three years Every two years Every year		
Every year Every six months Every three months		
Other, Describe		

#13c Meal Benefit – Base 2

Exit	Go To: #13c Meal Benefit - Base 2	
evious Next (Validate) Valida	NO	
re an enrollee Coinsurance?	Is there an enrollee Copayment?	
es o	C Yes C No	
ate Minimum Coinsurance percentage:	Indicate Minimum Copayment amount:	
eate Maximum Coinsurance percentage:	Indicate Maximum Copayment amount:	
re an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following: ☐ None	
es Io	Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review	
cate Deductible Amount:	Other, describe Is a referral required for the Meal Benefit?	
	C Yes C No	
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#13c Meal Benefit – Base 3

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revious	Next	(Validate)	Validate)					
Benefit Notes								
may include a	dditional info	mation to descril	be benefit in this	service category. Do not repeat inform	tion captured in data entry.			
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#13d Other 1 – Base 1

PBP Data Entry System - Section B-13, Cont <u>File Help Add Variable</u>	ract X0001, Plan 001, Segment 000	_ 8 ×
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Exit Exit (No Previous Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Plan Benefit Coverage amount:	
Note: After completing your data entry in this category, if you delete ALL text in the "Enter name of Service (Optional): field you will lose all previously entered data. You may edit the name of the service text partially without losing all previously entered data. Do not put Medicare-covered benefits in this service category (e.g., do not include homehealth, nutritional support, transportation, medical devices etc). Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-138. If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title. Enter name of Service (Optional):	Indicate Maximum Plan Benefit Coverage periodicity: C Every three years C Every two years C Every year C Every three months C Other, Describe Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes O No	
	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select type of benefit: Mandatory Optional Is there a service-specific Maximum Plan Benefit Coverage amount? Yes No	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Every two years Every year Every six months Other, Describe	

#13d Other 1 – Base 2

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ere an enrollee Coinsurance?	Is there an enrollee Copayment?	
'es Io	C Yes C No	
cate Minimum Coinsurance percentage:	Indicate Minimum Copayment amount:	
	Indicate Meximum Consummations with	
cate Maximum Coinsurance percentage:	Indicate Maximum Copayment amount:	
	Enrollee must receive Authorization from one or more of the following:	
re an enrollee Deductible?	Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist	
es	🗌 Organization Medical Director/Utilization Management/Utilization Review	
0	□ Other, describe	
cate Deductible Amount:	Is a referral required for Other Services? O Yes	
	C No	

#13d Other 1 – Base 3

le <u>H</u> elp Ad	d Variable				
		Exit	Exit (No Validate)	Go To: #13d Other 1 - Base 3	
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ner 1 Notes					
	dditional info	rmation to decaril	ne here efit in thi	service category. Do not repeat information captured in data entry.	
te may include a	Goldonai mio	ination to descrit	be benefit in this	service category. Do norrepeat mormation captored in data entry.	
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#13e Other 2 – Base 1

PBP Data Entry System - Section B-13, Contr	act X0001, Plan 001, Segment 000	- 8 ×
Eile Help Add Variable	To: #13e Other 2 - Base 1	
Exit Exit (No		
Previous Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Plan Benefit Coverage amount:	
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).	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	
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 there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No	
is not an acceptable title. Enter name of Service (Optional):	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select type of benefit: C Mandatory C Optional	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every year C Every year	
Is there a service-specific Maximum Plan Benefit Coverage amount?	C Every ski months C Every three months C Other, Describe	
C No		

#13e Other 2 – Base 2

Industry Exit (No Validate) Go To: #13e Other 2 - Base 2 an enrollee Coinsurance? Is there an enrollee Copayment? C Yes No e Minimum Coinsurance percentage: Indicate Minimum Copayment amount:	Next Exit (No Go To: #130 Other 2 - Base 2 enrollee Coinsurance? Is there an enrollee Copayment? C Yes Animum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Maximum Coinsurance percentage: Indicate Maximum Copayment amount: Indicate Deductible? Enrollee must receive Authorization from one or more of the following: Primary Care Physician (InternistyFamily Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Orther, describe Deductible Amount: Is a referral required for Other Services?		-13, Contract X0001, Plan 001, Segment 000	
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an enrollee Deductible? 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 Deductible Amount: Is a referral required for Other Services? C Yes	Enrollee must receive Authorization from one or more of the following: In None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Organization Medical Director/Utilization Review Is a referral required for Other Services? Yes	te Minimum Coinsurance percentage:	Indicate Minimum Copayment amount:	
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Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist 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? Yes	Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Oeductible Amount: Other, describe Is a referral required for Other Services? Yes	an enrollee Deductible?	None	
e Deductible Amount: Other, describe Is a referral required for Other Services? C Yes	Deductible Amount: Other, describe Is a referral required for Other Services?		Physician Specialist	
Is a referral required for Other Services?	Is a referral required for Other Services?			

#13e Other 2 – Base 3

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er 2 Notes											
e may include a	additional info	rmation to descri	be benefit in thi	s service category. Do not	epeat information captur	ed in data entry.					
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Fu Associates, Ltd.

#13f Other 3 – Base 1

🔡 PBP Data Entry System - Section B-13, Contra	ct X0001, Plan 001, Segment 000	- 8 ×
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#13f Other 3 – Base 2

	8-13, Contract X0001, Plan 001, Segment 000	_
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revious Next (Validate)	Y Go To: #13f Other 3 - Base 2. Exit (No Jaildate)	
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ere an enrollee Coinsurance?	Is there an enrollee Copayment?	
Yes No	C Yes C No	
icate Minimum Coinsurance percentage:	Indicate Minimum Copayment amount	
cate winning in constrance percentage.		
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icate Maximum Coinsurance percentage:	Indicate Maximum Copayment amount:	
ere an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:	
Yes No	Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist	
cate Deductible Amount:	Organization Medical Director/Utilization Management/Utilization Review Other, describe	
	Is a referral required for Other Services?	
	Č No	

#13f Other 3 – Base 3

evious	Next	Exit (Validate)	Exit (No Validate)	Go To: #13f Other 3 - Base 3			
3 Notes							
may include a	dditional info	rmation to descril	be benefit in thi	s service category. Do not repeat information	captured in data entry.		
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#13g Dual Eligible SNPs with Highly Integrated Services – Base 1

🔜 PBP Data Entry System - Section B-13, Contract X0001	1, Plan 001, Segment 000	_ 8 ×
<u>File</u> <u>H</u> elp Add Variable		
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Previous Next (Validate) Validate)		
	la than a san la san aife Harlann Dha Daarfe Gaussian ann an 10	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes	
Plans only fill out this section if they have received written notification from CMS that they qualify for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services.		
Dual Eligible SNPs with Highly Integrated Services Benefit Attestation		
I attest that I have received written notification from CMS that this individual SNP	Indicate Maximum Plan Benefit Coverage periodicity:	
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	C Every three years	
 additional supplemental benefit(s) that the SNP describes in this section of the PBP do not inappropriately duplicate an existing service(s) that enrollees are 	O Every two years O Every year	
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 months	
You may edit the name of the service text partially without losing all previously	C Other, Describe	
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.	O Yes O No	
Enter name of Service (Optional):	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
	Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:	
Select type of benefit:	C Every three years	
C Mandatory	C Every two years	
C Optional	O Every year O Every six months	
	C Every three months	
	C Other, Describe	

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

	-13, Contract X0001, Plan 001, Segment 000	
ile <u>H</u> elp Add Variable	♥ Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 2	
Previous Next (Validate) V	Y Go To: ≢13g Dual Eligible SNPs with Highly Integrated Services - Base 2 xit (No alidate)	
(validate) V	andate)	
there an enrollee Coinsurance?	Is there an enrollee Copayment?	
Yes No	C Yes C No	
2 - 2000	Indicate Minimum Copayment amount:	
Indicate Minimum Coinsurance percentage:		
Indicate Maximum Coinsurance percentage:	Indicate Maximum Copayment amount:	
there an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:	
Yes No	Primary Care Physician (Internist/Family Practice, General Practice)	
dicate Deductible Amount:	Physician Specialist Organization Medical Director/Utilization Management/Utilization Review	
	Other, describe Is a referral required for Other Services?	
	C Yes	
	C No	

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

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e may include	additional info	rmation to descril	be benefit in thi	s service category. Do not repeat inform	tion captured in data entry.			
es:								
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Previous Next (Validate) Go To: #13	h Additional Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Enter name of Other 1 Service:	
es the plan provide Additional Services? Yes	Enter name of Other 2 Service:	
No		
Select Additional Services (select all that apply):		
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Enter name of Other 3 Service:	
Tobacco Cessation Counseling for Pregnant Women Freestanding Birth Center Services		
Respiratory Care Services		
Family Planning Services	Enter name of Other 4 Service:	
Nursing Home Services		
Home and Community Based Services Personal Care Services	Enter name of Other 5 Service:	
Self-Directed Personal Assistance Services		
Private Duty Nursing Services		
Case Management (Long Term Care) Institution for Mental Disease Services for Individuals 65 or Older	Enter name of Other 6 Service:	
Services in an Intermediate Care Facility for Individuals with Intellectual Disabilitie		
Case Management		
Other 1	Enter name of Other 7 Service:	
Other 2 Other 3		
Other 4		
Other 5	Enter name of Other 8 Service:	
Other 6		
Other 7 Other 8		
Other 9	Enter name of Other 9 Service:	
Other 10		
Other 11	Enter name of Other 10 Service:	
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Other 15	Enter name of Other 11 Service:	
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Other 18		
Other 19	Enter name of Other 12 Service:	
Other 20		
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nter name of Other 18 Service:	Enter name of Other 31 Service:	
nter name of Other 19 Service:	Enter name of Other 32 Service:	
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Indicate units a limit will be provided in for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: Select Additional Services provided? Indicate units a limit will be provided in for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: Construct Select Additional Services provided in for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: Construct Provide Services Resprintory Care Services Partice Services Partice Services Provide Care Services Provide Duty Nursing Services Case Management Other 1 Other 5 Other 6 Other 7 Other 1 Othe	Exit Exit (No	
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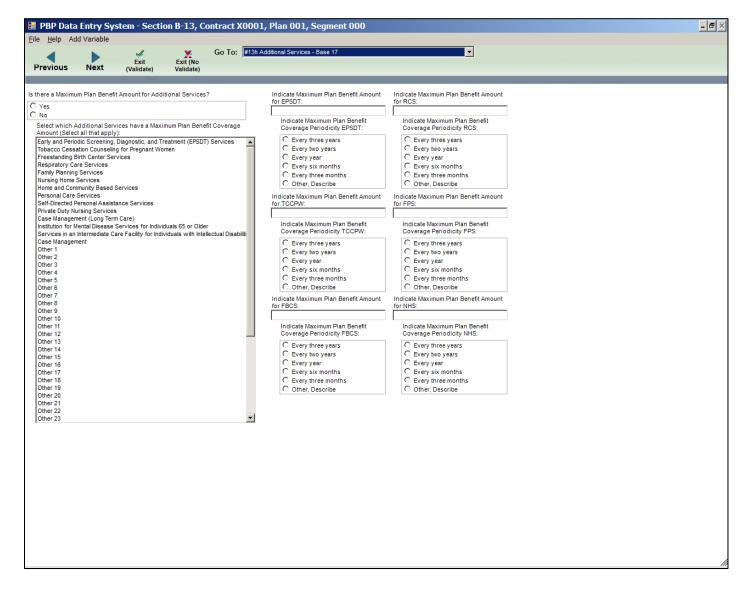
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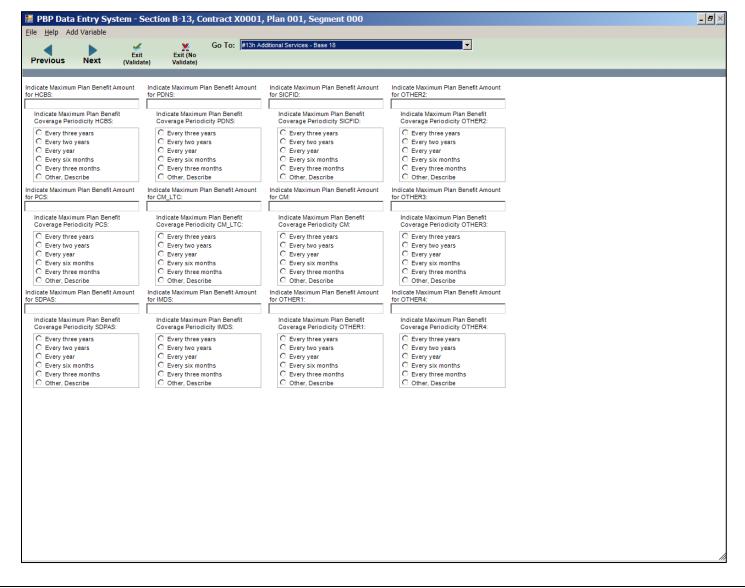
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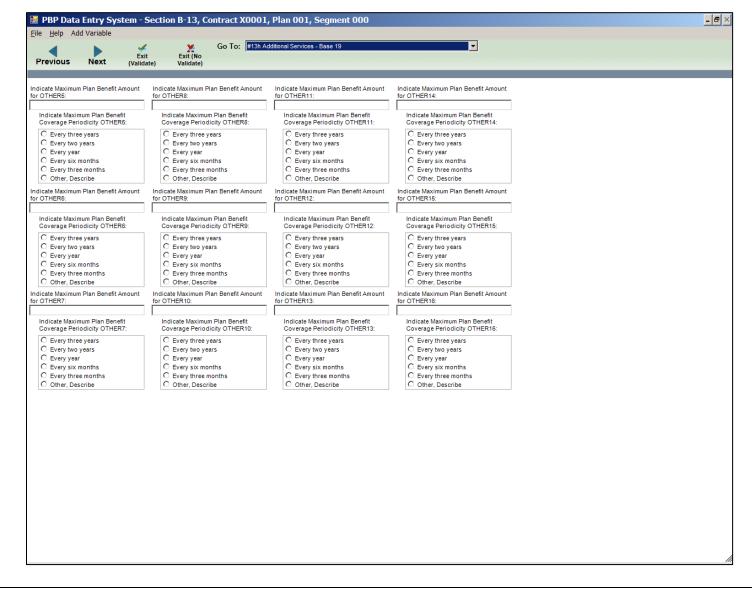
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elect limit on services periodicity for Other 33:	Select limit on services periodicity for Other 35:
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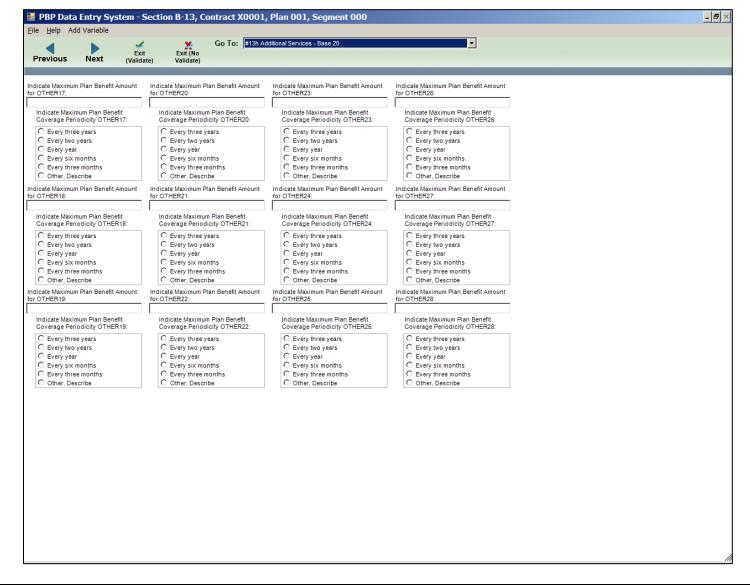


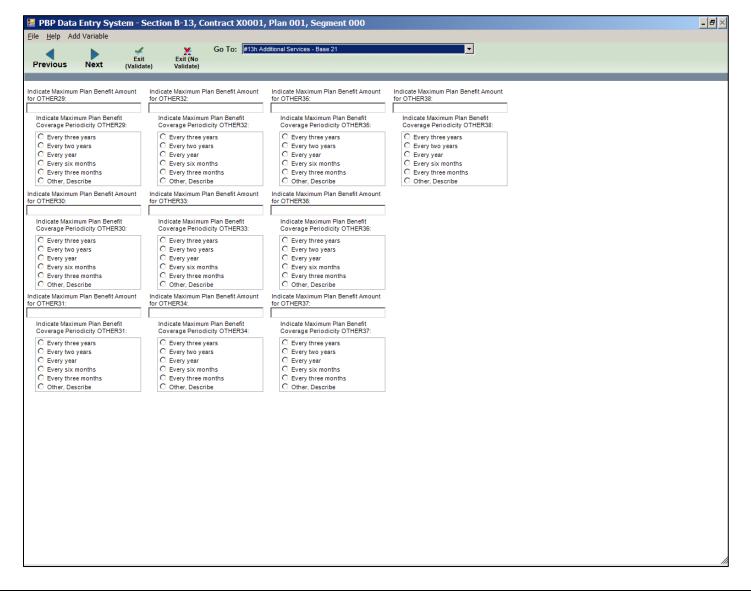




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s any service require qualification for and enrollment in a state-operated er program?	Is a beneficiary receiving any benefit subject to a state-required monthly payment amount that is based on his or her financial resources (for example: a "patient pay amount")?	
res Io	O Yes O No	
V Select services that require qualification for and enrollment in a state-opera valver program: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women Freestanding Birth Center Services Respiratory Care Services Farniky Planning Services Personal Care Services Self-Directed Personal Assistances 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 Disabili Case Management Cher 1 Other 2 Other 3 Other 4 Other 5 Other 6 Other 7 Other 1 Other 12 Other 13 Other 14 Other 13 Other 14 Other 12 Other 13 Other 14 Other 13 Other 14 Other 13 Other 14 Other 13 Other 14 Other 2 Other 23 Other 3 Other 4	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 Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women Freestanding Birth Center Services Respiratory Care Services Respiratory Care Services Nursing Home Services Nursing Home Services Self-Directed Personal Assistance Services Personal Care Services Self-Directed Personal Assistance Services Private Duty Nursing Services Case Management (Long Term Care) Institution for Mental Disease Services for Individuals 65 or Older	

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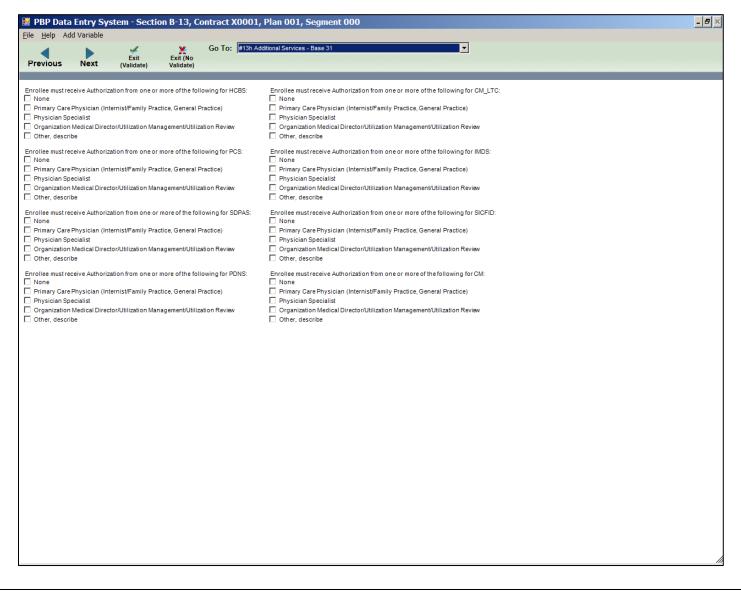
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			Freestanding Birth Center Services	
			Family Planning Services Nursing Home Services	
			Personal Care Services	
			Private Duty Nursing Services Case Management (Long Term Care)	
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espiratory Care Services			Other 3			
amily Planning Services			Other 4			
ursing Home Services			Other 5			
ome and Community Based Services			Other 6			
ersonal Care Services			Other 7			
elf-Directed Personal Assistance Services			Other 8			
rivate Duty Nursing Services			Other 9			
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ervices in an Intermediate Care Facility for dividuals with Intellectual Disabilities			Other 12			

er 14 Other 27 Image: Constraint of the state of	Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #13	n Additional Services	- Base 29
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PBP Data Entry System - Section B-13, Contract X0001,	Plan 001, Segment 000	
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Authorization required for any Additional Services:		
Yes		
No		
Enrollee must receive Authorization from one or more of the following for EPSDT:	Enrollee must receive Authorization from one or more of the following for RCS:	
Primary Care Physician (Internist/Family Practice, General Practice)	None Primary Care Physician (Internist/Family Practice, General Practice)	
Physician Specialist	Physician Specialist	
Organization Medical Director/Utilization Management/Utilization Review	Organization Medical Director/Utilization Management/Utilization Review	
Other, describe	Other, describe	
Enrollee must receive Authorization from one or more of the following for TCCPW:	Enrollee must receive Authorization from one or more of the following for FPS: None	
Primary Care Physician (Internist/Family Practice, General Practice)	Primary Care Physician (Internist/Family Practice, General Practice)	
Physician Specialist	Physician Specialist	
Organization Medical Director/Utilization Management/Utilization Review	Organization Medical Director/Utilization Management/Utilization Review	
Other, describe	Other, describe	
nrollee must receive Authorization from one or more of the following for FBCS:	Enrollee must receive Authorization from one or more of the following for NHS: None	
None Primary Care Physician (Internist/Family Practice, General Practice)	None Primary Care Physician (Internist/Family Practice, General Practice)	
Physician Specialist	Physician Specialist	
Organization Medical Director/Utilization Management/Utilization Review	Organization Medical Director/Utilization Management/Utilization Review	
Other, describe	Conter, describe	



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and all international second with the second	3h Additional Services - Base 37
is a referral required for one or more Additional Services?	Additional Services Notes
O Yes O No	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
Select which Additional Services need a Referral (Select all that apply): Early and Periodic Screening, Diagnostic, and Treatment (CPSDT) Services Tobacco Cessation Counseling for Pregnant Women Freestanding Birth Center Services Respiratory Care Services Pamily Planning Services Personal Care Services Self-Directed Personal Assistance Services Private Duty Nursing Services Self-Directed Personal Assistance Services Private Duty Nursing Services Self-Directed Personal Assistance Services Private Duty Nursing Services Services in an Intermediate Care Facility for Individuals 65 or Older Services in an Intermediate Care Facility for Individuals with Intellectual Disability Case Management Other 1 Other 2 Other 3 Other 4 Other 5 Other 6 Other 7 Other 13 Other 14 Other 13 Other 14 Other 15 Other 16 Other 19	Notes: Additional Notes:
Other 20 Other 21 Other 22 Other 23	

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#14a Medicare-covered Zero Dollar Preventive Services

File Help Add Variable Previous Next Exit (No Validate) Co To: File Medicare-covered Zero Dollar Preventive Services CLICK FOR DESCRIPTION OF BENEFIT Medicare-covered Zero Dollar Preventive Services Notes Medicare-covered Zero Dollar Preventive Services Attestation Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing. Notes: Note: Notes: Note: For Oliar or eferral for certain S0 cost sharing preventive services, for example, screening manimograms. Enrollee must receive Authorization from one or more of the following: Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Foralization Medicat Director/Utilization Management/Utilization Review Other, describe Is a referral required? Is a referral required? Is a referral required?
CLICK FOR DESCRIPTION OF BENEFIT Medicare-covered Zero Dollar Preventive Services Notes Idecide additional information to describe benefit in this service category. Do not repeat information captured in data entry. Note may include additional information captured in data entry. I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing. Notes: Note: Notes: Note: Image: Services for example, screening mammograms. Enrollee must receive Authorization form one or more of the following: Image: Services for example, screening mammograms. Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Other, describe
2 Yes 0 No

#14b Annual Physical Exam – Base 1

PBP Data Entry System - Section B-14, Contract >	X0001, Plan 001, Segment 000	- 8
File Help Add Variable Go To:	#14b Annual Physical Exam - Base 1	
Previous Next (Validate) Go To:		
(valuate) valuate)		
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount?	
nter Medicare-covered preventive services at \$0 cost sharing in PBP ervice category 14a.	C Yes C No	
ou should only use these supplemental benefits for Annual Physical kams not covered by Original Medicare. You may charge copays for ese Annual Physical Exams. NOTE: Medicare-covered preventive struces are always plan covered, and consequently they are not.	Indicate Maximum Plan Benefit Coverage amount:	
opropriate as a supplemental benefit. Des the plan provide the Annual Physical Exam as a supplemental benefit Inder Part C?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C: Yes	
) Yes	U NO	
No Select type of benefit for the Annual Physical Exam:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
C Mandatory		
C Optional		

#14b Annual Physical Exam – Base 2

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revious Next (Validate) Validate)		
ere an enrollee Coinsurance?		
es	Is there an enrollee Copayment?	
0	C No	
Indicate Minimum Coinsurance percentage for each Annu Exam:	ual Physical Indicate Minimum Copayment amount for each Annual Physical Exam:	
Indicate Maximum Coinsurance percentage for each Annu Exam:		
	Annual Physical Exam:	
re an enrollee Deductible?		
'es Io		
licate Deductible Amount:		

#14b Annual Physical Exam – Base 3

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ile <u>H</u> elp Adi	d Variable Next	Exit (Validate)	Exit (No Validate)	Go To: 📕	lb Annual Physical E	xam - Base 3					
None Primary Care Pl Physician Spec Organization M Other, describe a referral require	hysician (Inte sialist ledical Directo	ion from one or m rnist/Family Practi r/Utilization Mana ual Physical Exan	ce, General Pr gement/Utiliza	actice)							
Yes No											
nnual Physical E lote may include a		ormation to descri	be benefit in thi	s service catego	y. Do n <mark>ot repeat info</mark>	ormation captured in	n data entry.				
ites:								*			
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CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Health Education:	Select type of benefit for Telemonitoring Services:		
oes the plan provide Eligible Supplemental Benefits as Defined in Chapter 4 as a benefit ider Part C?	C Mandatory C Optional	O Mandatory O Optional		
) Yes) No	Select type of benefit for Nutritional/Dietary Benefit: O Mandatory	Select type of benefit for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline):		
Select enhanced benefit (Select all that apply):	O Optional	C Mandatory C Optional		
Health Education Nutritional/Dietary Benefit	Is this benefit unlimited for Nutritional/Dietary Benefit?	Select type of benefit for Bathroom Safety Devices:		
Additional sessions of Smoking and Tobacco Cessation Counseling itness Benefit* Inhanced Disease Management	C Yes C No, indicate number	C Mandatory C Optional		
Telemonitoring Services*	Indicate number of visits for Nutritional/Dietary Benefit:	Select type of benefit for Counseling Services:		
Bathroom Safety Devices* Counseling Services	Benenit	C Mandatory C Optional		
In-Home Safety Assessment Personal Emergency Response System (PERS)	Indicate setting for Nutritional/Dietary Benefit:	Is this benefit unlimited for Counseling Services?		
Medical Nutrition Therapy (MNT) Post discharge In-home Medication Reconciliation Re-admission Prevention	O Individual Sessions O Group Sessions	C Yes C No, indicate number		
Wigs for Hair Loss Related to Chemotherapy Weight Management Programs* Alternative Therapies*	C Both Sessions (Individual and Group) Select type of benefit for Additional sessions of Smoking and Tobacco Cessation Counseling:	Indicate number of visits for Counseling Services:		
= A note is required when this benefit is offered.	C Mandatory C Optional	Indicate setting for Counseling Services:		
	Indicate number of visits offered in addition to Medicare:	C Group Sessions C Both Sessions (Individual and Group)		
		Indicate duration of sessions (in minutes):		
	Select type of benefit for Fitness Benefit:	Select type of benefit for In-Home Safety Assessment:		
	C Mandatory C Optional	C Mandatory C Optional		
	Select type of benefit for Enhanced Disease Management:	Select type of benefit for Personal Emergency Response System (PERS):		
	O Mandatory O Optional	O Mandatory O Optional		

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📕 PBP Data Entry System - Section B-14, Contra	ct X0001, Plan 001, Segment 000	- -
<u>File Help</u> Add Variable		
Exit Exit (No	To: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 2	•
Previous Next (Validate) Validate)		
Select type of benefit for Medical Nutrition Therapy (MNT):	Select type of benefit for Re-admission Prevention:	
O Mandatory	O Mandatory	
C Optional	C Optional	
Do you offer Additional Sessions for Medicare-covered diseases?	What does your Re-admission Prevention benefit include (check	
C No	all that apply): Meals	
Indicate the limit for Additional Sessions:	Medication Reconciliation	
O Visits	In-Home Safety Assessment	
O Hours	C Other, Describe	
Indicate numerical limiton the services provided for Additional Sessions:	Enter name of Service:	_
Do you offer Coverage for non-Medicare-covered diseases? (Specify	Please describe the Meal benefit included in Re-admission Prevention:	
the diseases and describe the coverage in the notes field)	How many days does your Meal Benefit last?	
C Yes		
O No Indicate units a limit will be provided in for Coverage for non-	What is the maximum number of meals the benefit provides?	
Medicare covered diseases:		
O Visits		
C Hours	Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:	
Indicate numerical limit on the services provided for Coverage for non-Medicare covered diseases:	○ Mandatory ○ Optional	
	Select type of benefit for Weight Management Programs:	
Selecttype of benefit for Post discharge In-home Medication Reconciliation:	C Mandatory	
O Mandatory	C Optional	
C Optional	Select type of benefit for Alternative Therapies:	
	C Mandatory	
	C Optional	
	Indicate number of visits offered for Alternative Therapies:	

evious Next (Validate) Go	To: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base	3 	
Is there a service-specific Maximum Plan Benefit Coverage amount for Eligible Supplemental Benefits as Defined in Chapter 4? C Yes C No Select which Eligible Supplemental Benefits as Defined in Chapter 4 have a Maximum Plan Benefit Sas Defined in Chapter 4 have a Maximum Plan Benefit Coverage amount (Select all that apply): Heath Education Nutritional/Dietary Benefit Additional Sessions of Smoking and Tobacco Cessation Counsel Fitness Benefit Enhanced Disease Management Telemonitoring Services Remote Access Technologies (including Web/Phone based techn Bathroom Safety Devices Counseling Services	Indicate Maximum Plan Benefit Coverage amount for Additional sessions of Smoking and Tobacco Cessation Counseling: Select Maximum Plan Benefit Coverage periodicity for Additional sessions of Smoking and Tobacco Cessation Counseling: C Every three years C Every two years C Every two years C Every two years C Every three months C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit	Indicate Maximum Plan Benefit Coverage amount for Remote Access Technologies (including Web/Phonebased technologies and Nursing Hotline): Select Maximum Plan Benefit Coverage periodicity for Remote Access Technologies (including Web/Phonebased technologies and Nursing Hotline): C Every three years C Every three years C Every year C Every year C Every three months C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Bathroom Safety Devices: Select Maximum Plan Benefit Coverage periodicity for Bathroom	
Personal Emergency Response System (PERS) Medical Nutrition Therapy (MIT) Post discharge In-home Medication Reconciliation Re-admission Prevention Wigs for Hair Loss Related to Chemotherapy Weight Management Programs Indicate Maximum Plan Benefit Coverage amount for Health Education:	C Every three years C Every three years C Every two years C Every two is months C Every three months C Nonthly C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Enhanced Disease Management	Safety Devices: C Every three years C Every two years C Every year C Every six months C Every six months C Every six months C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Counseling Services:	
Select Maximum Plan Benefit Coverage periodicity for Health Education: C Every three years C Every three years C Every year C Every year C Every six months C Every three months C Other, Describe	Select Maximum Plan Benefit Coverage periodicity for Enhanced Disease Management: C Every three years C Every two years C Every year C Every year C Every sear C Every sear C Every three months	Salect Maximum Plan Benefit Coverage periodicity for Counseling Services: C Every two years C Every year C Every year C Every year C Every six months C Every three months C Other, Describe	
Indicate Maximum Plan Benefit Coverage amount for Nutritional/Dietary Benefit: Select Maximum Plan Benefit Coverage periodicity for Nutritional/Dietary Benefit: C Every three years C Every thore years C Every two years	C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Telemonitoring Services: Select Maximum Plan Benefit Coverage periodicity for Telemonitoring Services: C Every three years C Every two years	Indicate Maximum Plan Benefit Coverage amount for In-Home Safety Assessment: Select Maximum Plan Benefit Coverage periodicity for In-Home Safety Assessment: C Every three years C Every thro years	
C Every six months C Every six months C Every three months C Other, Describe	C Every year C Every six months C Every three months C Other, Describe	C Every year C Every six months C Every three months C Other, Describe	

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mergency Response System (PERS): ad Devery three years C Devery two years C Devery year C Devery year C Devery six months C Devery three months C Other, Describe C Indicate Maximum Plan Benefit Coverage amount for Medical utrition Therapy (MNT): Ha	elect Maximum Plan Benefit Coverage periodicity for Re- dmission Prevention: Every three years Every two years Every year Every year Every six months Other, Describe dicate Maximum Plan Benefit Coverage amount for Wigs for	Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies: C Every three years C Every two years C Every year C Every year C Every six months C Every three months
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O Other, Describe C ndicate Maximum Plan Benefit Coverage amount for Medical Inn lutrition Therapy (MNT): Ha	O Other, Describe	
Hatition Therapy (MNT):	dicate Maximum Plan Benefit Coverage amount for Wigs for	O Other, Describe
	air Loss Related to Chemotherapy:	Is there a service-specific Maximum Enrollee Out -of-Pocket Costfor Eligible Supplemental Benefits as Defined in Chapter 47
	elect Maximum Plan Benefit Coverage periodicity for Wigs for	C Yes C No
	air Loss Related to Chemotherapy:	
	C Every three years	Indicate Maximum Enrollee Out-of-Pocket Cost
	C Every two years	amount:
C Every year C	D Every year	
	C Every six months	
	D Every three months	Select the Maximum Enrollee Out-of-Pocket
O Other, Describe	Other, Describe	Cost periodicity:
ndicate Maximum Plan Benefit Coverage amount for Post Indischarge In-home Medication Reconciliation: Ma	Idicate Maximum Plan Benefit Coverage amount for Weight Ianagement Programs:	C Every three years C Every two years C Every year C Every six months
	elect Maximum Plan Benefit Coverage periodicity for Weight lanagement Programs:	C Every six months C Every three months O Other, Describe
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	Every two years	
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	Every six months	
C Every three months C	D Every three months	
O Other, Describe	Other, Describe	

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PBP Data Entry System - Section B-14, Contract X0001,	Plan 001, Segment 000
Elle Help Add Variable Go To: #140 Elig Exit Exit No	ble Supplemental Benefits as Defined in Chapter 4 - Base 7
Previous Next (Validate) Validate)	
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	Additional sessions of Smoking and Tobacco Cessation Counseling Notes:
s a referral required for Eligible Supplemental Benefits as Defined in Chapter 4?	
C Yes C No	Fitness Benefit Notes:*
ligible Supplemental Benefits as Defined in Chapter 4 Notes:	<u>A</u>
ote may include additional information to describe benefit in this service category. o not repeat information captured in data entry.	
 This notes field is required when the corresponding benefit is offered. ealth Education Notes: 	
<u> </u>	Enhanced Disease Management Notes:
	<u> </u>
2	
utritional/Dietary Benefit Notes:	×
A	Telemonitoring Services Notes:*
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e Help Add Variable	Go To: # Exit (No Validate)	#14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 8	
mote Access Technology (including Web/Phon d Nursing Hotline) Notes:*	e based technologies	Personal Emergency Response System (PERS) Notes:	
throom Safety Devices Notes:*	•	Medical Nutrition Therapy (MNT) Notes:	
andoni Saley Devices roles.			
	x		
unseling Services Notes:	×	Post discharge In-home Medication Reconciliation Notes:	
Home Safety Assessment Notes:		Re-admission Prevention Notes:	
	×		
	×		

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igs for Hair Lo	oss Related to	Chemotherapy N	lotes:	100				
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ght Manage	ement Notes:*			*				
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rnative The	apies Notes:*			×				
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#14d Kidney Disease Education Services – Base 1

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Maximum Plan Be s there a service O Yes O No Indicate Maxim	its are not appl enefit Coverage -specific Maxin num Enrollee C visimum Enrollee o years ar months ee months	F BENEFIT icable for this Seru e is not applicable num Enrollee Out- but-of-Pocket Cost e Out-of-Pocket C	for this Service of-Pocket Cost t amount:	1?	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? C Yes Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	

#14d Kidney Disease Education Services – Base 2

revious Next (Validate) Validate	Go To: #14d - Kidney Disease Education Services Base 2	
revious Next (Validate) Validate	a)	
ere an enrollee Deductible?	Enrollee must receive Authorization from one or more of the following:	
Yes	None	
No	Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist	
icate Deductible Amount:	Organization Medical Director/Utilization Management/Utilization Review	
	Conter, describe	
ere an enrollee Copayment?	Is a referral required for Kidney Disease Education Services?	
'es	C Yes	
40	C No	
icate Minimum Copayment amount for Medicare-covered nefits:		
cate Maximum Copayment amount for Medicare-covered	d	
efits:		

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#14d Kidney Disease Education Services – Base 3

e <u>H</u> elp Ad		acan Secur	л Б 14 , С	ntract X0001, Plan 001, Segment 000		- 8
		Exit (Validate)	Exit (No Validate)	Go To: #14d - Kidney Disease Education Services Base 3	v	
Previous	Next	(Validate)	Validate)			
ney Disease E	lucation Servi	ces Notes				
te may include a	dditional info	rmation to descril	be benefit in thi	service category. Do not repeat information captured in data en	ry.	
es:						
					<u>*</u>	
					<u>×</u>	

File Help Add Variable Previous Exit Waildate CLICK FOR DESCRIPTION OF BENEFIT Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services? Ves Select Other Medicare-covered Preventive Services (Select all that apply): Other 1 Other 3 Other 4 Other 4 Other 4 Other 5 Select Other Medicare-covered Preventive Services (Select all that apply): Other 1 Other 1 Other 4 Other 1 Other 1 Other 1 Select Other Name: Other 2 Name: Select Other Medicare-covered Preventive Services (Select all that apply): Select Other Name: Other 1 Other 1 Other 1 Select Other Name: Other 1 Other 3 Other 3 Other 4 Other 4 Other 3 Other 4 Other 4 Other 5 Select Other Medicare-covered Preventive Services (Select all that apply): Other 4 Other 5 Select Other Medicare-covered Preventive Services (Select all that apply): Other 4 Other 5 Select Other Service (Selec	
Previous Next Date (Validate) Exit (No Validate) CLICK FOR DESCRIPTION OF BENEFIT	
CLICK FOR DESCRIPTION OF BENEFIT Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-Covered Preventive Category. Itaximum Plan Benefit Coverage is not applicable for this Service Category.	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-Covered Preventive Services? o you offer any Other Medicare-covered Preventive Services? Yes No Select Which Services have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply): Other 1 Select Other Medicare-covered Preventive Services (Select all that apply): Other 2 Other 3 Other 4 Other 5 Medicare-Covered Preventive Services (Select all that apply): Other 4 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 1 Name: Other 2 Name: Other 3 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 3 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 3 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost of ther 3 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 3 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 3 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 3 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 3 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years Other 3 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years Other 4 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years Other 4 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years Other 4 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years Other 4 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years Other 4 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket C Every three years Other 4 Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket C Every three years Other 4 Select the Glaucoma Screening Maximum En	
Inhanced Benefits are not applicable for this Service Category. Medicare-Covered Preventive Services? iaximum Plan Benefit Coverage is not applicable for this Service Category. No o you offer any Other Medicare-covered Preventive Services? Select which Services have a Maximum Enrollee Out-of-Pocket O Yes Select Which Services have a Maximum Enrollee Out-of-Pocket O Yes Select Other Medicare-covered Preventive Services (Select all that apply): O ther 1 Other 1 O Other 2 Other 3 O ther 5 Indicate Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 5 Indicate Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 1 Name: Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 2 Name: Other 3 Name:	
Iaximum Plan Benefit Coverage is not applicable for this Service Category. In you offer any Other Medicare-covered Preventive Services? Select which Services have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply): Image: Cost (Select all that apply): Select Other Medicare-covered Preventive Services (Select all that apply): Select Other Medicare-covered Preventive Services (Select all that apply): Select Other Medicare-covered Preventive Services (Select all that apply): Select Other Medicare-covered Preventive Services (Select all that apply): Select Other Medicare-covered Preventive Services (Select all that apply): Select Other Medicare-covered Preventive Services (Select all that apply): Select Other Medicare-covered Preventive Services (Select all that apply): Select Other Medicare-covered Preventive Services (Select all that apply): Select Other Medicare-covered Preventive Services (Select all that apply): Select Other Medicare-covered Preventive Services (Select all that apply): Select Other 1 Other 2 Other 3 Other 4 Other 4 Image: Select Other Maximum Enrollee Out-of-Pocket Cost Moter 1 Name: Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost periodicity: Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Select the Glaucoma Screening Maximum Enr	
Yes Cost (Select all that apply): Other Medicare-covered Preventive Services (Select all that apply): Glaucoma Screening Other 1 Other 1 Other 2 Other 3 Other 3 Other 4 Other 4 Other 4 Other 5 Indicate Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 1 Name: Select the Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount: Other 2 Name: Cost periodicity: Other 3 Name: C Every thre years	
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Other 3 Name: O Every two years	
C Every year	
O Every six months	
Other 4 Name: O Every three months	
O Other, Describe	
Other 5 Name:	
Indicate Diabetes Self-Management Traning Maximum Enrollee Out-of- Pocket Cost amount:	
Select the Diabetes Self-Management Traning Maximum Enrollee Out -of-Pocket Cost periodicity:	
O Every three years	
C Every two years	
O Every year O Every six months	
C Every six months	
C Other, Describe	

PBP Data Entry System - Section B-14, Contrac	ct X0001, Plan 001, Segment 000	- 8
e Help Add Variable	To: #14e Other Medicare-covered Preventive Services - Base 2	
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icate Other 1 Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Other 4 Maximum Enrollee Out-of-Pocket Cost amount:	
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ect the Other 2 Maximum Enrollee Out-of-Pocket Cost periodicity:	Select the Other 5 Maximum Enrollee Out-of-Pocket Cost periodicity:	
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ect the Other 3 Maximum Enrollee Out-of-Pocket Cost periodicity:		
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Is there an enrollee Coinsu	rance?	Is there an enrollee Deductible?	
O Yes		O Yes	
C No		C No	
Select which Services hav Glaucoma Screening Diabetes Self-Managen Other 1 Other 2	re a Coinsurance (Select all that apply): ment Training	Select which Services have a Deductible (Select all that apply): Glaucoma Screening Diabetes Self-Management Training Other 1 Other 2	
C Other 3		C Other 3	
Other 4		Other 4	
C Other 5		Other 5	
	Minimum Maximum Coinsurance Coinsurance	Indicate Glaucoma Screening Deductible Amount:	
Glaucoma Screening		Indicate Diabetes Self-Management Training Deductible Amount:	
Diabetes Self- Management Training		Indicate Other 1 Deductible Amount:	
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Other 2			
Other 3		Indicate Other 3 Deductible Amount:	
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		Indicate Other 5 Deductible Amount:	

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evious Nex	t (Validate) Validate)		
ere an enrollee Copa	yment?			
Yes No				
J NO				
Select which Services ha	ive a Copayment (Select all that apply)		
Diabetes Self-Manage	ment Training			
Other 1				
Other 2 Other 3				
Other 4				
Other 5				
	Minimum	Maximum		
	Copayment	Copayment		
Glaucoma Screening				
		·		
Diabetes Self- Management Training				
Other 1				
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Other 2				
Other 3				
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📕 PBP Data Entry System - Section B-14, Contract X0001	l, Plan 001, Segment 000	×
Eile Help Add Variable	Other Medicare-covered Preventive Services - Base 5	
Previous Next (Validate) Go To: #14e (
(validate) validate)		
Enrollee must receive Authorization from one or more of the following for Glaucoma Screening: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Enrollee must receive Authorization from one or more of the following for Diabetes Self-Management Training:	Enrollee must receive Authorization from one or more of the following for Other 3: Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe Enrollee must receive Authorization from one or more of the following for Other 4:	
Ser-Maragement Training. None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe	None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe	
Enrollee must receive Authorization from one or more of the following for Other 1: Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe	Enrollee must receive Authorization from one or more of the following for Other 5: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe 	
Enrollee must receive Authorization from one or more of the following for Other 2: None Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review Other, describe		

PBP Data Entry System - Section B-14, Contract X0001, Help Add Variable		
Go To: #14e Othe	er Medicare-covered Preventive Services - Base 6	
Previous Next (Validate) Validate)		_
a referral required for any Services?	Diabetes Self-Management Training Notes:	
Yes	<u> </u>	
No		
lect which Services require a Referral (Select all that apply):		
Glaucoma Screening		
Diabetes Self-Management Training Other 1		
Other 2		
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Other 5	Other 1 Notes:	
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ote may include additional information to describe benefit in this service tegory. Do not repeat information captured in data entry.		
laucoma Screening Notes:		
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nay include additional information to desc	e benefit in this service category. Do not repeat information captured in data entry.	
r 2 Notes:	Other 4 Notes:	
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r 3 Notes:	Other 5 Notes:	
	<u>*</u>	
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#15 Medicare Part B Rx Drugs – Base 1

📕 PBP Data Entry System - Section B-15, C	ontract X0001, Plan 001, Segment 000	- 8 ×
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Previous Next (Validate)	Go To: #15 Medicare Part B Rx Drugs - Base 1	
Previous Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance? C Yes	
	C No	
Is there a Maximum Enrollee Out-of-Pocket Cost?	Select which Medicare Part B Rx Drugs have a	
C No	Coinsurance (Select all that apply): Medicare Part B Chemotherapy Drugs	
	Conter Medicare Part B Drugs	
Indicate Maximum Enrollee Out-of-Pocket Cost Amount:	Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:	
	Indicate the Maximum Coinsurance percentage	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	for Medicare Part B Chemotherapy Drugs:	
C Every three years C Every two years		
C Every year	Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	
C Every six months C Every three months		
C Every month C Other, Describe	Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:	
C Other, Describe		
		11.

#15 Medicare Part B Rx Drugs – Base 2

😸 PBP Data Entry System - Section B-15, C	Contract X0001, Plan 001, Segment 000	- 8
Eile Help Add Variable Previous Next (Validate) Validate)	Go To: #15 Medicare Part B Rx Drugs - Base 2	
s there an enrollee Deductible? Yes No Indicate Deductible Amount: Is there an enrollee Copayment? Yes No Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply): Medicare Part B Chemotherapy Drugs Other Medicare Part B Chemotherapy Drugs: Medicare Part B	Indicate Minimum Copayment Amount for direr indecidence Part B Drugs: the Indicate Maximum Copayment Amount for direr indecidence Part B Drugs: the Amount indecidence Part B Drugs: the Indicate Maximum Copayment Amount for the Indicate Part B Drugs: the Indicate Part B Drugs	

#15 Medicare Part B Rx Drugs – Notes

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evious	Next	(Validate)	Validate)	_					 	_	
care Part B R	x Drugs Note	5									
may include	additional info	mation to descri	be bene <mark>fit in thi</mark>	service category.	Do not repeat ir	nformation capture	ed in data entry.				
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#15 Home Infusion Bundled Services

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	#15 Home Infusion Bundled Services	
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Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Does the plan pay for Part D drug home infusion services and supplies as a Medicaid benefit?	
C Yes C No	C Yes C No	
If you select "Yes' to 'Does the plan provide Part Dhome infusion drugs as part of a bundled service as a supplemental benefit?", you must indicate these specific medications in a flat file which must be uploaded through the Formular Submission Module by Friday, June 10, 2016 at 11:59am Eastern Time.		
You must also ensure that your benefit includes not only the home infusion drug, but any services and supplies associated with the home infusion drug's administration.		
If your organization elects to provide Part D home infusion drugs as part of a supplemental bundled service then those services must be provided at \$0 coss haring. As described in the CV 2010 Call Letter this waiver is conditioned on the application of zero cost sharing for the bundle of home infusion services provided under a supplemental benefit.		

#16a Preventive Dental – Base 1

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Previous Next (Validate)	Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Select the Oral Exams periodicity:	Select type of benefit for Fluoride Treatment:	
	O Every three years	O Mandatory	
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	C Every two years C Every year	C Optional	
O Yes O No	C Every six months C Every three months	Is this benefit unlimited for Fluoride Treatment?	
Select enhanced benefits:	C Other, Describe	C No, indicate number	
Oral Exams Prophylaxis (Cleaning)	Select type of benefit for Prophylaxis (Cleaning): C Mandatory	Indicate number of visits for Fluoride Treatment:	
☐ Fluoride Treatment ☐ Dental X-Rays	C Optional		
Select type of benefit for Oral Exams:	Is this benefitunlimited for Prophylaxis (Cleaning)?	Select the Fluoride Treatment periodicity: C Every three years	
C Mandatory C Optional	C No, indicate number	C Every two years C Every year	
Is this benefit unlimited for Oral Exams?	Indicate number of visits for Prophylaxis (Cleaning)	C Every six months C Every three months	
C Yes C No, indicate number	Select the Prophylaxis (Cleaning) periodicity:	C Other, Describe	
Indicate number of visits for Oral Exams:	C Every three years C Every two years		
	O Every year O Every six months		
	O Every three months O Other, Describe		
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#16a Preventive Dental – Base 2

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Select type of benefit for Dental X-Rays: C Mandatory	Is there a service-specific Maximum Plan Benefit Coverage amount?	
C Optional	C No	
Is this benefit unlimited for Dental X-Rays? C Yes C No, indicate number	Does the Maximum Plan Benefit Coverage amount apply to In- network services only OR does it apply to both In-network and Out- of-network services?	
Indicate number of visits for Dental X-Rays:	C In-network services only C Both In-network and Out-of-network services	
	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 six months C Every three months	C Every three years C Every two years C Every year C Every six months	
C Other, Describe	C Every six months C Every three months C Other, Describe	

#16a Preventive Dental – Base 3

#16a Preventive Dental – Base 4

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nere an enrollee Deductible?	Indicate Copayment amount for Office Visit	
Yes		
No		
Indicate Deductible Amount:	Indicate Minimum Copayment amount for Oral Exams:	
	Indicate Maximum Copayment amount for Oral Exams:	
nere an enrollee Copayment?		
Yes	Indicate Minimum Copayment amount for Prophylaxis (Cleaning):	
No		
elect which Preventive Dental Services have a Copayment elect all that apply):	Indicate Maximum Copayment amount for Prophylaxis (Cleaning):	
Oral Exams		
Prophylaxis (Cleaning) Fluoride Treatment	Indicate Minimum Copayment amount for Fluoride Treatment:	
Dental X-Rays		
there a combination of services included in a single cost per	Indicate Maximum Copayment amount for Fluoride Treatment:	
fice Visit?		
Yes No	Indicate Minimum Copayment amount for Dental X-Rays:	
1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		
Select which combination of services are included in a single cost per Office Visit:	Indicate Maximum Copayment amount for Dental X-Rays:	
Oral Exams		
Prophylaxis (Cleaning) Fluoride Treatment		
Dental X-Rays		
Donarxitars		

#16a Preventive Dental – Base 5

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Enrollee must receive Authorization from one or more of the following:	
Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist Organization Medical Director/Utilization Management/Utilization Review	
Other, describe Is a referral required for Preventive Dental Services?	
C Yes C No	
Preventive Dental Services Notes	
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
Notes:	

🔡 PBP Data Entry System - Section B-16, Contr	ract X0001, Plan 001, Segme	nt 000	- 8 ×
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CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Non-routine Services:	Select type of benefit for Diagnostic Services:	
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	C Mandatory C Optional	C Mandatory C Optional	
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Is this benefit unlimited for Non-routine Services?	Is this benefit unlimited for Diagnostic Services?	
C Yes C No	C Yes C No, indicate number	C Yes C No, indicate number	
Select enhanced benefits: Dian-routine Services Diagnostic Services Restorative Services	Indicate number of visits for Non- routine Services:	Indicate number of visits for Diagnostic Services:	
Endodontics/Periodontics/Extractions Prosthodontics, Other Oral/Maxillofacial Surgery, Other 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 year C Every six months C Every three months C Other, Describe	
	C Other, Describe		

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Exit	Go To: #16b Comprehensive D Exit (No	ental - Base 2	
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Select type of benefit for Restorative Services:	Select type of benefit for	Select type of benefit for Prosthodontics, Other	
C Mandatory	Endodontics/Periodontics/Extractions:	Oral/Maxillofacial Surgery, Other Services:	
C Optional	C Mandatory C Optional	C Mandatory C Optional	
Is this benefit unlimited for Restorative Services?			
C Yes	Is this benefit unlimited for Endodontics/Periodontics/Extractions?	Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	
C No, indicate number	C Yes	C Yes	
Indicate number of visits for Restorative Services:	O No, indicate number	C No, indicate number	
	Indicate number of visits for Endodontics/Periodontics/Extractions:	Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Select the Restorative Services periodicity: C Every three years	Select the Endodontics/Periodontics/Extractions	Select the Prosthodontics/Other Oral/Maxillofacial	
C Every two years	C Every three years	Surgery/Other Services periodicity: C Every three years	
C Every year C Every six months	C Every two years	C Every two years	
C Every three months	C Every year	C Every year	
C Other, Describe	C Every six months C Every three months	C Every six months C Every three months	
	O Other, Describe	O Other, Describe	
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Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes	
C No	C No	
Select the Maximum Plan Benefit Coverage type:	Select the Maximum Enrollee Out-of-Pocket Cost type:	
C Covered under Preventive Dental Category 16a C Plan-specified amount per period	C Covered under Preventive Dental Category 16a C Plan-specified amount per period	
Does the Maximum Plan Benefit Coverage amount apply to In-network	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
services only OR does it apply to both In-network and Out-of-network services?	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
C In-network services only C Both In-network and Out-of-network services	C Every three years	
Indicate Maximum Plan Benefit Coverage amount:	C Every two years C Every year	
	C Every six months C Every three months	
Select the Maximum Plan Benefit Coverage periodicity:	C Other, Describe	
C Every three years		
O Every two years O Every year		
C Every six months C Every three months		
O Other, Describe		

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Exit Exit (No	#16b Comprehensive Dental - Base 4	
Previous Next (Validate) Validate)		
Is there an enrollee Coinsurance?	Indicate Minimum Coinsurance percentage for Restorative Services:	
C Yes		
C No	Indicate Maximum Coinsurance percentage for Restorative Services:	
Select which Comprehensive Dental Services have a Coinsurance (Select al that apply):		
Medicare-covered Benefits		
Non-routine Services Diagnostic Services	Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extradions:	
Restorative Services		
Endodontics/Periodontics/Extradions Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	la dista Universi Osissena a seconda a fas	
Indicate the Minimum Coinsurance percentage for Medicare-covered	Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:	
Benefits:		
Indicate the Maximum Coinsurance percentage for Medicare-covered	Indicate Minimum Coinsurance percentage for Prosthodontics, Other	
Benefits:	Oral/Maxillofacial Surgery, Other Services:	
Indicate Minimum Coinsurance percentage for Non-routine Services:		
	Indicate Maximum Coinsurance percentage for Prosthodontics, Other	
Indicate Maximum Coinsurance percentage for Non-routine Services:	Oral/Maxillofacial Surgery, Other Services:	
	Is there an enrollee Deductible?	
Indicate Minimum Coinsurance percentage for Diagnostic Services:	C Yes C No	
	Indicate Deductible Amount:	
Indicate Maximum Coinsurance percentage for Diagnostic Services:		

ile <u>H</u> elp Add Variable		
Exit Exit	Go To: #16b Comprehensive Dental - Base 5	
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here an enrollee Copayment?	Indicate Maximum Copayment amount for Diagnostic	
Yes	Services:	
No		
elect which Comprehensive Dental Services ave a Copayment (Select all that apply):	Indicate Minimum Copayment amount for Restorative	
Medicare-covered Benefits	Services:	
Non-routine Services		
Diagnostic Services		
Restorative Services	Indicate Maximum Copayment amount for Restorative	
Endodontics/Periodontics/Extractions	Services:	
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services		
dicate Minimum Copayment amount for Medicare-		
overed Benefits:	Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions:	
dicate Maximum Copayment amount for Medicare-		
overed Benefits:	Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions:	
dicate Minimum Copayment amount for Non-routine		
ervices:	Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
	One oraliwaxinolacial sugery, other services.	
dicate Maximum Copayment amount for Non-routine		
ervices:	Indicate Maximum Copayment amount for Prosthodontics,	
	Other Oral/Maxillofacial Surgery, Other Services:	
dicate Minimum Copayment amount for Diagnostic		
ervices:		

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Enrollee must receive Primary Care Phys Physician Speciali Organization Medi Other, describe Is a referral required fo Yes No Comprehensive Dente	Authorization from one or m ician (Internist/Family Pract st cal Director/Utilization Mana or Comprehensive Dental S	Validate) nore of the folic tice, General Pi agement/Utiliza ervices?	actice) tion Review	r. Do not repeat inf	formation captured	l in data entry.				

#17a Eye Exams – Base 1

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Previous Exit (Validate) Exit (Validate) Exit Validate) CLICK FOR DESCRIPTION OF BENEFIT Is there a service-specific Maximum Plan Benefit Coverage amount? Is there a service-specific Maximum Plan Benefit Is Does the plan provide Eye Exams as a supplemental benefit under Part C? Is there a service-specific Maximum Plan Benefit Is Over Services only OR does it apply Select enhanced benefit: Does the Maximum Plan Benefit Coverage amount apply to in-network services only OR does it apply to both in-network services only Image: Coverage amount apply to in-network services only Image: Coverage amount apply to in-network services only Select enhanced benefit: Image: Coverage amount apply to in-network and Out-of-network services only Image: Coverage amount apply to in-network and Out-of-network services Select the Maximum Plan Benefit Coverage amount apply to in-network and Out-of-network services Coverage Select the Maximum Plan Benefit Coverage periodicity. Select the Maximum Plan Benefit Coverage periodicity.	Is three a service-specific Maximum Enrollee Out- of-Pocket Cost

#17a Eye Exams – Base 2

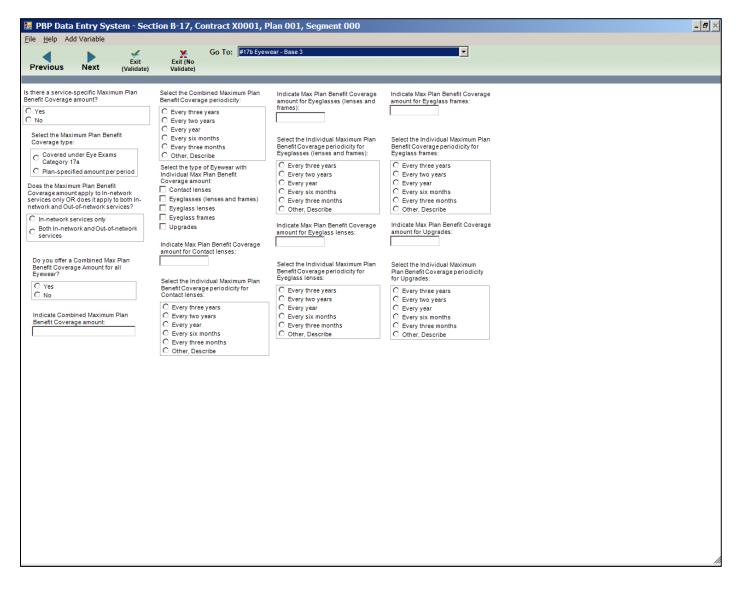
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Previous Next (Validate)		
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
C Yes C No		
Select which Eye Exams have a Coinsurance (Select all that apply): Medicare-covered Benefits Routine Eye Exams/Other	Select which Eye Exams have 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 Exams/Other:	
Indicate Maximum Coinsurance percentage for Routine Eye Exams/Other:	Indicate Maximum Copayment amount per Routine Eye Exams/Other:	
Is there an enrollee Deductible?		
C Yes C No		
Indicate Deductible Amount:		

#17a Eye Exams – Base 3

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Eile <u>H</u> elp Ad		4	¥	Go To:	#17a Eye Exams - Base 3	
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nollee must rece	eive Authorizat	ion from one or m		wing:		
None		nist/Family Practi				
Physician Spec	cialist					
Organization N Other, describe		r/Utilization Mana	gement/Utiliza	tion Review		
a referral require	ed for Eye Exa	ms?				
) Yes) No						
ve Exams Notes						
	additional info	rmation to describ	e benefit in this	service		
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CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Contact lenses:	Select type of benefit for Eyeglasses (lenses and frames):	
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	C Mandatory C Optional	C Mandatory C Optional	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Is this benefit unlimited for Contact lenses?	Is this benefit unlimited for Eyeglasses (lenses and frames)?	
C Yes C No	C No, indicate number	C Yes C No, indicate number	
Select enhanced benefits: Contact lenses Eyeglasses (lenses and frames)	Indicate quantity (number of pairs) for Contact lenses:	Indicate quantity for Eyeglasses (lenses and frames):	
Eyeglass lenses	Select Contact lenses periodicity:	Select Eyeglasses (lenses and frames)	
☐ Eyeglass frames ☐ Upgrades	C Every three years C Every two years	periodicity: C Every three years C Every two years	
	C Every year C Every six months C Every three months	C Every year C Every six months C Every three months	
	C Other, Describe	C Other, Describe	
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elect type of benefit for Eyeglass lenses:	Select type of benefit for Eyeglass frames:	
Mandatory Optional	C Mandatory C Optional	
this benefit unlimited for Eyeglass lenses?	Is this benefit unlimited for Eyeglass frames?	
Yes No, indicate number	C Yes C No, indicate number	
ndicate quantity (number of pairs) for Eyeglass lenses:	Indicate quantity for Eyeglass frames:	
Select Eyeglass lenses periodicity:	Select Eyeglass frames periodicity:	
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	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	



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nere a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Minimum Coinsurance percentage for Medicare-covered	Indicate Minimum Coinsurance percentage for Eyeglass frames:	
Yes No	Benefits:		
NO			
lect the Maximum Enrollee Out-of-Pocket Cost type:	Indicate Maximum Coinsurance percentage for Medicare-covered	Indicate Maximum Coinsurance percentage for Eyeglass frames:	
Covered under Eye Exams Category 17a Plan-specified amount per period	Benefits:		
dicate 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			
O Every year			
C Every six months	Indicate Minimum Coinsurance percentage for Eyeglasses (lenses		
C Every three months C Other, Describe	and frames):		
here an enrollee Coinsurance?			
Yes	Indicate Maximum Coinsurance percentage for Eyeglasses (lenses and frames):		
No			
elect which Eyewear Benefits have a Coinsurance (Select all that pply):			
Medicare-covered Benefits	Indicate Minimum Coinsurance percentage for Eyeglass lenses:		
Contact lenses Eyeglasses (lenses and frames)			
Eyeglasses (enses and names)	Indicate Maximum Coinsurance percentage for Eyeglass lenses:		
Eyeglass frames			
Upgrades			

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Is there an enrollee Copayment? Indicate Minimum Copayment amount for Eyeglasses (lenses and frames): Indicate Minimum Copayment amount for Upgrades: C Yes Indicate Minimum Copayment amount for Eyeglasses (lenses and frames): Indicate Minimum Copayment amount for Upgrades: Select which Eyewar Benefits have a Copayment (Select all that apply): Indicate Maximum Copayment amount for Eyeglasses (lenses and frames): Indicate Maximum Copayment amount for Upgrades: Medicare-covered Benefits Indicate Minimum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Eyeglass lenses: Eyeglass Indicate Server Indicate Minimum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Eyeglass lenses: Indicate Maximum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Eyeglass lenses: Indicate Maximum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Eyeglass lenses: Indicate Maximum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Medicare-covered	
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No Select which Eyewear Benefits have a Copayment (Select all that apply): Medicare-covered Benefits Contact lenses Eyeglasses (lenses and frames) Indicate Minimum Copayment amount for Eyeglass lenses: Eyeglass lenses Eyeglass lenses Indicate Minimum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Medicare-covered	
Select which Eyewear Benefits have a Copayment (Select all that apply): Indicate Maximum Copayment amount for Eyeglasses (lenses and frames): Indicate Maximum Copayment amount for Upgrades: Contact lenses Indicate Minimum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Eyeglass lenses: Eyeglass frames Indicate Maximum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Eyeglass lenses:	
apply): Indicate Covered Benefits Contact lenses Indicate Minimum Copayment amount for Eyeglass lenses: Eyeglass serves Indicate Minimum Copayment amount for Eyeglass lenses: Eyeglass frames Indicate Maximum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Eyeglass lenses: Indicate Maximum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Eyeglass lenses:	
Contact lenses Indicate Minimum Copayment amount for Eyeglass lenses: Eyeglass lenses Indicate Minimum Copayment amount for Eyeglass lenses: Eyeglass frames Indicate Minimum Copayment amount for Eyeglass lenses: Upgrades Indicate Maximum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Medicare-covered Indicate Minimum Copayment amount for Eyeglass lenses: Indicate Minimum Copayment amount for Medicare-covered Indicate Minimum Copayment amount for Eyeglass lenses:	
Eyeglass lenses Eyeglass frames Upgrades Indicate Maximum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Medicare-covered	
Eyeglass frames Upgrades Indicate Maximum Copayment amount for Eyeglass lenses: Indicate Maximum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Medicare-covered	
Indicate Minimum Copayment amount for Medicare-covered Enefits: Indicate Maximum Copayment amount for Medicare-covered	
Benefits: Indicate Maximum Copayment amount for Medicare-covered	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	
Indicate Maximum Copayment amount for Medicare-covered Benefits:	

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000	_ 8 ×
Eile Help Add Variable	
Previous Next (Validate) Go To: #17b Eyewear - Base 6	
Previous Next (Validate) Validate)	_
nrollee must receive Authorization from one or more of the following:	
None	
Primary Care Physician (Internist/Family Practice, General Practice) Physician Specialist	
Organization Medical Director/Utilization Management/Utilization Review	
Other, describe	
s a referral required for Eyewear?	
) Yes) No	
yewear Notes	
to te may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
lotes:	
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	1.

PBP Data Entry System - Section B-18, C	ontract X0001, Plan 001, Segment 000	
Ele Help Add Variable	Go To: #18a Hearing Exams - Base 1	
Previous Next (Validate) Validate) CLICK FOR DESCRIPTION OF BENEFIT	Select Routine Hearing Exams periodicity: Every three years Every three months Other, Describe Select type of benefit for Fitting/Evaluation for Hearing A/d? Optional Select Fitting/Evaluation for Hearing A/d? Ore years On indicate number Indicate number for Fitting/Evaluation for Hearing A/d? Ore years Ore years	

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😸 PBP Data Entry System - Section	B-18, Contract X0001, Plan 001	, Segment 000	_ 8 ×
<u>F</u> ile <u>H</u> elp Add Variable			
Exit	Go To: #18a Hearing Exams - Exit (No	Base 2	
Previous Next (Validate)	Validate)		
Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	
C Yes C No	C Yes C No		
Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	
C In-network services only C Both In-network and Out-of-network services	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Minimum Coinsurance percentage for Routine Hearing Exams:	
Indicate Maximum Plan Benefit Coverage amount:	C Every three years C Every two years C Every year		
Select the Maximum Plan Benefit Coverage periodicity:	C Every six months C Every three months C Other, Describe	Indicate Maximum Coinsurance percentage for Routine Hearing Exams:	
C Every three years C Every two years C Every year C Every six months	Is there an enrollee Coinsurance?	Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:	
C Every three months C Other, Describe	Select which Hearing Exam Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits		
Is there an enrollee Deductible?	Routine Hearing Exams Fitting/Evaluation for Hearing Aid	Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:	
Indicate Deductible Amount:			
1			

PBP Data Entry System - Section B-18, Co	ntract X0001, Plan 001, Segment 000	_ 6
revious Next (Validate)	Go To: #18a Hearing Exams - Base 3	
there an enrollee Copayment? ? Yes No	Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	
elect which Hearing Exam Benefits have a Copayment (Select that apply): Medicare-covered Benefits Routine Hearing Exams	Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	
Fitting/Evaluation for Hearing Aid dicate Minimum Copayment amount for Medicare-covered enefits:	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	
dicate Maximum Copayment amount for Medicare-covered enefits:	Other, describe Is a referral required for Hearing Exams? C: Yes	
ndicate Minimum Copayment amount for Routine Hearing xams:	C No	
dicate Maximum Copayment amount for Routine Hearing ams:		

le <u>H</u> elp Ad Previous	d Variable	Exit (Validate)	Exit (No Validate)	Go To: #18a	Hearing Exams - E	3ase 4			•		_ 6
aring Exams No te may include a		rmation to descril	be benefit in this	service category.	Do not repeat info	ormation captured i	n data entry.				
tes:								*			
								*			

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😸 PBP Data Entry System - Sectio	n B-18, Contract X0001, Plan	001, Segment 000		_ 8 ×
<u>File</u> <u>H</u> elp Add Variable				
	Go To: #18b Hearing Aid Exit (No	s - Base 1		
Previous Next (Validate)	Exit (No Validate)			
(validato)	Validatoy			
CLICK FOR DESCRIPTION OF BENEFIT	Select Hearing Aids (all types) periodicity:	Select Hearing Aids - Inner Ear periodicity:		
	C Every three years	C Every three years		
Does the plan provide Hearing Aids as a	C Every two years	C Every two years		
supplemental benefit under Part C?	C Every year C Every six months	O Every year O Every six months		
O Yes	C Every six months	C Every three months		
C No	C Other, Describe	C Other, Describe		
Select enhanced benefits:		Select type of benefit for Hearing Aids - Outer Ear:		
 Hearing Aids (all types) Hearing Aids - Inner Ear 	Select type of benefit for Hearing Aids - Inner Ear:	C Mandatory	1	
Hearing Aids - Outer Ear	C Mandatory	O Optional		
Hearing Aids - Over the Ear	C Optional		-	
Select type of benefit for Hearing Aids]	Is this benefit unlimited for Hearing Aids - Outer Ear?	_	
(all types):	Is this benefit unlimited for Hearing Aids -	C Yes		
C Mandatory	Inner Ear?	C No, indicate number		
C Optional	O Yes O No, indicate number	Indicate quantity for Hearing Aids - Outer Ear:		
In this has after the limited for the size Aids (all				
Is this benefit unlimited for Hearing Aids (all types)?	Indicate quantity for Hearing Aids - Inner			
O Yes	Ear:	Select Hearing Aids - Outer Ear periodicity:		
C No, indicate number		C Every three years		
Indicate quantity for Hearing Aids (all types):		C Every two years		
Indexe quantity for rearing Alds (any pes).		 Every year Every six months 		
		C Every three months		
		C Other, Describe		
				///

PBP Data Entry System - Section B-18, C	Contract X0001, Plan 001, Segment 000	- 8
Eile Help Add Variable Previous Next (Validate)	Go To: #18b Hearing Aids - Base 2	
C Mandatory C Optional Is this benefit unlimited for Hearing Aids - Over the Ear?	Does the Maximum Plan Benefit Coverage Amount apply per ear or for bin ears combined Select the Maximum Plan Benefit Coverage type: Covered under Hearing Exams Category - 18 Plan-specified amount per period Does the Maximum Plane Benefit Coverage amount apply bin-network services only CM does lapply to both in-network and Out-of-network services Does the Maximum Plane Benefit Coverage amount indicate Maximum Plane Benefit Coverage amount cover y and the of-network services Description and Out-of-network services Description and Out-of-network services Cover y aves Cover	

🔡 PBP Data Entry System - Section B-18	8, Contract X0001, Plan 001, Segmer	it 000	
Eile Help Add Variable	Go To: #18b Hearing Aids - Base 3		
Previous Next (Validate)	No .		
Is there a service-specific Maximum Enrollee Out-of- Pocket Cost? O Yes	Indicate Minimum Coinsurance percentage for Hearing Aids (all types):	Indicate Minimum Coinsurance percentage for Hearing Aids - Over the Ear:	
C No Select the Maximum Enrollee Out-of-Pocket Cost type:	Indicate Maximum Coinsurance percentage for	Indicate Maximum Coinsurance percentage for	
C Covered under Hearing Exams Category - 18a C Plan-specified amount per period	Hearing Aids (all types):	Hearing Aids - Over the Ear:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Minimum Coinsurance percentage for Hearing Aids - Inner Ear:		
Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years	Indicate Maximum Coinsurance percentage for Hearing Aids - Inner Ear:		
C Every year C Every six months C Every three months C Other, Describe	Indicate Minimum Coinsurance percentage for Hearing Aids - Outer Ear:		
Is there an enrollee Coinsurance? C Yes C No	Indicate Maximum Coinsurance percentage for Hearing Aids - Outer Ear:		
Select which Hearing Aids Benefits have a Coinsurance (Select all that apply): Hearing Aids - Inner Ear Hearing Aids - Outer Ear Hearing Aids - Over the Ear			

🔡 PBP Data Entry System - Section B-18, Cont	ract X0001, Plan 001, Segment 000		_ 8 ×
File Help Add Variable	Go To: #18b Hearing Aids - Base 4	•	
Previous Next (Validate) G			
Inner Ear: Indicate Maximum Copayment amount per Hearing Aid - Inner Ear: Indicate Minimum Copayment amount per two Hearing Aids -	Indicate Minimum Copayment amount per Hearing Aid- Outer Ear: Indicate Maximum Copayment amount per Hearing Aid - Outer Ear: Indicate Minimum Copayment amount per two Hearing Aids - Outer Ear: Indicate Maximum Copayment amount per Hearing Aid - Outer Ear: Indicate Minimum Copayment amount per Hearing Aid - Over the Ear: Indicate Minimum Copayment amount per Hearing Aid - Over the Ear: Indicate Minimum Copayment amount per two Hearing Aid - Over the Ear: Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear: Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear:	Is there an enrollee Deductible?	

	n B-18, Contract X0001, Plan 001, Segment 000	-8>
Eile Help Add Variable	Go To: #18b Hearing Aids - Base 5	
Previous Next (Validate)	Exit (No Validate)	
Enrollee must receive Authorization from one or mor None Primary Care Physician (Internist/Family Practice Physician Specialist Organization Medical Director/Utilization Manage Other, describe Is a referral required for Hearing Alds? C Yes No Hearing Alds Notes Note may include additional information to describe Notes:	e, General Practice)	

📕 PBP Data Entry System - Section	on B-20, Contract X0001, Plan	1 001, Segment 000	<u>- 8 ×</u>
<u>File</u> <u>H</u> elp Add Variable			
Exit	Go To: #20 Outpatient D Exit (No	Drugs - Base 1	
Previous Next (Validate)	Exit (No Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Is there a Maximum Plan Benefit Coverage amount for drugs?	Indicate Max Plan Benefit Coverage amount annually for drugs:	
Does the plan provide Outpatient Drugs as a supplemental benefit under Part C?	C Yes C No	Indicate Max Plan Benefit Coverage amount semi-	
C Yes C No	Indicate type of Maximum Plan Benefit Coverage:	annually for drugs:	
Select type of benefit:	All drug groups covered by plan Combination of drug groups	Indicate Max Plan Benefit Coverage amount quarterly for drugs;	
C Mandatory C Optional	Individual drug groups		
Indicate the number of drug groupings that are offered:	Is the Maximum Plan Benefit Coverage net of the enrollee copay? C Yes	Indicate Max Plan Benefit Coverage amount monthly for drugs:	
C 1 C 2	C Yes C No	Indicate Max Plan Benefit Coverage amount for Other for	
C 3 C 4	Indicate Maximum Plan Benefit Coverage periodicity for drugs:	drugs:	
C 5	Annually Semi-annually		
	Quarterly Monthly		
	Other, describe		
			li

PBP Data Entry System - Section B-20, Contract >	X0001, Plan 001, Segment 000
e Help Add Variable	#20 Outpatient Drugs - Base 2
Exit Exit (No	P20 Outpatient Drugs - Dase 2
Previous Next (Validate) Validate)	
n any unused amounts be carried forward to the next period within the tract period?	Indicate Max Plan Benefit Coverage amount annually for combination of
Yes	drug groups:
No	
ect what combination of drug groups are included in the Maximum Plan	Indicate Max Plan Benefit Coverage amount semi-annually for combination of drug groups:
efit: Group 1	
Group 2	Indicate Max Plan Benefit Coverage amount quarterly for combination of
Group 3 Group 4	drug groups:
Group 5	
icate Maximum Plan Benefit Coverage periodicity for combination of	Indicate Max Plan Benefit Coverage amount monthly for combination of
g groups: Annually	drug groups:
Semi-annually	
Quarterly	Indicate Max Plan Benefit Coverage amount for Other for combination of
Monthly Other, describe	drug groups:

Ele Lieby Add Variable Providua Next Contract	Previous Next Exit (validate) Go To: #20 Outpatient Drugs - Base 3 Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached? Indicate Maximum Enrollee Out-of-Pocket Cost amount: Yes Select the Maximum Plan Benefit Coverage is waived: Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived: Every year Group 1 Every yik months Every year Group 1 Every three months Every three months Group 3 Is there an enrollee Coinsurance for Medicare-covered Benefits? Yes No Does the enrollee incur a cost in addition to the Coinsurance or Copay available? Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply): (Gortee Part B Drugs	
Previous Exit (validate) s a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached? Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Previous Exit (validate) Exit validate) Exit (validate) Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached? Indicate Maximum Enrollee Out-of-Pocket Cost amount: Ves Select the Maximum Enrollee Out-of-Pocket Cost periodicity: No Select the Maximum Plan Benefit Coverage is waived: Group 1 Every year Group 2 Is there an enrollee Coinsurance for Medicare-covered Benefits? Group 3 Is there an enrollee Coinsurance for Medicare-covered Benefits? Does the enrollee incur a cost in addition to the Coinsurance or Copay available? Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply): Medicare Part B Drugs	
Prevolus Next (validate) Validate) is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached? Indicate Maximum Enrollee Out-of-Pocket Cost amount: C Yes	Previous Next (Validate) Validate) Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached? Indicate Maximum Enrollee Out-of-Pocket Cost amount: O Yes Select the Maximum Plan Benefit Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Indicate Maximum Plan Benefit Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Coverage is waived: C Every year Group 1 C Every yix months Group 2 Is there an enrollee Coinsurance for Medicare-covered Benefits? Group 3 Is there an enrollee Coinsurance for Medicare-covered Benefits? Or specing a higher priced drug when a less expensive drug is available? Select which Medicare-covered Outpatient Drugs have a Coinsurance (Gelect all that apply): Coverage Cove	
Banefit Coverage amount has been reached? C Yes No Indicate the selected group(s) for which the Maximum Plan Benefit C Yes Group 1 Group 3 Group 4 Group 4 Group 5 Does the enrollee incur a cost in addition to the Coinsurance or Copey for selecting a higher priced drug when a less expensive drug is available? C Yes C Yes No Dees the enrollee incur a cost in addition to the Coinsurance or Copey for selecting a higher priced drug when a less expensive drug is available? C Yes C Yes Other Medicare Part B Drugs Indicate Maximum Enrollee Out-of-Pocket Cost? C Yes No Select which Medicare-covered Qupatient Drugs have a Coinsurance (Select all that apply): Indicate Part B Drugs Other Medicare Part B Drugs Other Medicare Part B Drugs: Out-of-Pocket Cost? Yes Select which mum Coinsurance percentage for Medicare Part B Drugs: Out-of-Pocket Cost? Group 1 Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs: Oring p 2	Bandfi Coverage amount has been reached? Bandfi Coverage amount has been reached? Pys No Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived: Group 1 Group 2 Group 3 Group 4 Coverage 5 Dess the enrollee incur a costin addition to the Coinsurance or Copage is available? Coverage is waived: Coverage is unaived: Group 1 Group 2 Group 3 Is there an enrollee Coinsurance for Medicare-covered Benefits? Coverage is waived: Coverage is unaived: Group 4 Coverage is enrollee incur a costin addition to the Coinsurance or Copage is available? Coverage is costin addition to the Coinsurance or Copage is available?	
Sametit Coverage amount has been reached? C Yes No Indicate the selected group(s) for which the Maximum Plan Benefit C Yes Group 1 Group 4 Group 4 Select which Medicare-covered Benefits? C Yes Group 4 Select which Medicare-covered Outpatient Drugs have a Coinsurance or Medicare-covered Benefits? C roup 4 Select which Medicare-covered Outpatient Drugs have a Coinsurance or Selective At the Maximum Enrollee Coinsurance or Medicare-covered Outpatient Drugs have a Coinsurance (Select at 11 that apply): Does the enrollee incur a cost in addition to the Coinsurance or Copey for Selecting a higher priced drug when a less expensive drug is Yes No Dest the enrollee Out-of-Pocket Cost? Yes No Indicate Maximum Enrollee Out-of-Pocket Cost? Yes Out-of-Pocket Cost: Group 1 Indicate Maximum Coinsurance percentage for Medicare Part B Orego for U Indicate Maximum Coinsurance percentage for other Medicare Part B Orego for 0 Indicate Maximum Coinsurance percentage for other Medicare Part B Orego for 0 <	Bandfit Coverage amount has been reached? C Yes No Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Indicate the selected group(s) for which the Maximum Plan Benefit C Yes Coverage is waived: Group 1 Group 2 Group 3 Is there an enrollee Coinsurance for Medicare-covered Benefits? C Yes Oroup 4 C roup 5 Dest heenrollee incur a cost in addition to the Coinsurance or Copart available? C Wice	
No Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Indicate the selected group(s) for which the Maximum Pian Benefit Every year Coverage is waived: Every six months Group 1 Every six months Group 2 Is there an enrollee Coinsurance for Medicare-covered Benefits? Group 3 Is there an enrollee Coinsurance for Medicare-covered Benefits? Group 4 Yes Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply): Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply): Does the enrollee incur a cost in addition to the Coinsurance or Copay available? One Yes One Is there a Maximum Enrollee Out-of-Pocket Cost? One Medicare Part B Chemotherapy Drugs Yes One Medicare Part B Chemotherapy Drugs: Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs: Indicate Minimum Coinsurance percentage for Other Medicare Part B Coroup 1 Indicate Minimum Coinsurance percentage for other Medicare Part B Coroup 2 Indicate Minimum Coinsurance percentage for other Medicare Part B Coroup 3 Indicate Minimum Coinsurance percentage for other Medicare Part B Coroup 4 Indicate Minimum Coinsurance percenta	No Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Indicate the selected group(s) for which the Maximum Plan Benefit C Every year Group 1 C Every six months Group 2 Stere an enrollee Coinsurance for Medicare-covered Benefits? Group 4 C Yes Group 5 Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply): Does the enrollee incur a cost in addition to the Coinsurance or Copay available? Select which Medicare-are Part B Chemotherapy Drugs C Xer Other Medicare Part B Drugs	
Indicate the selected group(s) for which the Maximum Plan Benefit C Every year Group 1 C Every year months Group 2 Is there an enrollee Coinsurance for Medicare-covered Benefits? Group 4 C Yes Group 5 Select which Medicare-covered Outpatient Drugs have a Coinsurance Operating a higher priced drug when a less expensive drug is available? Medicare Part B Chemotherapy Drugs Ves Indicate Maximum Enrollee Out-of-Pocket Cost? No Indicate Maximum Enrollee Select what combination of drug groups applies for Maximum Enrollee Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs: Select what combination of drug groups applies for Maximum Enrollee Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs: Group 1 Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs: Group 1 Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs: Indicate Maximum Enrollee Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs: Group 1 Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs: Group 1 Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs: Group 3 Indicate Maximum Coinsurance percentage for other Medicare Part	Indicate the selected group(s) for which the Maximum Plan Benefit C Every year Covery six wonths Every six months Group 1 C Every year Group 2 Every three months Group 3 Is there an enrollee Coinsurance for Medicare-covered Benefits? Group 4 C Yes Group 5 C No Dess the enrollee incur a cost in addition to the Coinsurance or Copay available? Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply): Corselecting a higher priced drug when a less expensive drug is available? Other Medicare Part B Orugs	
	No Indicate Minimum Collisionance percentage for Medicare Part B Is there a Maximum Enrollee Out-of-Pocket Cost? Indicate Minimum Collisionance percentage for Medicare Part B C No Indicate Minimum Coinsurance percentage for Medicare Part B C No Chemotherapy Drugs: Select what combination of drug groups applies for Maximum Enrollee Chemotherapy Drugs: Out-of-Pocket Cost: Indicate Minimum Coinsurance percentage for other Medicare Part B G roup 1 Indicate Minimum Coinsurance percentage for other Medicare Part B G roup 2 Indicate Minimum Coinsurance percentage for other Medicare Part B G roup 3 Drugs: G roup 4 Indicate Maximum Coinsurance percentage for other Medicare Part B	
		,

🧱 PBP Data Entry System - Section B-20, Contra	ct X0001, Plan 001, Segment 000
Eile Help Add Variable	Co: #20 Outpatient Drups - Rase 4
Exit Exit (No	Fo: #20 Outpatient Drugs - Base 4
Previous Next (Validate) Validate)	
Is there an enrollee Deductible?	Indicate Minimum Copayment amount for Medicare Part B Chemotherapy Drugs:
O Yes O No	Chemotherapy Drugs.
Select what combination of drug groups applies for Deductible:	Indicate Maximum Copayment amount for Medicare Part B
Group 1	Chemotherapy Drugs:
Group 3	
Group 4	
Group 5 Medicare Covered Benefits	Indicate Minimum Copayment for other Medicare Part B Drugs:
Indicate Deductible amount:	
	Indicate Maximum Copayment for other Medicare Part B Drugs:
Is there an enrollee Copayment for Medicare-covered Benefits?	
C Yes	Enrollee must receive Authorization for drugs from one or more of the followi
C No	Primary Care Physician (Internist/Family Practice, General Practice)
Select which Medicare-covered Outpatient Drugs have a Copayment	Physician Specialist/Dentist
(Select all that apply): Medicare Part B Chemotherapy Drugs	Organization Medical Director/Utilization Management/Utilization Review
C Other Medicare Part B Drugs	Cother, describe

#20 Outpatient Drugs – Notes

	Section B-20, Contract X0	001, Plan 001, Segment 000		_
ile <u>H</u> elp Add Variable	🗙 🛛 Go To: 🖡	20 Outpatient Drugs - Notes		
Previous Next (Valida	Go To: Exit (No te) Validate)			
tpatient Drugs Notes				
te may include additional information to	describe benefit in this service categ	ory. Do not repeat information captured in data e	ntry.	
tes:			A	

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#20 Outpatient Drugs – Group 1 – Base 1

PBP Data Entry System - Section B-20, Cont	tract X0001, Plan 001, Segment 000	-
Help Add Variable	Go To: #20 Outpatient Drugs - Group 1 - Base 1	
revious Next (Validate) Validate)		
elect a label for Group 1:	Indicate Maximum Plan Benefit Coverage annual amount for	
_	Group 1:	
	Indicate Maximum Plan Benefit Coverage semi-annual	
elect the drug type(s) covered for Group 1: Generic	amount for Group 1:	
Preferred Brand Brand		
	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:	
here a Maximum Plan Benefit Coverage amount for Group 1? Yes		
No	Indicate Maximum Plan Benefit Coverage monthly amount for	
icate Maximum Plan Benefit Coverage for Group 1 periodicity: Annually	Group 1:	
Semi-annually Quarterly	Indicate Maximum Plan Benefit Coverage amount per	
Monthly Per Prescription	prescription for Group 1:	
Other, describe		
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:	

#20 Outpatient Drugs – Group 1 – Base 2

Help Add Variable			
revious Next (Validate)	Go To: #20 Outpatient Drugs - Group 1 - Bas	e 2 🔽	
(validate) validate)			
ct from where Group 1 Drugs can be acquired: esignated Retail Pharmacy			
MO-Owned Pharmacy			
ail Order ther, describe			
re an enrollee Coinsurance for Group 1?	Is there an enrollee Copayment for Group 1?		
o	C No		
	and the structure tables and a second		
icate Coinsurance percentage for Group 1 Designated Retail irmacy:	Indicate Copayment amount for Group 1 Designated Retail Pharmacy:	Up to a day supply covered for Group 1 Designated Retail Pharmacy:	
cate Coinsurance percentage for Group 1 HMO-Owned	Indicate Copayment amount for Group 1	Up to a day supply covered for	
macy:	HMO-Owned Pharmacy:	Group 1 HMO-Owned Pharmacy:	
cate Coinsurance percentage for Group 1 Mail Order:	Indicate Copayment amount for Group 1	Up to a day supply covered for	
ate constrance percentage for Group 1 mail Order.	Mail Order:	Up to a day supply covered for Group 1 Mail Order:	
cate Coinsurance percentage for Group 1 Other:	Indicate Copayment amount for Group 1	Up to a day supply covered for	
	Other:	Group 1 Other:	

#20 Outpatient Drugs – Group 2 – Base 1

🔡 PBP Data Entry System - Section B-20,	Contract X0001, Plan 001, Segment 000	<u>- 8 ×</u>
Elle Help Add Variable	Go To: #20 Outpatient Drugs - Group 2 - Base 1	
Select a label for Group 2:	Indicate Maximum Plan Benefit Coverage annual amount for Group 2:	
Select the drug type(s) covered for Group 2: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:	
Is there a Maximum Plan Benefit Coverage amount for Group 2?	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:	
C Yes C No		
Indicate Maximum Plan Benefit Coverage for Group 2 periodicity: Annually Semi-annually	Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:	
Quarterly Monthly Per Prescription Other, describe	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:	
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:	

#20 Outpatient Drugs – Group 2 – Base 2

	1 B-20, Contract X0001, Plan 001, S	Segment 000	- 8 ×
Eile Help Add Variable	Go To: #20 Outpatient Drugs - Gro	oup 2 - Base 2	
Previous Next (Validate)	Validate)		
Select from where Group 2 Drugs can be acquired Designated Retail Pharmacy Mail Order Other, describe Is there an enrollee Coinsurance for Group 2? Yes No Indicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy: Indicate Coinsurance percentage for Group 2 for HMO-Owned Pharmacy: Indicate Coinsurance percentage for Group 2 for Mail Order: Indicate Coinsurance percentage for Group 2 for Other: Indicate Coinsurance percentage for Group 2 for Other:	Is there an enrollee Copayment for Group 2? C Yes No Indicate Copayment amount for Group 2 Designated Retail Pharmacy: Indicate Copayment amount for Group 2 HMO-Owned Pharmacy: Indicate Copayment amount for Group 2 Other: Indicate Copayment amount for Group 2 Other: Indicate Copayment amount for Group 2	Up to a day supply covered for Group 2 Designated Retail Pharmacy: Up to a day supply covered for Group 2 MMO-Owned Pharmacy: Up to a day supply covered for Group 2 Mail Order: Up to a day supply covered for Group 2 Other:	

#20 Outpatient Drugs – Group 3 – Base 1

	Contract X0001, Plan 001, Segment 000	_ 6
ile Help Add Variable	Go To: #20 Outpatient Drugs - Group 3 - Base 1	
Previous Next (Validate) Validat		_
ect a label for Group 3:	Indicate Maximum Plan Benefit Coverage annual amount for Group 3:	
lect the drug type(s) covered for Group 3: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 3:	
there a Maximum Plan Benefit Coverage amount for oup 3?	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3:	
Yes		
dicate Maximum Plan Benefit Coverage Group 3 riodicity: Annually	Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:	
Semi-annually Quarterly Monthly Per Prescription	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 3:	
Other, describe	Indicate Maximum Plan Benefit Coverage amount for Other for Group 3:	

#20 Outpatient Drugs – Group 3 – Base 2

📓 PBP Data Entry System - Section B-20,	Contract X0001, Plan 001, Segr	nent 000	- 8 ×
Eile Help Add Variable	Go To: #20 Outpatient Drugs - Group 3	Base 2	
Previous Next (Validate) Validate)			
Select from where Group 3 Drugs can be acquired: Designated Retail Pharmacy HMO-Owned Pharmacy Other, describe Is there an enrollee Coinsurance for Group 3? Yes No Indicate Coinsurance percentage for Group 3 Designated Retail Pharmacy: Indicate Coinsurance percentage for Group 3 HMO-Owned Pharmacy: Indicate Coinsurance percentage for Group 3 Mail Order: Indicate Coinsurance percentage for Group 3 Mail Order: Indicate Coinsurance percentage for Group 3 Other:	Is there an enrollee Copayment for Group 3? C Yes No Indicate Copayment amount for Group 3 Designated Retail Pharmacy: Indicate Copayment amount for Group 3 HMO-Owned Pharmacy: Indicate Copayment amount for Group 3 Mail Order: Indicate Copayment amount for Group 3 Other: Indicate Copayment amount for Group 3 Other: Indicate Copayment amount for Group 3	Up to aday supply covered for Group 3 Designated Retail Pharmacy: Up to aday supply covered for Group 3 HMC-Owned Pharmacy: Up to aday supply covered for Group 3 Office: Up to aday supply covered for Group 3 Office:	

Fu Associates, Ltd.

#20 Outpatient Drugs – Group 4 – Base 1

🔡 PBP Data Entry System - Section B-20, (Contract X0001, Plan 001, Segment 000
Eile Help Add Variable Previous Next Exit (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 Prefered Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 4:
Is there a Maximum Plan Benefit Coverage amount for Group 4? C Yes	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4:
C No 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

🔜 PBP Data Entry System - Section B-20, C	Contract X0001, Plan 001, Segm	ient 000	_ 8 ×
Eile Help Add Variable	Go To: #20 Outpatient Drugs - Group 4 - I	Base 2	
Previous Next (Validate) Validate)			
Previous Next (Validate) Validate) Select from where Group 4 Drugs can be acquired:	Is there an enrollee Copayment for Group 4? Yes No Indicate Copayment amount for Group 4 Designated Retail Pharmacy: Indicate Copayment amount for Group 4 HMO-Owned Pharmacy: Indicate Copayment amount for Group 4 dial Order: Indicate Copayment amount for Group 4 Other:	Up to aday supply covered for Group 4 Designated Retail Pharmacy: Up to aday supply covered for Group 4 HMO-Owned Pharmacy: Up to aday supply covered for Group 4 Mail Order: Up to aday supply covered for Group 4 Other:	

#20 Outpatient Drugs – Group 5 – Base 1

🔡 PBP Data Entry System - Section B-20, C	Contract X0001, Plan 001, Segment 000	- 8 ×
Eile Help Add Variable 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 Group 5?	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:	
No Indicate Maximum Plan Benefit Coverage for Group 5 periodicity: Annually Semi-annually	Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:	
Quarterly Monthly 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

PBP Data Entry System - Section B-20,	, Contract X0001, Plan 001, Segr	ient 000	<u>-</u> [
Help Add Variable	Go To: #20 Outpatient Drugs - Group 5	Base 2	
evious Next (Validate) Validate	o e)		
lect from where Group 5 Drugs can be acquired:			
Designated Retail Pharmacy HMO-Owned Pharmacy			
Mail Order Other, describe			
there an enrollee Coinsurance for Group 5?	Is there an enrollee Copayment for Group 5?		
Yes	C Yes		
No	C No		
ndicate Coinsurance percentage for Group 5 lesignated Retail Pharmacy:	Indicate Copayment amount for Group 5 Designated Retail Pharmacy:	Up to a day supply covered for Group 5 Designated Retail Pharmacy:	
ndicate Coinsurance percentage for Group 5 HMO-)wned Pharmacy:	Indicate Copayment amount for Group 5 HMO-Owned Pharmacy:	Up to a day supply covered for Group 5 HMO-Owned Pharmacy:	
whee Phannacy.			
ndicate Coinsurance percentage for Group 5 Mail Ord	Indicate Copayment amount for Group 5	Up to a day supply covered for	
	Mail Order:	Group 5 Mail Order:	
	.		
ndicate Coinsurance percentage for Group 5 Other:	Indicate Copayment amount for Group 5 Other:	Up to a day supply covered for Group 5 Other:	

#20 Home Infusion Bundled Services

📕 PBP Data Entry System - Section B-20, Contract X0	0001, Plan 001, Segment 000
Eile Help Add Variable	#20 Home Infusion Bundled Services
Exit Exit (No Validate) Validate)	
Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?	
C Yes C No	
If you select 'Yes' to 'Does the plan provide PartD home influsion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flatfile which must be uploaded through the Formulary Submission Module by Friday, June 10, 2016 at 11:59am Eastern Time.	of
You must also ensure that your benefit includes not only the home infusion drug but any services and supplies associated with the home infusion drug's administration.	э.
If your organization elects to provide Part D home infusion drugs as part of a bundled service then those services must be provided at \$0 cost sharing. As described in the CV 2010 Call Letter this waiver is conditioned on the applicatio of zero cost sharing for the bundle of home infusion services provided under a supplemental benefit.	n