

CY 2017 PBP Data Entry System Screens

Plan Deductible LPPO/RPPO Base 1

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

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Go To: Plan Deductible LPPO/RPPO Base 1

Previous Next Exit (Validate) Exit (No Validate)

Do you offer a Deductible?
 Yes
 No

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

Indicate Deductible Amount:

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

LPPO and RPPO plans must include ALL OON Medicare-covered Services in the Deductible, 14a preventive services may not be included in the In-Network deductible. If the plan chooses to use the 2016 Original Medicare amounts, please verify that any differential deductibles that are selected will not exceed the 2016 Original Medicare amounts that will be released by CMS.

Do you include 14a Medicare-covered Zero Dollar Preventive Services as part of your OON Medicare-covered Services Deductible?
 Yes
 No

Select the Service Categories that apply to your Deductible (Optional):
 In-Network Medicare-covered benefits
 In-Network Non-Medicare-covered benefits
 Out-of-Network Non-Medicare-covered benefits

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

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

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

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

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Plan Deductible LPPO/RPPO Base 2

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

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

Yes
 No

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

- 1a: Inpatient Hospital Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services
- 10b: Transportation Services
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 13g: Dual Eligible SNP with Highly Integrated Services
- 14b: Annual Physical Exam
- 14c: Eligible Supplemental Benefits as Defined in Chapter 4
- 15: Medicare Part B Rx Drugs
- 16a: Preventive Dental
- 16b: Comprehensive Dental
- 17a: Eye Exams
- 17b: Eyewear
- 18a: Hearing Exams

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

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

Yes
 No

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

- 1a: Inpatient Hospital Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services
- 10b: Transportation Services
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 13g: Dual Eligible SNP with Highly Integrated Services
- 14b: Annual Physical Exam
- 14c: Eligible Supplemental Benefits as Defined in Chapter 4
- 15: Medicare Part B Rx Drugs
- 16a: Preventive Dental
- 16b: Comprehensive Dental
- 17a: Eye Exams
- 17b: Eyewear
- 18a: Hearing Exams

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Plan Deductible LPPO/RPPO Base 3

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Previous Next Exit (Validate) Exit (No Validate)

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

Yes
 No

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

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

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

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Plan Deductible LPPO/RPPO Base 4

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

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Go To: Plan Deductible LPPO/RPPO Base 4

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

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

Indicate Differential Deductible Amounts for Skilled Nursing Facility (SNF) including Tiers 1, 2, and 3, where appropriate:

Indicate Differential Deductible Amount for Cardiac and Pulmonary Rehabilitation Services:

Indicate Differential Deductible Amount for Worldwide Emergency/Urgent Coverage:

Indicate Differential Deductible Amount for Partial Hospitalization:

Indicate Differential Deductible Amount for Home Health Services:

Indicate Differential Deductible Amount for Primary Care Physician Services:

Indicate Differential Deductible Amount for Chiropractic Services:

Indicate Differential Deductible Amount for Occupational Therapy Services:

Indicate Differential Deductible Amount for Physician Specialist Services:

Note: No single Differential Deductible can be greater than the deductible. The total of all of the Differential Deductibles can be greater than the deductible.

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Plan Deductible LPPO/RPPO Base 5

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✔ Exit (Validate)
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Indicate Differential Deductible Amount for Mental Health Specialty Services - Non-Psychiatric: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Outpatient Diagnostic and Therapeutic Radiological Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Transportation Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for OTC: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Podiatry Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Outpatient Hospital Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Durable Medical Equipment (DME): <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Meal Benefit: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Other Health Care Professional Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Ambulatory Surgical Center (ASC) Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Prosthetics/Medical Supplies: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Other 1: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Psychiatric Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Outpatient Substance Abuse Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Diabetic Supplies and Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Other 2: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Physical Therapy and Speech-Language Pathology Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Outpatient Blood Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Dialysis Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Other 3: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Outpatient Diagnostic Procedures and Test and Lab Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Ambulance Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Acupuncture: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Dual Eligible SNPs with Highly Integrated Services: <input style="width: 100%;" type="text"/>

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Plan Deductible LPPO/RPPO Base 6

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

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Go To: Plan Deductible LPPO/RPPO Base 6

Previous Next Exit (Validate) Exit (No Validate)

Indicate Differential Deductible Amount for the Annual Physical Exam: <input type="text"/>	Indicate Differential Deductible Amount for Preventive Dental: <input type="text"/>	Indicate Differential Deductible Amount for Hearing Aids: <input type="text"/>
Indicate Differential Deductible Amount for Eligible Supplemental Benefits as Defined in Chapter 4: <input type="text"/>	Indicate Differential Deductible Amount for Comprehensive Dental: <input type="text"/>	
Indicate Differential Deductible Amount for Kidney Disease Education Services: <input type="text"/>	Indicate Differential Deductible Amount for Eye Exams: <input type="text"/>	
Indicate Differential Deductible Amount for Other Medicare-covered Preventive Services: <input type="text"/>	Indicate Differential Deductible Amount for Eyewear: <input type="text"/>	
Indicate Differential Deductible Amount for Medicare Part B Rx Drugs: <input type="text"/>	Indicate Differential Deductible Amount for Hearing Exams: <input type="text"/>	

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Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 1

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Go To: **Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 1**

Previous Next Exit (Validate) Exit (No Validate)

Select the mandatory enhanced benefits that will receive deductible amounts:

- 1a: Inpatient Hospital Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3: Cardiac and Pulmonary Rehabilitation Services
- 4c: Worldwide Emergency/Urgent Coverage
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e: Mental Health Specialty Services
- 7f: Podiatry Services
- 7g: Other Health Care Professional

Indicate deductible for one or more of the following services

	Deductible Amount
Inpatient Hospital Acute	<input type="text"/>
Inpatient Hospital Psychiatric	<input type="text"/>
Skilled Nursing Facility (SNF)	<input type="text"/>
Cardiac and Pulmonary Rehabilitation Services	<input type="text"/>
Worldwide Emergency/Urgent Coverage	<input type="text"/>
Partial Hospitalization	<input type="text"/>
Home Health Services	<input type="text"/>
Primary Care Physician Services	<input type="text"/>
Chiropractic Services	<input type="text"/>
Occupational Therapy Services	<input type="text"/>
Physician Specialist Services	<input type="text"/>
Mental Health Specialty Services	<input type="text"/>
Podiatry Services	<input type="text"/>

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Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 2

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✔ Exit (Validate)
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Indicate deductible for one or more of the following services

	Deductible Amount		Deductible Amount		Deductible Amount
Other Health Care Professional	<input type="text"/>	Dialysis Services	<input type="text"/>	Telemonitoring Services	<input type="text"/>
Psychiatric Services	<input type="text"/>	Acupuncture	<input type="text"/>	Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)	<input type="text"/>
Physical Therapy and Speech-Language Pathology Services	<input type="text"/>	Over-the-Counter (OTC) Items	<input type="text"/>	Bathroom Safety Devices	<input type="text"/>
Diagnostic Procedures/Tests/Lab Services	<input type="text"/>	Meal Benefit	<input type="text"/>	Counseling Services	<input type="text"/>
Outpatient Diagnostic/Therapeutic Radiological Services	<input type="text"/>	Other 1	<input type="text"/>	In-Home Safety Assessment	<input type="text"/>
Outpatient Hospital Services	<input type="text"/>	Other 2	<input type="text"/>	Personal Emergency Response System (PERS)	<input type="text"/>
Ambulatory Surgical Center (ASC) Services	<input type="text"/>	Other 3	<input type="text"/>	Medical Nutrition Therapy (MNT)	<input type="text"/>
Outpatient Substance Abuse	<input type="text"/>	Dual Eligible SNP with Highly Integrated Services	<input type="text"/>	Post discharge In-home Medication Reconciliation	<input type="text"/>
Outpatient Blood Services	<input type="text"/>	Annual Physical Exam	<input type="text"/>	Re-admission Prevention	<input type="text"/>
Ambulance Services	<input type="text"/>	Health Education	<input type="text"/>	Wigs for Hair Loss Related to Chemotherapy	<input type="text"/>
Transportation Services	<input type="text"/>	Nutritional/Dietary Benefit	<input type="text"/>	Weight Management Programs	<input type="text"/>
Durable Medical Equipment (DME)	<input type="text"/>	Additional sessions of Smoking and Tobacco Cessation Counseling	<input type="text"/>	Alternative Therapies	<input type="text"/>
Prosthetics/Medical Supplies	<input type="text"/>	Fitness Benefit	<input type="text"/>	Kidney Disease Education Services	<input type="text"/>
Diabetic Supplies and Services	<input type="text"/>	Enhanced Disease Management	<input type="text"/>	Glaucoma Screening	<input type="text"/>

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Plan Deductible (In-Network)

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

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Go To: Plan Deductible (In-Network)

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Is there an In-Network Plan Deductible?
 Yes
 No

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

Indicate In-Network Plan Deductible Amount:

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

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

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

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

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

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

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

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

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

CY 2017 PBP Data Entry System Screens

Plan Deductible (Combined) – Base 1

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Go To: Plan Deductible (Combined) - Base 1

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

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

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

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

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

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

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

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

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

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

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

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

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Plan Deductible (Combined) – Base 2

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Go To: Plan Deductible (Combined) - Base 2

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

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

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

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

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

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

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

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

CY 2017 PBP Data Entry System Screens

Plan Deductible (Out-of-Network)

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Go To: Plan Deductible (Out-of-Network)

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Is there an Out-of-Network (OON) Plan Deductible?
 Yes
 No

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

Indicate Out-of-Network Plan Deductible Amount:

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

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

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

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

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

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

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

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

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

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Plan Deductible (Non-Network)

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Go To: Plan Deductible (Non-Network)

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Is there a Plan Deductible?
 Yes
 No

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

Indicate Plan Deductible Amount:

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

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

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

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

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

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

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

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

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

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Max Enrollee Cost Limit (In-Network)

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Go To: Max Enrollee Cost Limit (In-Network)

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✔ Exit (Validate)
✘ Exit (No Validate)

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

Yes
 No

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

Voluntary
 Mandatory

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

Note for D-SNPs: For purposes of submitting bids to CMS, D-SNPs must include Parts A, B, and Part D Medicare services in the PBP, along with approved optional and mandatory supplemental benefits. No Medicaid benefits may be included in the PBP. D-SNPs have the flexibility to establish \$0 as the MOOP amount, thereby guaranteeing there is no cost sharing for plan enrollees, including those who are liable for Medicare cost sharing. Otherwise, if the D-SNP does charge cost sharing for covered services (or non-covered), it must track enrollees' out-of-pocket spending and it is up to the plan to develop the process and vehicle for doing so.

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

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

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

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

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

Yes
 No

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

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

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

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

Yes
 No

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

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

1a: Inpatient Hospital Acute
1b: Inpatient Hospital Psychiatric
2: Skilled Nursing Facility (SNF)
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: Pulmonary Rehabilitation Services
4c: Worldwide Emergency/Urgent Coverage
6: Home Health Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7f: Podiatry Services

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CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

CY 2017 PBP Data Entry System Screens

Max Enrollee Cost Limit (Combined) – Base 1

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

File Help Add Variable

Go To: Max Enrollee Cost Limit (Combined) – Base 1

Previous Next Exit (Validate) Exit (No Validate)

Is there a Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

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

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

Note for D-SNPs: For purposes of submitting bids to CMS, D-SNPs must include Parts A, B, and Part D Medicare services in the PBP, along with approved optional and mandatory supplemental benefits. No Medicaid benefits may be included in the PBP. D-SNPs have the flexibility to establish \$0 as the MOOP amount, thereby guaranteeing there is no cost sharing for plan enrollees, including those who are liable for Medicare cost sharing. Otherwise, if the D-SNP does charge cost sharing for covered services (or non-covered), it must track enrollees' out-of-pocket spending and it is up to the plan to develop the process and vehicle for doing so.

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

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

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

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

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

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

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

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

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

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

CY 2017 PBP Data Entry System Screens

Max Enrollee Cost Limit (Combined) – Base 2

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

File Help Add Variable

Go To: Max Enrollee Cost Limit (Combined) - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

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

Yes
 No

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

Yes
 No

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

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

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

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

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

CY 2017 PBP Data Entry System Screens

Max Enrollee Cost Limit (Out-of-Network)

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

File Help Add Variable

Go To: Max Enrollee Cost Limit (Out-of-Network)

Previous Next Exit (Validate) Exit (No Validate)

Is there an Out-of-Network Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

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

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

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

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

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

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

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

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

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

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

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

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

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

CY 2017 PBP Data Entry System Screens

Max Enrollee Cost Limit (Non-Network)

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

File Help Add Variable

Go To: Max Enrollee Cost Limit (Non-Network)

Previous Next Exit (Validate) Exit (No Validate)

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

Voluntary
 Mandatory

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

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

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

Medicare-covered benefits
 Non-Medicare-covered benefits

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

Yes
 No

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

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

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

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

Yes
 No

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

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

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

CY 2017 PBP Data Entry System Screens

Max Plan Benefit Coverage

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

File Help Add Variable

Go To: Max Plan Benefit Coverage

Previous Next Exit (Validate) Exit (No Validate)

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

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

Yes
 No

Is there a Maximum Plan Benefit Coverage Amount?
 Yes
 No

Indicate Maximum Plan Benefit Coverage Amount:

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

Select the benefits that apply to the Maximum Plan Benefit Coverage Amount:
 In-Network Non-Medicare-covered benefits
 Out-of-Network Non-Medicare-covered benefits

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

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

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

Does the Maximum Plan Benefit Coverage amount apply to all Out-of-Network Non-Medicare-covered plan services?
 Yes
 No

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

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

- 1a: Inpatient Hospital Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 4c: Worldwide Emergency/Urgent Coverage
- 6: Home Health Services

CY 2017 PBP Data Entry System Screens

Max Plan Benefit Coverage (Non-Network)

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

File Help Add Variable

Go To: Max Plan Benefit Coverage (Non-Network)

Previous Next Exit (Validate) Exit (No Validate)

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

Is there a Maximum Plan Benefit Coverage Amount?

Yes
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity

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

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

Yes
 No

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

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

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

CY 2017 PBP Data Entry System Screens

Plan Premium/Rebate Reduction

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

File Help Add Variable

Go To: Plan Premium/Rebate Reduction

Previous Next Exit (Validate) Exit (No Validate)

Indicate Plan Premium Amount (Part A/B):

Indicate Plan Premium Amount (B Only):

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

Indicate the Part B Premium reduction amount:

CY 2017 PBP Data Entry System Screens

MMP – Medicaid/plan covered cost sharing

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

File Help Add Variable

Go To: MMP - Medicaid/plan covered cost sharing

Previous Next Exit (Validate) Exit (No Validate)

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

Yes
 No

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

Select all of the benefits that are covered under Medicaid:

- 1a1: Additional Days for Inpatient Hospital Acute
- 1a2: Non-Medicare-covered Stay for Inpatient Hospital Acute
- 1a3: Upgrades for Inpatient Hospital Acute
- 1b1: Additional Days for Inpatient Hospital Psychiatric
- 1b2: Non-Medicare-covered Stay for Inpatient Hospital Psychiatric
- 2-1: Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)
- 2-2: Non-Medicare-covered Stay for Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 4c: Worldwide Emergency/Urgent Coverage
- 6-1: Additional Hours of Care
- 6-2: Personal Care Services
- 6-3: Other 1 for Home Health Services
- 6-4: Other 2 for Home Health Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7f: Podiatry Services
- 7f1: Other 1 for PT and SP Services
- 7f2: Other 2 for PT and SP Services
- 9d: Outpatient Blood Services
- 10b1: Transportation Services - Plan Approved Location
- 10b2: Transportation Services - Any Location
- 11a1: Durable Medical Equipment for use outside the home
- 11a2: Other 1 for Durable Medical Equipment

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

- 1a1: Additional Days for Inpatient Hospital Acute
- 1a2: Non-Medicare-covered Stay for Inpatient Hospital Acute
- 1a3: Upgrades for Inpatient Hospital Acute
- 1b1: Additional Days for Inpatient Hospital Psychiatric
- 1b2: Non-Medicare-covered Stay for Inpatient Hospital Psychiatric
- 2-1: Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)
- 2-2: Non-Medicare-covered Stay for Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 4c: Worldwide Emergency/Urgent Coverage
- 6-1: Additional Hours of Care
- 6-2: Personal Care Services
- 6-3: Other 1 for Home Health Services
- 6-4: Other 2 for Home Health Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7f: Podiatry Services
- 7f1: Other 1 for PT and SP Services
- 7f2: Other 2 for PT and SP Services
- 9d: Outpatient Blood Services
- 10b1: Transportation Services - Plan Approved Location
- 10b2: Transportation Services - Any Location
- 11a1: Durable Medical Equipment for use outside the home

CY 2017 PBP Data Entry System Screens

PFFS Balance Billing

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File", "Help", and "Add Variable". Below the menu bar are navigation buttons: "Previous" (left arrow), "Next" (right arrow), "Exit (Validate)" (green checkmark), and "Exit (No Validate)" (red X). A "Go To:" dropdown menu is set to "PFFS Balance Billing".

The main content area contains the following sections:

- Do you permit balance billing?** with radio buttons for "Yes" and "No".
- Balance Billing is a percentage of plan payment rate provider may collect.**
- Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.**
- Enter Minimum percentage for balance billing:** with an input field.
- What category of providers do you permit to balance bill?** with a list box containing the following categories:
 - 1a: Inpatient Hospital Acute
 - 1b: Inpatient Hospital Psychiatric
 - 2: Skilled Nursing Facility (SNF)
 - 3-1: Cardiac Rehabilitation Services
 - 3-2: Intensive Cardiac Rehabilitation Services
 - 3-3: Pulmonary Rehabilitation Services
 - 4a: Emergency Care
 - 4b: Urgently Needed Services
 - 5: Partial Hospitalization
 - 6: Home Health Services
 - 7a: Primary Care Physician Services
 - 7b: Chiropractic Services
 - 7c: Occupational Therapy Services
 - 7d: Physician Specialist Services
 - 7e: Mental Health Specialty Services
 - 7f: Podiatry Services
 - 7g: Other Health Care Professional
 - 7h: Psychiatric Services
 - 7i: Physical Therapy and Speech-Language Pathology Services
 - 8a: Diagnostic Procedures/Tests/Lab Services
 - 8b: Outpatient Diagnostic/Therapeutic Radiological Services
 - 9a: Outpatient Hospital Services
 - 9b: Ambulatory Surgical Center (ASC) Services
 - 9c: Outpatient Substance Abuse
 - 9d: Outpatient Blood Services
 - 10a: Ambulance Services
- Enter Maximum percentage for balance billing:** with an input field.

CY 2017 PBP Data Entry System Screens

MSA Annual Deductible/Deposit

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File", "Help", and "Add Variable". Below the menu bar is a navigation area with "Previous" and "Next" buttons, "Exit (Validate)" and "Exit (No Validate)" buttons, and a "Go To:" dropdown menu currently set to "MSA Annual Deductible/Deposit". The main content area contains two input fields: "Indicate Annual MSA Deductible amount:" and "Indicate the Annual amount CMS will deposit into the Enrollee MSA".

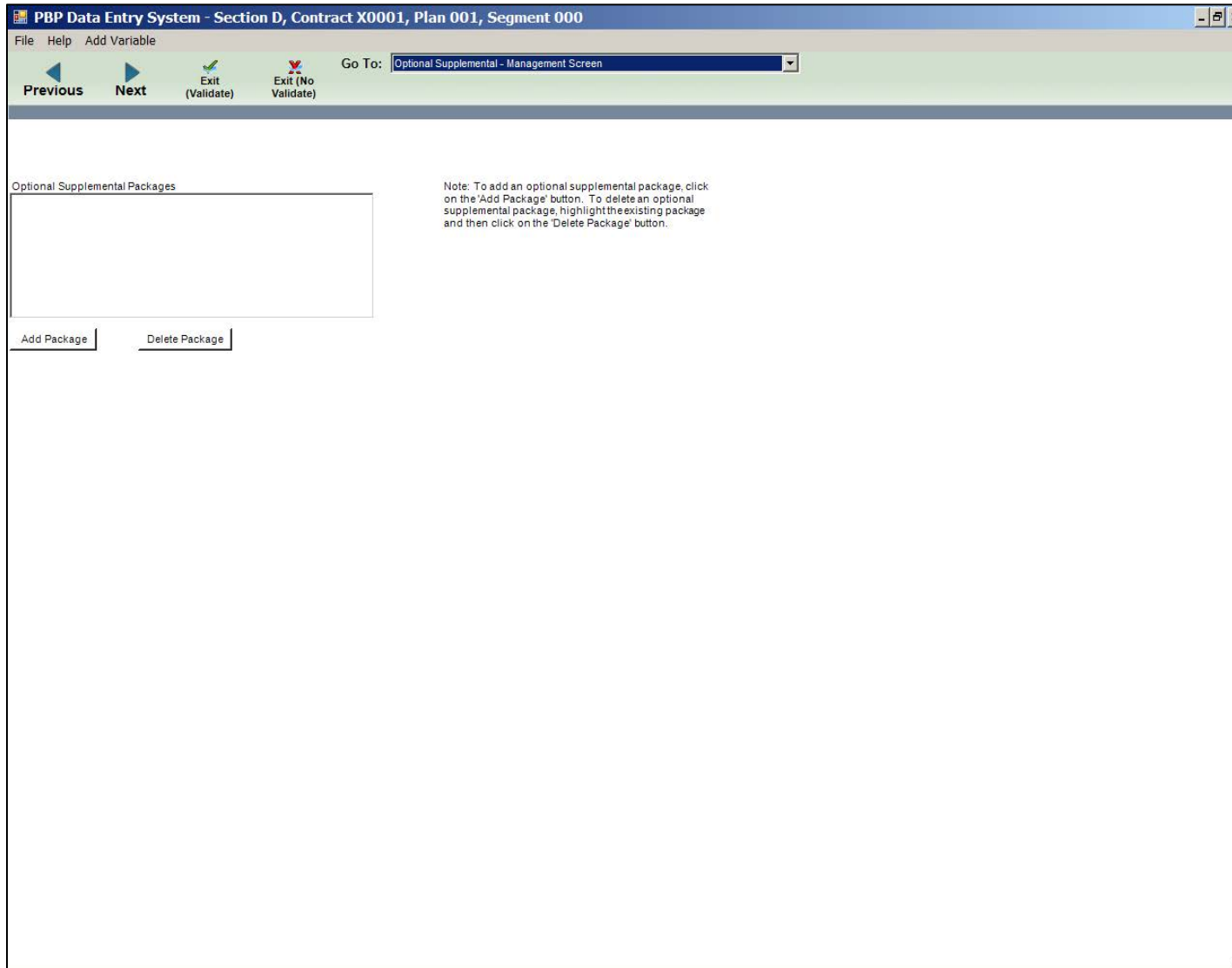
CY 2017 PBP Data Entry System Screens

Notes

The screenshot displays a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File", "Help", and "Add Variable". Below the menu bar is a navigation toolbar with buttons for "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)", along with a "Go To:" dropdown menu currently set to "Notes". A text instruction reads: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." The main area contains two empty text input fields, each labeled "Notes:" with a vertical scrollbar on the right side.

CY 2017 PBP Data Entry System Screens

Optional Supplemental – Management Screen



CY 2017 PBP Data Entry System Screens

Optional Supplemental – Label and Premium

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

The main content area is divided into several sections:

- Optional Supplemental Benefits ID:** A text input field.
- Optional Supplemental Package Description:** A text input field.
- Indicate Optional Supplemental Premium Amount:** A text input field.
- Is there a Maximum Plan Benefit Coverage Amount for this package?** Radio buttons for "Yes" and "No".
- Indicate Maximum Plan Benefit Coverage Amount for this package:** A text input field.
- Select the Maximum Plan Benefit Coverage periodicity:** Radio buttons for "Every three years", "Every two years", "Every year", "Every six months", "Every three months", and "Other, Describe".
- Is there an enrollee Deductible for this package?** Radio buttons for "Yes" and "No".
- Indicate Deductible Amount:** A text input field.
- Select the benefits to which the deductible applies:** A scrollable list of service categories including:
 - 1a: Inpatient Hospital Acute
 - 1b: Inpatient Hospital Psychiatric
 - 2: Skilled Nursing Facility (SNF)
 - 3-1: Cardiac Rehabilitation Services
 - 3-2: Intensive Cardiac Rehabilitation Services
 - 3-3: Pulmonary Rehabilitation Services
 - 4a: Emergency Care
 - 4b: Urgently Needed Services
 - 4c: Worldwide Emergency/Urgent Coverage
 - 5: Partial Hospitalization
 - 6: Home Health Services
 - 7a: Primary Care Physician Services
 - 7b: Chiropractic Services
 - 7c: Occupational Therapy Services
 - 7d: Physician Specialist Services
 - 7e: Mental Health Specialty Services
 - 7f: Podiatry Services
 - 7g: Other Health Care Professional
 - 7h: Psychiatric Services
 - 7i: Physical Therapy and Speech-Language Pathology Services
 - 8a: Diagnostic Procedures/Tests/Lab Services
 - 8b: Outpatient Diagnostic/Therapeutic Radiological Services
- Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.**
- Notes:** A text input field for additional notes.

CY 2017 PBP Data Entry System Screens

Optional Supplemental – Service Categories

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

File Help Add Variable

Go To: **Optional Supplemental - Service Categories**

Previous Next Exit (Validate) Exit (No Validate)

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

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

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

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

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

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

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

Important: The following examples cannot be an optional supplemental benefit:
 (1) cost-share buy-down of original Medicare benefits and (2) State Medicaid wraparound benefits. Please refer to Chapter 4 of the Medicare Managed Care Manual and the MA Regulation (CFR § 422.102) for additional information.

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

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

CY 2017 PBP Data Entry System Screens

Optional Supplemental – OON Optional

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

The main content area contains several sections of data entry fields:

- Does this category include Out-of-Network benefits?** with radio buttons for "Yes" and "No".
- Are the OON cost shares the same as the In-Network cost shares?** with radio buttons for "Yes" and "No".
- Is there an OON Coinsurance?** with radio buttons for "Yes" and "No".
- Enter Minimum Coinsurance Percentage:** and **Enter Maximum Coinsurance Percentage:** text input fields.
- Is there an OON Copayment?** with radio buttons for "Yes" and "No".
- Enter Minimum Copayment Amount:** and **Enter Maximum Copayment Amount:** text input fields.
- Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.** followed by a **Notes:** text area.

CY 2017 PBP Data Entry System Screens

Optional Supplemental – OON Step-up

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

File Help Add Variable

Go To: **Optional Supplemental - OON Step-up**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

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

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

Is there an OON Coinsurance?
 Yes
 No

Enter Minimum Coinsurance Percentage:

Enter Maximum Coinsurance Percentage:

Is there an OON Copayment?
 Yes
 No

Enter Minimum Copayment Amount:

Enter Maximum Copayment Amount:

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

Notes:

CY 2017 PBP Data Entry System Screens

Step-up #7b Chiropractic Services – Base 1

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

File Help Add Variable

Go To: **Step-up #7b Chiropractic Services - Base 1**

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

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

Select enhanced benefit:
 Routine Care/Other

Select type of benefit for Routine Care/Other:
 Mandatory
 Optional

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

Indicate number of visits for Routine Care/Other:

Do you offer a combined Acupuncture and Chiropractor Services benefit?
 Yes
 No

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

CY 2017 PBP Data Entry System Screens

Step-up #7b Chiropractic Services – Base 2

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

File Help Add Variable

Go To: Step-up #7b Chiropractic Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?

Yes
 No

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

Medicare-covered Chiropractic Services
 Routine Care/Other

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

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

Indicate the Minimum Coinsurance percentage per visit for Routine Care/Other:

Indicate the Maximum Coinsurance percentage per visit for Routine Care/Other:

CY 2017 PBP Data Entry System Screens

Step-up #7b Chiropractic Services – Base 3

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

File Help Add Variable

Go To: **Step-up #7b Chiropractic Services - Base 3**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Indicate Minimum Copayment amount per visit for Routine Care/Other:

Indicate Maximum Copayment amount per visit for Routine Care/Other:

Is there an enrollee Copayment?
 Yes
 No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

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

Is a referral required for Chiropractic Services?
 Yes
 No

CY 2017 PBP Data Entry System Screens

Step-up #7b Chiropractic Services – Base 4

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

File Help Add Variable

Previous Next Exit (Validate) Exit (No Validate) Go To: Step-up #7b Chiropractic Services - Base 4

Chiropractic Services Notes

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

Notes:

[Empty text input field with scrollbar]

CY 2017 PBP Data Entry System Screens

Step-up #7f Podiatry Services – Base 1

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

File Help Add Variable

Go To: **Step-up #7f Podiatry Services – Base 1**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

CLICK FOR DESCRIPTION OF BENEFIT

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

Select enhanced benefits:
 Routine Foot Care

Select type of benefit for Routine Foot Care:
 Mandatory
 Optional

Is this benefit unlimited for Routine Foot Care?
 Yes
 No

Indicate number of Routine Foot Care visits:

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

CY 2017 PBP Data Entry System Screens

Step-up #7f Podiatry Services – Base 2

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

File Help Add Variable

Go To: **Step-up #7f Podiatry Services - Base 2**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Is there an enrollee Coinsurance?
 Yes
 No

Is there an enrollee Copayment?
 Yes
 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?
 Yes
 No

Indicate Deductible Amount:

CY 2017 PBP Data Entry System Screens

Step-up #7f Podiatry Services – Base 3

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File", "Help", and "Add Variable". Below the menu is a navigation bar with buttons for "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)", along with a "Go To:" dropdown menu currently set to "Step-up #7f Podiatry Services – Base 3".

The main content area contains the following sections:

- Enrollee must receive Authorization from one or more of the following:**
 - None
 - Primary Care Physician (Internist/Family Practice, General Practice)
 - Physician Specialist
 - Organization Medical Director/Utilization Management/Utilization Review
 - Other, describe
- Is a referral required for Podiatrist Services?**
 - Yes
 - No
- Podiatry Services Notes**

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

A large text area for entering notes, currently empty.

CY 2017 PBP Data Entry System Screens

Step-up #10b Transportation Services – Base 1

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

File Help Add Variable

Go To: Step-up #10b Transportation Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

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

Select enhanced benefit:
 Plan-approved Location
 Any Location

Select type of benefit for Plan-approved Location:
 Mandatory
 Optional

Is this benefit unlimited for number of trips for Plan-approved Location?
 Yes
 No

Indicate number of trips for Plan-approved Location:
[]

Select Plan-approved Location Trips periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Select Type of Transportation for Plan-approved Location:
 One-way
 Round Trip
 Days
 Other, describe

Indicate number of days for Plan-approved Location:
[]

Select Mode of Transportation for Plan-approved Location:
 Taxi
 Bus/Subway
 Van
 Medical Transport
 Other, describe

Select type of benefit for Any Location:
 Mandatory
 Optional

Is this benefit unlimited for number of trips for Any Location?
 Yes
 No

Indicate number of trips for Any Location:
[]

Select Any Location Trips periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Select Type of Transportation for Any Location:
 One-way
 Round Trip
 Days
 Other, describe

Indicate number of days for Any Location:
[]

Select Mode of Transportation for Any Location:
 Taxi
 Bus/Subway
 Van
 Medical Transport
 Other, describe

CY 2017 PBP Data Entry System Screens

Step-up #10b Transportation Services – Base 2

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

File Help Add Variable

Go To: Step-up #10b Transportation Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Plan Benefit Coverage amount: <input type="text"/></p> <p>Select Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Enrollee Out-of-Pocket Cost amount: <input type="text"/></p> <p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Minimum Coinsurance percentage: <input type="text"/></p> <p>Indicate Maximum Coinsurance percentage: <input type="text"/></p> <p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Deductible Amount: <input type="text"/></p>
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CY 2017 PBP Data Entry System Screens

Step-up #10b Transportation Services – Base 3

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

File Help Add Variable

Go To: Step-up #10b Transportation Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?

Yes

No

Indicate Minimum Copayment amount per trip:

Indicate Maximum Copayment amount per trip:

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

None

Primary Care Physician (Internist/Family Practice, General Practice)

Physician Specialist

Organization Medical Director/Utilization Management/Utilization Review

Other, describe

Is a referral required for Transportation Services?

Yes

No

Transportation Services Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

Step-up #16a Preventive Dental – Base 1

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

File Help Add Variable

Go To: **Step-up #16a Preventive Dental - Base 1**

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

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

Yes
 No

Select enhanced benefits:

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

Select type of benefit for Oral Exams:

Mandatory
 Optional

Is this benefit unlimited for Oral Exams?

Yes
 No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

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

Select type of benefit for Prophylaxis (Cleaning):

Mandatory
 Optional

Is this benefit unlimited for Prophylaxis (Cleaning)?

Yes
 No, indicate number

Indicate number of visits for Prophylaxis (Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

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

Select type of benefit for Fluoride Treatment:

Mandatory
 Optional

Is this benefit unlimited for Fluoride Treatment?

Yes
 No, indicate number

Indicate number of visits for Fluoride Treatment:

Select the Fluoride Treatment periodicity:

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

CY 2017 PBP Data Entry System Screens

Step-up #16a Preventive Dental – Base 2

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

File Help Add Variable

Go To: **Step-up #16a Preventive Dental - Base 2**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Select type of benefit for Dental X-Rays:
 Mandatory
 Optional

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

Is this benefit unlimited for Dental X-Rays?
 Yes
 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?
 In-network services only
 Both In-network and Out-of-network services

Indicate number of visits for Dental X-Rays:

Indicate Maximum Plan Benefit Coverage amount:

Select the Dental X-Rays periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

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

CY 2017 PBP Data Entry System Screens

Step-up #16a Preventive Dental – Base 3

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

File Help Add Variable

Go To: Step-up #16a Preventive Dental - Base 3

<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <input style="width: 100%;" type="text"/> <p>Select the Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p> <p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which Preventive Dental Services have a Coinsurance (Select all that apply):</p> <p><input type="checkbox"/> Oral Exams <input type="checkbox"/> Prophylaxis (Cleaning) <input type="checkbox"/> Fluoride Treatment <input type="checkbox"/> Dental X-Rays</p>	<p>Is there a combination of services included in a single cost per Office Visit?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which combination of services are included in a single cost per Office Visit:</p> <p><input type="checkbox"/> Oral Exams <input type="checkbox"/> Prophylaxis (Cleaning) <input type="checkbox"/> Fluoride Treatment <input type="checkbox"/> Dental X-Rays</p> <p>Indicate Coinsurance percentage for Office Visit:</p> <input style="width: 100%;" type="text"/> <p>Indicate Minimum Coinsurance percentage for Oral Exams:</p> <input style="width: 100%;" type="text"/> <p>Indicate Maximum Coinsurance percentage for Oral Exams:</p> <input style="width: 100%;" type="text"/>	<p>Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):</p> <input style="width: 100%;" type="text"/> <p>Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):</p> <input style="width: 100%;" type="text"/> <p>Indicate Minimum Coinsurance percentage for Fluoride Treatment:</p> <input style="width: 100%;" type="text"/> <p>Indicate Maximum Coinsurance percentage for Fluoride Treatment:</p> <input style="width: 100%;" type="text"/> <p>Indicate Minimum Coinsurance percentage for Dental X-Rays:</p> <input style="width: 100%;" type="text"/> <p>Indicate Maximum Coinsurance percentage for Dental X-Rays:</p> <input style="width: 100%;" type="text"/>
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CY 2017 PBP Data Entry System Screens

Step-up #16a Preventive Dental – Base 4

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

File Help Add Variable

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

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No	Indicate Copayment amount for Office Visit: <input type="text"/>
Indicate Deductible Amount: <input type="text"/>	Indicate Minimum Copayment amount for Oral Exams: <input type="text"/>
Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No	Indicate Maximum Copayment amount for Oral Exams: <input type="text"/>
Select which Preventive Dental Services have a Copayment (Select all that apply): <input type="checkbox"/> Oral Exams <input type="checkbox"/> Prophylaxis (Cleaning) <input type="checkbox"/> Fluoride Treatment <input type="checkbox"/> Dental X-Rays	Indicate Minimum Copayment amount for Prophylaxis (Cleaning): <input type="text"/>
Indicate Minimum Copayment amount for Fluoride Treatment: <input type="text"/>	Indicate Maximum Copayment amount for Prophylaxis (Cleaning): <input type="text"/>
Is there a combination of services included in a single cost per Office Visit? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Copayment amount for Fluoride Treatment: <input type="text"/>
Select which combination of services are included in a single cost per Office Visit: <input type="checkbox"/> Oral Exams <input type="checkbox"/> Prophylaxis (Cleaning) <input type="checkbox"/> Fluoride Treatment <input type="checkbox"/> Dental X-Rays	Indicate Maximum Copayment amount for Fluoride Treatment: <input type="text"/>
	Indicate Minimum Copayment amount for Dental X-Rays: <input type="text"/>
	Indicate Maximum Copayment amount for Dental X-Rays: <input type="text"/>

CY 2017 PBP Data Entry System Screens

Step-up #16a Preventive Dental – Base 5

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File", "Help", and "Add Variable". Below the menu is a navigation bar with "Previous" and "Next" buttons, "Exit (Validate)" and "Exit (No Validate)" buttons, and a "Go To:" dropdown menu currently set to "Step-up #16a Preventive Dental - Base 5".

The main content area contains the following sections:

- Enrollee must receive Authorization from one or more of the following:**
 - None
 - Primary Care Physician (Internist/Family Practice, General Practice)
 - Physician Specialist
 - Organization Medical Director/Utilization Management/Utilization Review
 - Other, describe
- Is a referral required for Preventive Dental Services?**
 - Yes
 - No
- 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:

CY 2017 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Select enhanced benefits:

Indicate number of visits for Non-routine Services:

Indicate number of visits for Diagnostic Services:

Select the Non-routine Services periodicity:

Select the Diagnostic Services periodicity:

CY 2017 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 2

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

File Help Add Variable

Go To: Step-up #16b Comprehensive Dental - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Restorative Services	Endodontics/Periodontics/Extractions	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Restorative Services: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select type of benefit for Endodontics/Periodontics/Extractions: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="radio"/> Mandatory <input type="radio"/> Optional
Is this benefit unlimited for Restorative Services? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Endodontics/Periodontics/Extractions? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services? <input type="radio"/> Yes <input type="radio"/> No, indicate number
Indicate number of visits for Restorative Services: []	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: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Select the Endodontics/Periodontics/Extractions periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe

CY 2017 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 3

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

File Help Add Variable

Go To: **Step-up #16b Comprehensive Dental - Base 3**

Previous Next Exit (Validate) Exit (No Validate)

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

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

Select the Maximum Plan Benefit Coverage type:
 Covered under Preventive Dental Category 16a
 Plan-specified amount per period

Select the Maximum Enrollee Out-of-Pocket Cost type:
 Covered under Preventive Dental Category 16a
 Plan-specified amount per period

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Indicate Maximum Plan Benefit Coverage amount:

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

CY 2017 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 4

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

File Help Add Variable

Go To: **Step-up #16b Comprehensive Dental - Base 4**

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Minimum Coinsurance percentage for Restorative Services:
[]

Indicate Maximum Coinsurance percentage for Restorative Services:
[]

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

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

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:
[]

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:
[]

Indicate Minimum Coinsurance percentage for Non-routine Services:
[]

Indicate Maximum Coinsurance percentage for Non-routine Services:
[]

Indicate Minimum Coinsurance percentage for Diagnostic Services:
[]

Indicate Maximum Coinsurance percentage for Diagnostic Services:
[]

Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions:
[]

Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:
[]

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

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

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:
[]

CY 2017 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 5

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

File Help Add Variable

Go To: **Step-up #16b Comprehensive Dental - Base 5**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Is there an enrollee Copayment?
 Yes
 No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Non-routine Services:

Indicate Maximum Copayment amount for Non-routine Services:

Indicate Minimum Copayment amount for Diagnostic Services:

Indicate Maximum Copayment amount for Diagnostic Services:

Indicate Minimum Copayment amount for Restorative Services:

Indicate Maximum Copayment amount for Restorative Services:

Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions:

Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions:

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

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

CY 2017 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 6

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

The main content area contains the following sections:

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

CY 2017 PBP Data Entry System Screens

Step-up #17a Eye Exams – Base 1

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

File Help Add Variable

Go To: **Step-up #17a Eye Exams - Base 1**

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

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

Select enhanced benefit:
 Routine Eye Exams/Other

Select type of benefit for Routine Eye Exams/Other:
 Mandatory
 Optional

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

Indicate number of exams for Routine Eye Exams/Other:

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

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

CY 2017 PBP Data Entry System Screens

Step-up #17a Eye Exams – Base 2

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

File Help Add Variable

Go To: **Step-up #17a Eye Exams - Base 2**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Is there an enrollee Copayment?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>Select which Eye Exams have a Coinsurance (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Benefits <input type="checkbox"/> Routine Eye Exams/Other</p>	<p>Select which Eye Exams have a Copayment (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Benefits <input type="checkbox"/> Routine Eye Exams/Other</p>
<p>Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:</p> <input type="text"/>	<p>Indicate Minimum Copayment amount for Medicare-covered Benefits:</p> <input type="text"/>
<p>Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:</p> <input type="text"/>	<p>Indicate Maximum Copayment amount for Medicare-covered Benefits:</p> <input type="text"/>
<p>Indicate Minimum Coinsurance percentage for Routine Eye Exams/Other:</p> <input type="text"/>	<p>Indicate Minimum Copayment amount per Routine Eye Exams/Other:</p> <input type="text"/>
<p>Indicate Maximum Coinsurance percentage for Routine Eye Exams/Other:</p> <input type="text"/>	<p>Indicate Maximum Copayment amount per Routine Eye Exams/Other:</p> <input type="text"/>
<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	
<p>Indicate Deductible Amount:</p> <input type="text"/>	

CY 2017 PBP Data Entry System Screens

Step-up #17a Eye Exams – Base 3

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File", "Help", and "Add Variable". Below the menu bar is a navigation area with "Previous" and "Next" buttons, "Exit (Validate)" and "Exit (No Validate)" buttons, and a "Go To:" dropdown menu currently set to "Step-up #17a Eye Exams - Base 3".

The main content area contains the following fields and instructions:

- Enrollee must receive Authorization from one or more of the following:
 - None
 - Primary Care Physician (Internist/Family Practice, General Practice)
 - Physician Specialist
 - Organization Medical Director/Utilization Management/Utilization Review
 - Other, describe
- Is a referral required for Eye Exams?
 - Yes
 - No
- Eye Exams Notes
- Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
- Notes:

CY 2017 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 1

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

File Help Add Variable

Go To: **Step-up #17b Eyewear - Base 1**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

CLICK FOR DESCRIPTION OF BENEFIT

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

Does the plan provide Eyewear as a supplemental benefit under Part C?
 Yes
 No

Select enhanced benefits:
 Contact lenses
 Eyeglasses (lenses and frames)
 Eyeglass lenses
 Eyeglass frames
 Upgrades

Select type of benefit for Contact lenses:
 Mandatory
 Optional

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

Indicate quantity (number of pairs) for Contact lenses:

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

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

Is this benefit unlimited for Eyeglasses (lenses and frames)?
 Yes
 No, indicate number

Indicate quantity for Eyeglasses (lenses and frames):

Select Eyeglasses (lenses and frames) periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

CY 2017 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 2

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

File Help Add Variable

Go To: Step-up #17b Eyewear - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Select type of benefit for Eyeglass lenses:
 Mandatory
 Optional

Select type of benefit for Eyeglass frames:
 Mandatory
 Optional

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

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

Indicate quantity (number of pairs) for Eyeglass lenses:

Indicate quantity for Eyeglass frames:

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

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

Select type of benefit for Upgrades:
 Mandatory
 Optional

CY 2017 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 3

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

File Help Add Variable

Go To: Step-up #17b Eyewear - Base 3

Previous
Next
Exit (Validate)
Exit (No Validate)

<p style="font-size: x-small;">Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p style="font-size: x-small;">Select the Maximum Plan Benefit Coverage type:</p> <p><input type="radio"/> Covered under Eye Exams Category 17a <input type="radio"/> Plan-specified amount per period</p> <p style="font-size: x-small;">Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?</p> <p><input type="radio"/> In-network services only <input type="radio"/> Both In-network and Out-of-network services</p> <p style="font-size: x-small;">Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p style="font-size: x-small;">Indicate Combined Maximum Plan Benefit Coverage amount:</p> <input style="width: 100%; height: 15px;" type="text"/>	<p style="font-size: x-small;">Select the Combined Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p> <p style="font-size: x-small;">Select the type of Eyewear with Individual Max Plan Benefit Coverage amount:</p> <p><input type="checkbox"/> Contact lenses <input type="checkbox"/> Eyeglasses (lenses and frames) <input type="checkbox"/> Eyeglass lenses <input type="checkbox"/> Eyeglass frames <input type="checkbox"/> Upgrades</p> <p style="font-size: x-small;">Indicate Max Plan Benefit Coverage amount for Contact lenses:</p> <input style="width: 100%; height: 15px;" type="text"/> <p style="font-size: x-small;">Select the Individual Maximum Plan Benefit Coverage periodicity for Contact lenses:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p style="font-size: x-small;">Indicate Max Plan Benefit Coverage amount for Eyeglasses (lenses and frames):</p> <input style="width: 100%; height: 15px;" type="text"/> <p style="font-size: x-small;">Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglasses (lenses and frames):</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p> <p style="font-size: x-small;">Indicate Max Plan Benefit Coverage amount for Eyeglass lenses:</p> <input style="width: 100%; height: 15px;" type="text"/> <p style="font-size: x-small;">Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglass lenses:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p style="font-size: x-small;">Indicate Max Plan Benefit Coverage amount for Eyeglass frames:</p> <input style="width: 100%; height: 15px;" type="text"/> <p style="font-size: x-small;">Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglass frames:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p> <p style="font-size: x-small;">Indicate Max Plan Benefit Coverage amount for Upgrades:</p> <input style="width: 100%; height: 15px;" type="text"/> <p style="font-size: x-small;">Select the Individual Maximum Plan Benefit Coverage periodicity for Upgrades:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>
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CY 2017 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 4

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

File Help Add Variable

Go To: Step-up #17b Eyewear - Base 4

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

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Eyeglass frames:

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

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Eyeglass frames:

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Minimum Coinsurance percentage for Contact lenses:

Indicate Minimum Coinsurance percentage for Upgrades:

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

Indicate Maximum Coinsurance percentage for Contact lenses:

Indicate Maximum Coinsurance percentage for Upgrades:

Indicate Minimum Coinsurance percentage for Eyeglasses (lenses and frames):

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Maximum Coinsurance percentage for Eyeglasses (lenses and frames):

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

Indicate Minimum Coinsurance percentage for Eyeglass lenses:

Indicate Maximum Coinsurance percentage for Eyeglass lenses:

CY 2017 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 5

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

File Help Add Variable

Go To: **Step-up #17b Eyewear - Base 5**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Indicate Minimum Copayment amount for Contact lenses:

Indicate Maximum Copayment amount for Contact lenses:

Indicate Minimum Copayment amount for Eyeglass frames:

Indicate Maximum Copayment amount for Eyeglass frames:

Is there an enrollee Copayment?
 Yes
 No

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

Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):

Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):

Indicate Minimum Copayment amount for Upgrades:

Indicate Maximum Copayment amount for Upgrades:

Indicate Minimum Copayment amount for Eyeglass lenses:

Indicate Maximum Copayment amount for Eyeglass lenses:

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

CY 2017 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 6

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

The main content area contains the following fields and options:

- Enrollee must receive Authorization from one or more of the following:
 - None
 - Primary Care Physician (Internist/Family Practice, General Practice)
 - Physician Specialist
 - Organization Medical Director/Utilization Management/Utilization Review
 - Other, describe
- Is a referral required for Eyewear?
 - Yes
 - No
- Eyewear Notes
 - Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
 - Notes: [Empty text area]

CY 2017 PBP Data Entry System Screens

Step-up #18a Hearing Exams – Base 1

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

File Help Add Variable

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

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Yes
 No

Select enhanced benefits:

Routine Hearing Exams
 Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Exams:

Mandatory
 Optional

Is this benefit unlimited for Routine Hearing Exams?

Yes
 No, indicate number

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

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

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

Mandatory
 Optional

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

Yes
 No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

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

CY 2017 PBP Data Entry System Screens

Step-up #18a Hearing Exams – Base 2

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

File Help Add Variable

Go To: Step-up #18a Hearing Exams - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

Step-up #18a Hearing Exams – Base 3

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

File Help Add Variable

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

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Is there an enrollee Copayment?
 Yes
 No

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

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

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

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

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Is a referral required for Hearing Exams?
 Yes
 No

Indicate Minimum Copayment amount for Routine Hearing Exams:

Indicate Maximum Copayment amount for Routine Hearing Exams:

CY 2017 PBP Data Entry System Screens

Step-up #18a Hearing Exams – Base 4

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File", "Help", and "Add Variable". Below the menu is a navigation bar with buttons for "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)", along with a "Go To:" dropdown menu currently set to "Step-up #18a Hearing Exams - Base 4". The main content area is titled "Hearing Exams Notes" and contains a text box with the instruction: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." Below this instruction is a large, empty text area for entering notes, with a vertical scrollbar on the right side.

CY 2017 PBP Data Entry System Screens

Step-up #18b Hearing Aids – Base 1

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

File Help Add Variable

Go To: Step-up #18b Hearing Aids - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Hearing Aids as a supplemental benefit under Part C?
 Yes
 No

Select enhanced benefits:
 Hearing Aids (all types)
 Hearing Aids - Inner Ear
 Hearing Aids - Outer Ear
 Hearing Aids - Over the Ear

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

Is this benefit unlimited for Hearing Aids (all types)?
 Yes
 No, indicate number

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Select type of benefit for Hearing Aids - Inner Ear:
 Mandatory
 Optional

Is this benefit unlimited for Hearing Aids - Inner Ear?
 Yes
 No, indicate number

Indicate quantity for Hearing Aids - Inner Ear:

Select Hearing Aids - Inner Ear periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Select type of benefit for Hearing Aids - Outer Ear:
 Mandatory
 Optional

Is this benefit unlimited for Hearing Aids - Outer Ear?
 Yes
 No, indicate number

Indicate quantity for Hearing Aids - Outer Ear:

Select Hearing Aids - Outer Ear periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

CY 2017 PBP Data Entry System Screens

Step-up #18b Hearing Aids – Base 2

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

File Help Add Variable

Go To: **Step-up #18b Hearing Aids - Base 2**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

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

Is this benefit unlimited for Hearing Aids - Over the Ear?
 Yes
 No, indicate number

Indicate quantity for Hearing Aids - Over the Ear:

Select Hearing Aids - Over the Ear periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

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

Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?
 Per ear
 Both ears combined

Select the Maximum Plan Benefit Coverage type:
 Covered under Hearing Exams Category - 18a
 Plan-specified amount per period

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

Indicate Maximum Plan Benefit Coverage amount:

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

CY 2017 PBP Data Entry System Screens

Step-up #18b Hearing Aids – Base 3

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

File Help Add Variable

Go To: **Step-up #18b Hearing Aids - Base 3**

Previous Next Exit (Validate) Exit (No Validate)

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

Indicate Minimum Coinsurance percentage for Hearing Aids (all types):

Indicate Minimum Coinsurance percentage for Hearing Aids - Over the Ear:

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

Indicate Maximum Coinsurance percentage for Hearing Aids (all types):

Indicate Maximum Coinsurance percentage for 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:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Indicate Maximum Coinsurance percentage for Hearing Aids - Inner Ear:

Indicate Minimum Coinsurance percentage for Hearing Aids - Outer Ear:

Is there an enrollee Coinsurance?
 Yes
 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

CY 2017 PBP Data Entry System Screens

Step-up #18b Hearing Aids – Base 4

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

File Help Add Variable

Go To: Step-up #18b Hearing Aids - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?

Yes
 No

Select which Hearing Aids Benefits have a Copayment (Select all that apply):

Hearing Aid - Inner Ear
 Hearing Aid - Outer Ear
 Hearing Aids - Over the Ear

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

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

Indicate Minimum Copayment amount per Hearing Aid - Inner Ear:

Indicate Maximum Copayment amount per Hearing Aid - Inner Ear:

Indicate Minimum Copayment amount per two Hearing Aids - Inner Ear:

Indicate Maximum Copayment amount per two Hearing Aids - Inner Ear:

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 two Hearing Aids - Outer Ear:

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

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

Is there an enrollee Deductible?

Yes
 No

Indicate Deductible Amount:

CY 2017 PBP Data Entry System Screens

Step-up #18b Hearing Aids – Base 5

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File", "Help", and "Add Variable". Below the menu bar is a navigation area with "Previous" and "Next" buttons, "Exit (Validate)" and "Exit (No Validate)" buttons, and a "Go To:" dropdown menu currently set to "Step-up #18b Hearing Aids - Base 5".

The main content area contains the following sections:

- Enrollee must receive Authorization from one or more of the following:**
 - None
 - Primary Care Physician (Internist/Family Practice, General Practice)
 - Physician Specialist
 - Organization Medical Director/Utilization Management/Utilization Review
 - Other, describe
- Is a referral required for Hearing Aids?**
 - Yes
 - No
- Hearing Aids Notes**

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

Notes: