PBP Data Entry System - Section D, Cont	tract X0001, Plan 001, Segment 000	- 8 :
ile <u>H</u> elp Add Variable Previous Next (Validate) Validate)	Go To: Plan Deductible LPPO/RPPO Base 1	
Do you offer a Deductible? Yes No What is the amount of your Deductible amount Medicare-Defined Part A Deductible amount Medicare-Defined Part B Deductible amount combined as a single deductible Other, indicate amount Indicate Deductible Amount: Differentially applied to Part A and Part B Deductible applied? Single Deductible Differentially applied to Part A and Part B Medicare-Services, reflecting Original Medicare payment structure. UPPO and RPPO plans must include ALL OON Medicare covered Services in the Deductible is that are selected will not exceed the 2016 Original Medicare amounts that will be released by CMS.	3-3: Pulmonary Renabilitation Services	

ious Next	Exit Exit (N	lo	Plan Deductible LPPO/RPPO Base 2	×	
ious ivext	(Validate) Validat	e)			_
lown the CTRL key on 1 is with your MOUSE. Af key on your keyboard. s the Deductible apply' fits? Yes No lect all of the In-Networ which the Deductible apply inpatient Hospital Payc Skilled Nursing Facility (3 Skilled Nursing Facility (3 Li Cardiac Rehabilitatio World wide Emergency Zu Intensive Cardiac Reh Bi Pulmonary Rehabilitatio World wide Emergency Zu Intensive Cardiac Reh Bi Pulmonary Rehabilitatio World wide Emergency Cardiac Rehabilitatio World wide Emergency Zu Intensive Cardiac Reh Delatry Services Podiatry Services Podiatry Services Doutpetient Blood Servi b: Transportation Servic b: Over-the-Counter (0T c: Meal Benefit d: Other 1 b: Other 2 f: Other 3 g: Dual Eligible SNP with b: Annual Physical Exam	our keyboard while selecting er selecting ALL of your opti o all In-Network Non-Medica (Non-Medicare-covered Ser piles: selection Services Urgent Coverage es C) Items Highly Integrated Services Senection C) Items	g the coverage ions release the are-covered rvice Categories	Hold down the CTRL key on your keyboard while selecting the co with your MOUSE. After selecting ALL of your options release th your keyboard. Does the Deductible apply to all Out-of-Network Non-Medicare- C Yes No Select all of the Out-of-Network Non-Medicare-covered Service which the Deductible applies: 1a: hoptient Hospital-Acut 1b: hoptient Hospital-Acut 2: Skilled Nursing Facility (SNF) 3:1: Cardiac Rehabilitation Services 3:2: hitensive Cardiac Rehabilitation Services 3:3: Pulmonary Rehabilitation Services 3:3: Pulmonary Rehabilitation Services 5: Chioprany Rehabilitation Services 5: Chioprany Rehabilitation Services 13: Acupuncture 13: Over-the-Counter (OTC) Items 13: Cher 1 13: Other 1 13: Other 1 13: Other 2 13: Other 2 13: Dual Eligible SNP with Highly Integrated Services 14: Annual Physical Exam 14: Eligible Supplemental Benefits as Defined in Chapter 4 15: Medicare Part B RX Drugs 16: Preventive Dential 17: Eyewear 18: Hearing Exams	e CTRL key on sovered benefits?	

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you have diff r In-Network	ferential servis Plan-level D	ce category-level eductible?	deductibles in a	addition to						
Yes				7						
No										
old down the ptions with yo FRL key on y	CTRL key on our MOUSE. A our keyboard	your keyboard wh fter selecting ALL	ile selecting th of your option	e coverage s release the						
Select all of t	he Service Ca	tegories to which	the differential	deductibles						
1a: Inpatient I	Hospital-Acute Hospital Psych	t liatric		_						
2: Skilled Nur	sing Facility (S	SNF)								
		Rehabilitation Servi Urgent Coverage	ces							
5: Partial Hos 6: Home Heal	pitalization									
7a: Primary C	are Physician	Services								
b: Chiroprac	ctic Services onal Therapy S									
7d: Physician	Specialist Ser	rvices								
7e: Mental He 7f: Podiatry S	ealth Specialty Services	Services								
7g: Other Hea	alth Care Profe	essional								
7h: Psychiatr 7i: Physical T		peech-Language P	athology Servic	es						
8a: Diagnosti	c Procedures/	Tests/Lab Services herapeutic Radiolo	3							
9a: Outpatien	t Hospital Serv	vices								
9b: Ambulato	ry Surgical Ce It Substance A	nter (ASC) Service	s							
9d: Outpatien	it Substance A It Blood Servic	es		-						

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Services including Acute Tiers 1, 2, and 3, where appropriate: Rehabilitation Services: greater than the deductible. The total of all of the Differential Deductibles can be greater than the deductible. Indicate Differential Deductible Amount for Worldwide Indicate Differential Deductible Amount for Worldwide Indicate Differential Deductible Amount for Partial Hospitalization: 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 Chiropractic Services: Indicate Differential Deductible Amount for Chiropractic Services: Indicate Differential Deductible Amount for Chiropractic Services: Indicate Differential Deductible Amount for Occupational Therapy Indicate Differential Deductible Amount for Occupational Therapy	Exit Exit (No			
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	Previous Next Exit (Validate) Exit (Validate) Indicate Differential Deductible Amounts for Inpatient Hospital Services including Acute 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 Chiropractic Services: Indicate Differential Deductible Amount for Chiropractic Services: Indicate Differential Deductible Amount for Occupational Therapy Services:	greater than the deductible. The total of all of the Differential Deductibles can be greater than the deductible.	

PBP Data Entry System - S Eile Help Add Variable	Section D, Contract X0001, Pla	nn 001, Segment 000		- 8 >
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Indicate Differential Deductible Amount for Mental Health Specialty Services - Non-Psychiatric:	Indicate Differential Deductible Amount for Outpatient Diagnostic and Therapeutic Radiological Services:	Indicate Differential Deductible Amount for Transportation Services:	Indicate Differential Deductible Amount for OTC:	
Indicate Differential Deductible Amount for Podiatry Services:	Indicate Differential Deductible Amount for Outpatient Hospital Services:	Indicate Differential Deductible Amount for Durable Medical Equipment (DME):	Indicate Differential Deductible Amount for Meal Benefit:	
Indicate Differential Deductible Amount for Other Health Care Professional Services:	Indicate Differential Deductible Amount for Ambulatory Surgical Center (ASC) Services:	Indicate Differential Deductible Amount for Prosthetics/Medical Supplies:	Indicate Differential Deductible Amount for Other 1:	
Indicate Differential Deductible Amount for Psychiatric Services:	Indicate Differential Deductible Amount for Outpatient Substance Abuse Services:	Indicate Differential Deductible Amount for Diabetic Supplies and Services:	Indicate Differential Deductible Amount for Other 2:	
Indicate Differential Deductible Amount for Physical Therapy and Speech- Language Pathology Services:	Indicate Differential Deductible Amount for Outpatient Blood Services:	Indicate Differential Deductible Amount for Dialysis Services:	Indicate Differential Deductible Amount for Other 3:	
Indicate Differential Deductible Amount for Outpatient Diagnostic Procedures and Test and Lab Services:	Indicate Differential Deductible Amount for Ambulance Services:	Indicate Differential Deductible Amount for Acupuncture:	Indicate Differential Deductible Amount for Dual Eligible SNPs with Highly Integrated Services:	

Help Add Variable Pevious Next (Validate)	Go To: Plan Deductib Exit (No Validate)	LPPO/RPPO Base 6	
dicate Differential Deductible Amount r the Annual Physical Exam:	Indicate Differential Deductible Amount for Other Medicare-covered Preventive Services:	Indicate Differential Deductible Amount for Eyewear:	
licate Differential Deductible Amount Eligible Supplemental Benefits as fined in Chapter 4:	Indicate Differential Deductible Amount for Medicare Part B Rx Drugs:	Indicate Differential Deductible Amount for Hearing Exams:	
icate Differential Deductible Amount Kidney Disease Education Services	Indicate Differential Deductible Amount for Preventive Dental:	Indicate Differential Deductible Amount for Hearing Aids:	
licate Differential Deductible Amount Medicare-covered Glaucoma reening Services:	Indicate Differential Deductible Amount for Comprehensive Dental:		
icate Differential Deductible Amount Medicare-covered Diabetes Self- nagement Training:	Indicate Differential Deductible Amount for Eye Exams:		

Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 1

Help Add Variable			
vious Next (Validate)	Go To: Deductible for LPPO/RPPO Mandatory Supplemente	al Beneffts – Base 1 ▼	
you offer a mandatory enhanced benefit enrollee deductible an	nount? Indicate deductible for one or more of the follow		
Yes No		Deductible	
elect the mandatory enhanced benefits that have an enrollee	Inpatient Hospital-Acute	Amount	
eductible: a: Inpatient Hospital-Acute	Inpatient Hospital Psychiatric		
b: Inpatient Hospital Psychiatric : Skilled Nursing Facility (SNF) : Cardiac and Pulmonary Rehabilitation Services	200 million of the second		
c: Worldwide Emergency/Urgent Coverage b: Chiropractic Services	Skilled Nursing Facility (SNF)		
f: Podiatry Services d: Outpatient Blood Services 0b: Transportation Services	Cardiac and Pulmonary Rehabilitation Services		
3a: Acupuncture 3b: Over-the-Counter (OTC) Items	Worldwide Emergency/Urgent Coverage		
3c: Meal Benefit 3d: Other 1	Chiropractic Services		
3e: Other 2	Podiatry Services - Routine Foot Care		
	Outpatient Blood Services		
	Transportation Services		
	Acupuncture		
	Over-the-Counter (OTC) Items		
	Meal Benefit		

Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 2

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Indicate deductible for one or more	×				
	Deductible Amount				
Other 1					
Other 2					
Other 3					
Dual Eligible SNP with Highly Integrated Services					
Annual Physical Exam					
Eligible Supplemental Benefits as Defined in Chapter 4					
Preventive Dental					
Comprehensive Dental					
Eye Exams					
Eyewear					
Hearing Exams					
Hearing Aids					

Plan Deductible (In-Network)

PBP Data Entry System - Section D, Contract e <u>H</u> elp Add Variable	t X0001, Plan 001, Segment 000	_ 4
	Go To: Plan Deductible (In-Network)	
there an In-Network Plan Deductible?) Yes) No Do you charge the Medicare-defined Part B Deductible amount? C Yes C No	1a: inpatient Hospital Psychiatric 2: Skiled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services	
Indicate In-Network Plan Deductible Amount:	3-3: Pulmonary Rehabilitation Services 5: Partial Hospitalization Does the In-Network Deductible apply to all In-Network Non-Medicare-covered plan services?	
elect the benefits that apply to the In-Network Deductible: In-Network Medicare-covered benefits In-Network Non-Medicare-covered benefits	C Yes C 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.	
oes the In-Network Deductible apply to all In-Network edicare-covered plan services? 7 Yes 7 No	Select all of the In-Network Non-Medicare-covered Service Categories to which the In-Network Deductible applies: 1a: inpatient Hospital FAcute 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 EmergencyUrgent Coverage 6: Home Health Services 7b: Chiropractic Services 7b: Chiropractic Services 7f: Poylosid Therapy Services 7f: Poylosid Therapy Services	

Plan Deductible (Combined) – Base 1

evious Next (Validate) Go	To: Plan Deductible (Combined) - Base 1	
Exit Exit (No	101 Image: Control of Control o	

Plan Deductible (Combined) – Base 2

PBP Data Entry System - Secti ile <u>Help</u> Add Variable	on D, Contract X	(0001, Plan 001, Segment 000	- 8
Previous Next (Validate)	¥ Go⊺ Exit (No Validate)	To: Plan Deductible (Combined) - Base 2	
boos the Combined Deductible apply to all Out overed plan services? Yes No Hold down the CTRL key on your keyboard w options with your MOUSE. After selecting ALI CTRL key on your keyboard. Select all of the Out-of-Network Medicare-cov which the Combined Deductible applies: 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital-Acute 1b: Inpatient Hospital-Acute 1b: Inpatient Hospital-Acute 1b: Inpatient Hospital-Acute 1b: Acute Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 7: Ortor Provision Services 7: Chroprotic Services 7: Chroprotic Services 7: Other Health Specially Services 7: Provision Frocedures/TestSILab Services 80: Outpatient Radiological Services 80: Outpatient Radiological Services 9a: Outpatient Hospital Services	hile selecting the coveri of your options release vered Service Categorie	Non-Medicare-covered plan services? C Yes C No age 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.	

Plan Deductible (Out-of-Network)

Exit Exit (No	Plan Deductible (Out-of-Network)	
vious Next (Validate) Validate)		_
tere an Out-of-Network (OON) Plan Deductible? Yes No you charge the Medicare-defined Indicate Out-of-Network Plan Deductible amount? Yes No ect the benefits that apply to the Out-of-Network Deductible: Out-of-Network Medicare-covered benefits es the Out-of-Network Deductible apply to all Out-of Network dicare-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-Metwork Medicare-covered Service Categories to which the Out-of-Metwork Index cervice as a selecting of the service of the serv	

Plan Deductible (Non-Network)

PBP Data Entry System - Section D, Contra ile <u>Help</u> Add Variable		
Previous Next (Validate)	Go To: Plan Deductible (Non-Network)	
Previous Next (Validate) Validate) Is there a Plan Deductible? <pre></pre>	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 Detectible applies: 1::::::::::::::::::::::::::::::::::::	

Max Enrollee Cost Limit (In-Network)

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here an In-Network Maximum Enrollee Out-of-Pocket Cost? Yes No your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at Yes Windary Character Windary State Windary State Windary Character Windary State Windare	Ne	ext	Exit				
Yes oplions with your MOUSE. After selecting ALL of your options release the CTRL key on your septoans. Maximum Enrollee Out-of-Pocket (MOOP) Cost at to Voluntary of Mandatory Lever? Yournary Mandatory Select al of the In-Network Madicare-covered Services Categories that are Mountary of Mandatory Lever? No Select al of the In-Network Madicare-covered Services Alg Bervices. For a site of the Yournary of Mandatory Veet? Select al of the Yournary Mandatory Select al of the Yournary Mandatory Alg Bervices. To site of the Yournary of Mandatory Veet? Select al of the Yournary Mandatory Maximum Enrollee Out-of-Pocket (MOOP) that covers Select al of the Yournary Mandatory Selection and Yies Select al of the Yournary Mandatory Selection and Yies Select al of the Yournary Mandatory Selection and Yies Select al of the Yournary Mandatory Selection and Yies Select al of the Yournary Mandatory Selection and Yies Select al of the Yournary Select al of the Yournary Cate Physicals Select al of the Yournary Select al of the Yournary Cate Physicals Yees Select al of the Yournary Cate Physicals Yees Select al of the Yournary Cate Physicals Yees Select al of the Yournary Cate Physicals Yees <td></td> <td></td> <td>(/</td> <td>,</td> <td></td> <td></td> <td></td>			(/	,			
Yes No Yournary Yournary	n-Network	k Maximur	n Enrollee Out	-of-Pocket Cos	t?		
Select all of the In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at Voluntary V						CTRL key on your keyboard.	
a Voluntary or Mandatory Level? Voluntary Mandatory	N		Ease line Out a		D) Constant		
Voluntary Mandatory Mandatory MA plans must have a maximum out-of-pocket (MOOP) that overs ARB services. For a list of the Voluntary and Mandatory Limits, please Mark services. For a list of the Voluntary and Mandatory Limits, please Mark services. For a list of the Voluntary and Mandatory Limits, please Mark services. For a list of the Voluntary and Mandatory Limits, please Mark services. For a list of the Voluntary and Mandatory Limits, please Mark services. For purposes of submitting bids to CMS, D-SNPs out include Parks. A B, and Part D Medicare services in the PBP. To. Pharmary Care Mysician Services Park Hosphaltardion B Home Health Services Tra. Primary Care Mysician Services Tra. Primary Care Mysician Services Tra. Primary Care Mysician Services Tra. Primary Services Tra. Second Service Cast paring Onthe Jan Io Set ter In-Network Maximum Enrollee Out-of-Pocket Cost. Tra. Second Service Cast paring Onthe Second Service Service Cast paring Onthe No. Judicate Primary Services Tra. Respirate Paring Services Tra. Compared Services Tra. Respirate Paring Services Tra. Service Services Tra. Service Services Tra. Service Services Tra. Ser				IT-POCKET (MOO	P) Cost at		
1: Cardiac Rehabilitation Services 1: Cardiac Re						1b: Inpatient Hospital Psychiatric	
A/B services. For a list of the Voluntary and Mandatory Limits, please (JOCP) Cost at the Voluntary or Mandatory Level?" guestion and view Variable Help. 3-3: Putimonary Rehabilitation Services 4: Emprenory Care 5: Portal Hospitalization 6: Home Health Services 7: Chrogradic	atory						
4:: Emergency Care 5: Partial Hospitalization 5: Partial Hospitalization 6: Home Health Services 5: Partial Hospitalization 6: Home Health Services 7: Dihopractic Services 6: Home Health Services 7: Dihopractic Services 7: Dihopractic Services 7: Dihopractic Services 7: Display Ledded Services 7: Poster Service Service Services 8: Hold down the CTRL key on your keyboard. 9: Veok 0: Ide Hon-Network M	ns must ha	ave a max	kimum out-of-p	ocket (MOOP)	that covers	3-2: Intensive Cardiac Rehabilitation Services	
IOOPC Cost at the Voluntary or Mandatory level?" question and view Has. Linking lenity Volate Vanable Heip. Se Artible Gent/Volate Vanable Heip. Se Artible Gent/Volate Vanable Heip. Se Artible Gent/Volate Se Artible Heip. Se Artible Gent/Volate Se Artible Heip. Se Artible Heip. Se Artible Ford Volate Se Artible Heip. Se Artible Ford Volate Se Artible Heip. Se Artible Ford Volate Se Artible Heip. Se Artible Heip. Se Artible Heip. Se Artible Ford Volate Se Artible Heip. Se Artible Heip. Se Artible Heip. Se Artible Ford Volate Max. Linking Berlives To: Docupation Herp Volate Max. Linking Berlives To: Docupation Herp Volate Max. Linking Berlives To: Docupation Herp Volate Max. Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Maximum Enrollee Out-of-Pocket Cost. Mol down the CTRL key on your keyboard Select all of the In-Network Maximum Enrollee Out-of-Pocket Cost. Select all of the In-Network Non-Medicare-covered Services Categories that are INCLUDED in the In-Network Non-Medicare-covered Services Categories that are INCLUDED in the In-Network Non-Medicare-covered Services Categories that are INCLUDED in the In-Network Non-Medicare-covered Se	/ices. For a on the "Is y	a list of the	ne Voluntary a letwork Maxim	nd Mandatory L um Enrollee Out	imits, please		
	ost at the V						
Deter to Low Services of Submitting Bods to CMS, Low SNPS Ta: Primary Care Physicians Services Dest this Lincke Park AB, and Park Dedicate services in the PBP, or SNPS are the existing to planenrolites, included in the PBP. DSNPS have the existing to planenrolites, included in the PBP. DSNPS have the exist sharing for planenrolites, included in the PBP. DSNPS have the exist sharing or planenrolites, included in the PBP. DSNPS have the exist sharing or planenrolites, included in the PBP. DSNPS have the exist sharing or planenrolites, included in the PBP. DSNPS have the exist sharing or planenrolites, included in the PBP. DSNPS have the exist sharing or planenrolites, included in the plane to exist sharing or planenrolites, included in the plane to exist sharing or plane plane to	le Help.					5: Partial Hospitalization	
ust include Pars A, B, and Part D Medicare services in the PBP, or synthematic Services A Hinary Cafe Provision Services C Corporational Therapy Services C Coupational Therapy Services C Orono-covered Services (or non-covered), it must services? C Yes C No Hold down the CTRL key on your keyboard while selecting but ory our points 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 Non-Medicare-covered Service Categories that are INCLUDED in the In-Network Non-Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost. In-Network Maximum Enrollee Out-of-Pocket Cost apply to all in the In-Network Maximum Enrollee Out-of-Pocket Cost and provide Services Select all of the In-Network Maximum Enrollee Out-of-Pocket Cost amount: In-Network Machine Enrollee Out-of-Pocket Cost apply to all in the In-Network Maximum Enrollee Out-of-Pocket Cost and provide Services C C rudiac Rehabilitation Services C Nonder Cardiac Rehabilitation Services C Wordtwide Emergency/Urgent Coverage<td>-SNPs: For</td><td>or purpos</td><td>es of submittin</td><td>a bids to CMS.</td><td>D-SNPs</td><td></td><td></td>	-SNPs: For	or purpos	es of submittin	a bids to CMS.	D-SNPs		
of Medicals benefits may be included in the PBP. D.SNPs have the product is benefits S0 as the MOOP amount, thready guaranteeing withing to setablish S0 as the MOOP amount, thready guaranteeing withing to setablish S0 as the MOOP amount, thready guaranteeing withing to setablish S0 as the MOOP amount, thready guaranteeing withing to setablish S0 as the MOOP amount, thready guaranteeing withing to setablish S0 as the MOOP amount, thready guaranteeing withing to setablish S0 as the MOOP amount, thready guaranteeing withing to setablish S0 as the MOOP amount, thready guaranteeing withing to setablish S0 as the MOOP amount, thready guaranteeing withing to setablish S0 as the MOOP amount, thready guaranteeing withing to setablish S0 as the MOOP amount, thready Setablish S0 as the MOOP amount MOUSE. After Setablish So as the MOOP amount MOUSE Aft	de Parts A.	A, B, and I	Part D Medicar	e services in th	e PBP,		
xixbility to establish 50 as the MOOP amount, thereby guaranteeing erels no costsharing for plan enrollees, including those who are table for Medicare-covered services (or non-covered), it must ack enrollees' out-of-pocket Spending and it is up to the plan to evelop the process and vehicle for doing so. Does the in-Network Maximum Enrollee Out-of-Pocket Cost apply to all in-Network Maximum Enrollee Out-of-Pocket Cost Amount:							
In-Network Maximum Enrollee Out-of-Pocket Cost Amount: In-Network Maximum Enrollee Out-of-Pocket Cost. In-Network Medicare-covered benefits In-Network Maximum Enrollee Out-of-Pocket Cost. In-Network Maximum Enrollee Out-of-Pocket Cost. In-Network Maximum Enrollee Out-of-Pocket Cost. In-Network Medicare-covered benefits In-Network Maximum Enrollee Out-of-Pocket Cost. In-Network Maximum Enrollee Out-of-Pocket Cost apply to all -Pocket Cost: In-Network Maximum Enrollee Out-of-Pocket Cost apply to all -Network Medicare-covered ban services? -Network Medicare-covered plan services? 'Yes	o establish	h SO as th	e MOOP amou	unt, thereby qua	ranteeing	Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all	
ststsharing for Medicare-covered services (or non-covered), it must ave kerrollees' out-of-pockst pending and it is up to the plan to avelop the process and vehicle for doing so. C Yes dicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount: Hold down the CTRL key on your keyboard while selecting ALL of your options release the CTRL key on your keyboard. ote: For Regional PPOs, all Medicare Part A/B services must be cluded in the Maximum Enrollee Out-of-Pocket Cost. Select all of the In-Network Non-Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost. select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket Cost: In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cardiac Rehabilitation Services - Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cardiac Rehabilitation Services - Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cardiac Rehabilitation Services - Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cardiac Rehabilitation Services - Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cardiac Rehabilitation Services - Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cardiac Rehabilitation Services - Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cardiac Rehabilitation Services - Network Maximum Enrolle						In-Network Non-Medicare-covered plan services?	
evelop the process and vehicle for doing so. No dicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount: Hold down the CTRL key on your keyboard while selecting ALL of your options release the CTRL key on your keyboard. ote: For Regional PPOs, all Medicare Part A/B services must be cluded in the Maximum Enrollee Out-of-Pocket Cost. Select all of the In-Network Moximum Enrollee Out-of-Pocket Cost. elect the benefits that apply to the In-Network Maximum Enrollee Out-FPocket cost: In: Inpatient Hospital Paychiatric 2: Skilled Nursing Facility (SMF) 3-1: Cardiac Rehabilitation Services 3: In-Network Macine covered benefits 3-3: Putimonary Rehabilitation Services 0: Notwork Maximum Enrollee Out-of-Pocket Cost apply to all Select Cost: 1: N-Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cost: 1: N-Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cost: 1: N-Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cost: 1: N-Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cost: 1: N-Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cost: 1: N-Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cost: 1: Network Maximum Enrollee Out-of-Pocket Cost apply to all Select Cost: 1: Network Medicare-covered benefits Select Co	ng for Medi	dicare-co	vered services	(or non-covere	d), it must	C Yes	
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oes the in-Network Maximum Enrollee Out-of-Pocket Cost apply to all 7b: Chiropractic Services -Network Medicare-covered plan services? 7c: Occupational Therapy Services Yes 7f: Podiatry Services		mourouro					
-Network Medicare-covered plan services? 7f: Podiatry Services						7b: Chiropractic Services	
Yes n n rouse yerves n	h-Network k Medicare	e-covered	l plan services	POCKELCOS	t apply to all		
						71. Fudiau y Services	

Max Enrollee Cost Limit (Combined) – Base 1

evious	Next	Exit (Validate)	Exit (No Validate)	Go To:	Max Enrollee Cost Limit (Combined) - Base 1	
here a Combi t-of-Pocket C		ork and Out-of-N	etwork) Maxim	um Enrollee	Hold down the CTRL key on your keyboard while selecting the coverage	
Yes	.031:				options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.	
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		ork and Out-of-Ne oluntary or Mand:			INCLUDED in the Combined Maximum Enrollee Out-of Pocket Cost Amount: 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital-Sychiatric	
O Voluntary					2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services	
ි Mandatory	1				3-1. Indiak Perlamana and Services	
		aximum out-of-po			3-3: Pulmonary Rehabilitation Services	
ght-click on the	s. For a list of he "Is your Co	the Voluntary an ombined Maximur	d Mandatory L n Enrollee Out-	mits, please of-Pocket	4a: Emergency Care 4b: Urgently Needed Services	
	at the Volunta	ry or Mandatory I			5: Partial Hospitalization	
te variable He	eip.				6: Home Health Services 7a: Primary Care Physician Services	
		ses of submitting Part D Medicare			7b: Chiropractic Services	
long with app lo Medicaid b	roved option enefits may b	al and mandatory the included in the the MOOP amour	supplemental PBP. D-SNPs	benefits. have the	Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all In- Network Non-Medicare-covered plan services?	
nere is no cost	t sharing for p	plan enrollees, inc	luding those w	hoare	C Yes	
		ring. Otherwise, if overed services (e			C No	
ack enrollees	out-of-pock	et spending and i hicle for doing so	t is up to the pla		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.	
ndicate Combi out-of-Pocket (vork and Out-of-N	etwork) Maxim	um Enrollee	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	
		y to the Combine			1b: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF)	
Pocket cost:	ents triat appi	y to the Combine	a Maximum En	rollee Out-or	3-1: Cardiac Rehabilitation Services	
		vered benefits			3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services	
		re-covered benefit			4c: Worldwide Emergency/Urgent Coverage	
		e-covered benefit dicare-covered be			76: Chiropractic Services 7f: Podiatry Services	
Out-on-Intern		alcare-covered be	rients		Al: Outpatient Blood Services	
		um Enrollee Out-o	f-Pocket Cost	apply to all In	10b: Transportation Services	
	care-covered	plan services?			13a: Acupuncture	
C Yes						
O No						

Max Enrollee Cost Limit (Combined) – Base 2

PBP Data Entry System - Section D, Contrac	ct X0001, Plan 001, Segment 000	- 8
Fxit Exit (No	Go To: Max Enrollee Cost Limit (Combined) - Base 2	
Previous Next (Validate) Validate)		_
All MA plans must have a maximum out-of-pocket (MOOP) that covers all AB services. For a list of the Voluntary and Mandatory Limits, please right-click on the 'Isy our Combined Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level? question and view the Varable Heip. Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Medicare-covered plan services? C Yes O No Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting the coverage options with your MOUSE After selecting the coverage options with your MOUSE. After selecting the coverage options with your Active the Combined Maximum Enrollee Out-of-Pocket Cost Amount. Ta: Inpatient Hospital-Acute 1tb: Inpatient Hospital-Acute 1tb: Inpatient Hospital-Acute 3-1: Cardiae Rehabilitation Services 3-2: Litensive Cardiac Rehabilitation Services 3-3: Pulmonay Rehabilitation Services 7: Cocupational Therapy Services 7: Cocupational Therapy Services 7: Chropractic Services 7: Mental Health Specialty Services	Dees the Combined Maximum Enrollee Out-of-Pocket Cost apply to allOut-of-NetworkNon-Medicare-covered plan services? C Yes No Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard. Select all of the Out-of-Network Non-Medicare-covered Service Categories that are INCLUDED in the Combined Maximum Enrollee Out-of Pocket Cost Amount: 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital-Pocket Cost Amount: 1a: Inpatient Hospital Psychiatric 2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-3: Putinoary Rehabilitation Services 3-3: Putinoary Rehabilitation Services 4: Workfwide Emergency/Urgent Coverage 7: Chriopractic Services 4: Workfwide Emergency/Urgent Coverage 7: Chrispratent Biod Services 13: Acupuncture 13: Over-time-Counter (OTC) tems	

Max Enrollee Cost Limit (Out-of-Network)

<u>H</u> elp Add	d Variable			_	
vious	Next	Exit (Validate)	Exit (No Validate)	Go To: 🔟	ax Enrollee Cost Limit (Out-of-Network)
Yes No your Out-of-1		ximum Enrollee mum Enrollee O			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 Madicare-covered Service Categories that are INCLUDED in the Out-of-Network Maximum Enrollee Out-of-Pocket
indatory? Voluntary					Cost amount: 1a: Inpatient Hospital-Acute
rvices. For a the "Is your Voluntary o	nust have a ma a list of the Volu r Combined M or Mandatory	untary and Mand aximum Enrolle level?" question	datory Limits, pl e Out-of-Pocket and view the V	that covers all A ease right-click (MOOP) Cost a ariable Help. et Cost Amount:	3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 5: Partial Hoopstalization 6: Home Health Services
Out-of-Pocke Out-of-Ne	et cost: etwork Medica	oly to the Out-of re-covered ben edicare-covered	efits	num Enrollee	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? C: Yes O: No
included in t	the Maximum B	all Medicare Pa Enrollee Out-of- Maximum Enrol	Pocket Cost.	must be et Cost apply to	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
all Out-of-Ne		Maximum Enrol ire-covered plar		et Cost apply to	Categories that are INCLUDED in the Out-of-Network Maximum Enrollee Out-of-Pocket Cost amount: Ta: inpatient Kospital-Acute
C No					1b: Inpatient Hospital Psychiatric 2: Skiled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Jintensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 4:: Worldwide Emergency/Urgent Coverage 7b: Chiropractic Services 9d: Outpatient Blood Services 9d: Outpatient Blood Services 10b: Transportation Services

Max Enrollee Cost Limit (Non-Network)

evious	Next	Exit (Validate)	Exit (No Validate)	Go To:	Aax Enrollee Cost Limit (Non-Network)	
		,,	,			
vour Maximu ndatory leve Voluntary Mandatory	m Enrollee Ou ?	t-of-Pocket (MO	OP) Cost at the	Voluntary or	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	
I MA plans m B services. F ht-click on t IOOP) Costa e Variable He	for a list of the he "Is your Co at the Voluntar elp.	aximum out-of-po Voluntary and M mbined Maximur y or Mandatory I lee Out-of-Pocke	fandatory Limit n Enrollee Out-o evel?" question	s, please of-Pocket	Maximum Enrollee Out-of-Pocket Cost Amount: 1a: Inpatient Hospital-Acute Inpatient Hospital Psychiatric Skiled Nursing Facility (SNF) S-11: Cardiac Rehabilitation Services S-2: Intensive Cardiac Rehabilitation Services S-3: Automorary Rehabilitation Services A: Emergency Care Image: State Services Services Services 	
					Does the Maximum Enrollee Out-of-Pocket Cost apply to all Non-Medicare covered plan services?	-
Medicare-c	efits that apply overed benefi are-covered b		i ⊏nroiiee Out-o	n-Pocket cost:	O Yes O No]
oes the Maxir vered plan s		Out-of-Pocket C	ost apply to all I	Medicare-	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.	
Yes No					Select all of the Non-Medicare-covered Service Categories INCLUDED in the Maximum Enrollee Out-of-Pocket Cost Amount:	ч.
					1a: Inpatient Hospital-Acute 1b: Inpatient Hospital Psychiatric 2: Skilled Mursing 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 9d: Outpatient Blood Services 9d: Outpatient Blood Services 10b: Transportation Services	

Max Plan Benefit Coverage

	Go To: Max Plan Benefit Coverage	
vious Next (Validate)		
Maximum Plan Benefit Coverage refers to Non-Medicare-	Does the Maximum Plan Benefit Coverage amount apply to all In-Network	
red benefits.	Non-Medicare-covered plan services?	
nere a Maximum Plan Benefit Coverage Amount?	C Yes C No	
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	
dicate Maximum Plan Benefit Coverage Amount:	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:	
elect Maximum Plan Benefit Coverage Amount Periodicity:	1b: Inpatient Hospital Psychiatric	
⊖ Every two years ⊖ Every year	3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services	
C Every six months	3-3: Pulmonary Rehabilitation Services	
C Every three months O Other, Describe	Does the Maximum Plan Benefit Coverage amount apply to all Out-of- Network Non-Medicare-covered plan services?	
elect the benefits that apply to the Maximum Plan Benefit overage Amount:	C Yes C No	
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 Out-of-Network Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies: Ta: Inpatient Nospital-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 ▼	
	0. Hume median Services	

Max Plan Benefit Coverage (Non-Network)

Help Add Variable		
Exit Exit (No	Go To: Max Plan Benefit Coverage (Non-Network)	
vious Next (Validate) Validate)		
Maximum Plan Benefit Coverage refers to Non-Medicare- ered benefits.	Does the Maximum Plan Benefit Coverage amount apply to all Non- Medicare-covered plan services?	
ere a Maximum Plan Benefit Coverage Amount?	C Yes	
Yes	C No	
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	
dicate Maximum Plan Benefit Coverage Amount:	CTRL key on your keyboard.	
	Select all of the Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies:	
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DEvery three years DEvery two years	2: Skilled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services	
C Every year	3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services ▼	
C Every six months C Every three months	5-3. Pulhohaly Kehaumanon Services	
O Other, Describe		

Plan Premium/Rebate Reduction

Help Ad	Next	Exit (Validate)	Exit (No Validate)	Go To: Plan Premium/Rebate	Reduction	 •	
licate Plan Pr	emium Amour	it (Part A/B):					
licate Plan Pr	emium Amour	t (B Only):					
Yes	ny of your pla B Premium?	n's MA rebates to					
No dicate the Pa	art B Premium	reduction amount					

MMP – Medicaid/plan covered cost sharing

PBP Data Entry System - Section D, Contract X000	01, Plan 001, Segment 000
ile Help Add Variable	MMP - Medicaid/plan covered cost sharing
Previous Next (Validate) Validate)	
Do you offer any Non-Medicare benefits (i.e., services not covered by Medicare)? C 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 1a2: Non-Medicare-covered Stay for Inpatient Hospital-Acute 1a3: Non-Medicare-covered Stay for Inpatient Hospital-Acute 1a4: Non-Medicare-covered Stay for Inpatient Hospital-Acute 1a5: Additional Days For Inpatient Hospital-Acute 1a5: Ann-Medicare-covered Stay for Inpatient Hospital Psychiatric 1b2: Ann-Medicare-covered Stay for Inpatient Hospital-Acute 1a5: Undivide Erregency Coverage 4c2: Wordwide Erregency Coverage 4c3: Wordwide Erregency Coverage 4c4: Wordwide Erregency Coverage 4c5: Wordwide Erregency Coverage 4c5: Wordwide Erregency Evrices 6c4: Other 1 for Home Heath Services 6c4: Other 1 for Home Heath Services 7c: Occupation Errorise 7c: Occupation Errorise 7c: Occupation Evrices 7c: Occupation Evr	4c1: Worldwide Emergency Coverage 4c2: Worldwide Emergency Transportation

PFFS Balance Billing

revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	PFFS Balance Billing	
o you permit b Yes No Hold down the options with y TCR key on y What category da: inpatient Ht b: inpatient Ht b: inpatient Ht b: inpatient Ht b: inpatient Ht 2: Skiled Nursi 3-1: Cardiac R4 2: Alt Cardiac R4 2: Alt Cardiac R4 2: Alt Cardiac R4 2: World wide S: Partial Hospi 6: Home Healt Hospi 6: Home Healt Hospi 7: Octopation 7: Physician S 7: Other Heal The Say Chart Heal The Paychatric The Physician S 7: Other Heal The Physician S 7: Other Heal The Physician S 7: Other Heal Standard S 2: Outpatient 1 8: Ambulatory 5: Outpatient 1 8: Ambulatory 5: Outpatient 1	Alance billing? CTRL key on your MOUSE. At your MOUSE. At your Keyboard. Af providers d spital-Acute spital-	Exit (Validate) Balance plan pa collect. our keyboard wh ter selecting ALL o you permit to b ic) vices tation Services envices ent Coverage rvices es rvices sonal ch-Language Patl ts/Lab Services is (ASC) Services	Validate) Billing is a per yment rate pro hile selecting th of your option alance bill?	rcentage of vider may the coverage is release the	Enter Minimum percentage for balance billing:	

MSA Annual Deductible/Deposit

Per Point Per Point <t< th=""><th></th><th></th><th>m - Section</th><th>D, Contra</th><th>act X0001</th><th>I, Plan 001, Segment 000</th><th>- 8 ×</th></t<>			m - Section	D, Contra	act X0001	I, Plan 001, Segment 000	- 8 ×
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Indicate Annual MSA Deductible amount:	Previous	Next	Exit (Validate)	Exit (No Validate)	GO 10: j		
				,			
	Indicate Annual I	ISA Deductible a	amount:				
Indicate the Annual amount CMB will deposit into the Enrollee MBA							
	Indicate the Annu	al amount CMS	will deposit into t	the Enrollee N	ISA		

Notes

•	l Variable	Exit (Validate)	Exit (No Validate)	Go To: Notes				•		
vious	Next	(Validate)	Validate)							
amay include	e additional in	formation to des	cribe benefit in	this service category	Do not repeat infor	mation captured in d	ata entry.			
15:										
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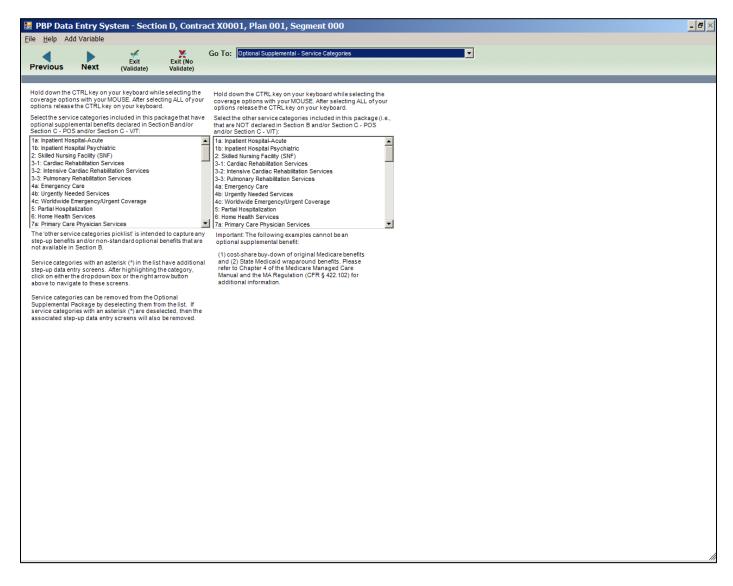
Optional Supplemental – Management Screen

avious	Next	Exit (Validate)	Exit (No Validate)	Go To: 🔽	tional Supplemental - Management Screen			
ional Supplen	nental Packa	ges			Note: To add an optional supple on the 'Add Package' button. To supplemental package, highligh and then click on the Delete Pac	mental package, click delete an optional theexisting package kkage' button.		
d Package		elete Package						

Optional Supplemental – Label and Premium

PBP Data Entry System - Section D, Contract X00 Ie Help Add Variable	01, Plan 001, Segment 000	- 8
	Coptional Supplemental - Label and Premium	
Optional Supplemental Benefits ID: Optional Supplemental Package Description: Indicate Optional Supplemental Premium Amount: Is there a Maximum Plan Benefit Coverage Amount for this package?	Select the benefits 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: Putmonary Rehabilitation Services 4: Emergency Care 4: Urgently Needed Services 5: Partial Hospitalization 6: Home Heath Services 7: Primary Care Physician Services	
C Yes C No Indicate Maximum Plan Benefit Coverage Amount for this package:	Tb: Chiropractic Services Tc: Occupational Therapy Services Tc: Decupational Therapy Services Td: Physicial Specialty Services Tr: Podiatry Services Tr: Podiatry Services Tr: Posteristic Services Tr: Physicial Therapy and Speech-Language Pathology Services 8b: Outpatient Diagnostic/Therapeutic Radiological Services	
C Every three years C Every two years C Every two years C Every six months C Every six months C other, Describe Do the Optional Supplemental benefits in this package apply to the MOOP for this plan? C Yes C No	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes: Image: Category in the service category. Do not repeat information captured in data entry.	
Is there an enrollee Deductible for this package? C Yes C No Indicate Deductible Amount:		

Optional Supplemental – Service Categories



Optional Supplemental – OON Optional

3P Data Entry System - Section D, Cont Help Add Variable	ract x0001, Flan 001, Segment 000	
vious Next (Validate)	Go To: Optional Supplemental - OON Optional	
this category include Out-of-Network benefits?	Is there an OON Copayment?	
es 0	C Yes C No	
the OON cost shares the same as the In-Network t shares?	Enter Minimum Copayment Amount:	
Yes No		
ere an OON Coinsurance?	Enter Maximum Copayment Amount:	
Yes No		
ter Minimum Coinsurance Percentage:	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
	Notes:	
iter Maximum Coinsurance Percentage:	~	

Optional Supplemental – OON Step-up

	tract X0001, Plan 001, Segment 000	- 8
e Help Add Variable Previous Next (Validate) Validate)	Go To: Optional Supplemental - OON Step-up	
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Step-up #7b Chiropractic Services – Base 1

Help Add Variable	Go To: Step-up #7b Chiropractic Services - Base	1	
evious Next (Validate) V	alidate)		_
CLICK FOR DESCRIPTION OF BENEFIT es the plan provide Chiropractic Services as a polemental benefit under Part C? Yes No lect enhanced benefit: Routine Care Other Select type of benefit for Routine Care: Other Select type of benefit for Routine Care: Other Is this benefit unlimited for Routine Care? Other Is this benefit unlimited for Routine Care? Other Indicate number of visits for Routine Care: Select Routine Care periodicity: C Every three years C Every year C Every year C Every three months C Other, Describe	Enter Name of Other Service: Select type of benefit for Other Service: Optional Is this benefit unlimited for Other Service? Yes No, indicate number Indicate number of visits for Other Service: Select Other Service periodicity: Every three years Every three wonths Other, Describe	Is there a service-specific Maximum Plan Benefit Coverage amount? Yes Yes Ves Ves Ves Ves Ves Ve	
o you offer a combined Acupuncture/Alternative herapies/Chiropractor Services benefit? > Yes > No Select the enhanced benefits that are included in the combined benefit (Select all that apply): Routine Care Other		C Other, Describe	

Step-up #7b Chiropractic Services – Base 2

Exit Exit (No	Go To: Step-up #7b Chiropractic Services - Base 2	
vious Next (Validate) Validate)		
here an enrollee Coinsurance?	Is there an enrollee Copayment?	Is there an enrollee Deductible?
Yes No	C Yes C No	C Yes C No
lect which Chiropractic Services have a Coinsurance (Select that apply): Medicare-covered Chiropractic Services Routine Care Other dicate Minimum Coinsurance percentage per visit for edicare-covered Benefits: dicate the Minimum Coinsurance percentage per visit for utine Care: dicate the Minimum Coinsurance percentage per visit for outine Care: dicate the Minimum Coinsurance percentage per visit for her Service:	Select which Chiropractic Services have a Copayment (Select all that apply): Medicare-covered Chiropractic Services Other Indicate Minimum Copayment amount for Medicare-covered Benefits: Indicate Maximum Copayment amount for Medicare-covered Benefits: Indicate Maximum Copayment amount per visit for Routine Care: Indicate Maximum Copayment amount per visit for Routine Care: Indicate Maximum Copayment amount per visit for Other Service: Indicate Maximum Copayment amount per visit for Other Service:	Indicate Deductible Amount:

Step-up #7b Chiropractic Services – Base 3

revious	Next	Exit (Validate)	Exit (No Validate)	Go To: Ste	o-up #7b Chiropractic Services	- Base 3		
ropractic Se	rvices Notes							
	e additional ir	formation to des	cribe benefit in t	his service categ	ory. Do not repeat information	captured in data entry.		
95:								

Step-up #7f Podiatry Services – Base 1

PBP Data Entry System - Section Help Add Variable			
Exit	Go To: Step-up #7f Podiatry Services - Base	1	
evious Next (Validate)	Validate)		_
CLICK FOR DESCRIPTION OF BENEFIT es the plan provide Podiatry Services as a pplemental benefit under Part C? 'Yes No elect enhanced benefits: Routine Foot Care: Ontional Is this benefit unlimited for Routine Foot Care? Yes No Indicate number of Routine Foot Care visits:	C Every three years C Every two years C Every six months C Every six months C Every six months C Other, Describe Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes No Indicate Maximum Plan Benefit Coverage amount:	there a service-specific Maximum Enrollee Out	

Step-up #7f Podiatry Services – Base 2

PBP Data Entry System - Section D, Contract X0001	, Plan 001, Segment 000	-8
	ep-up #7f Podiatry Services - Base 2	
Exit Exit (No	Is there an enrollee Copayment? Yes Select which Podiatry Services have a Copayment (Select all that apply): Medicare-covered Podiatry Services Routine Foot Care Indicate Minimum Copayment amount per visit for Medicare-covered Benefits: Indicate Maximum Copayment amount per visit for Routine Foot Care: Indicate Maximum Copayment amount per visit for Routine Foot Care:	

Step-up #7f Podiatry Services – Base 3

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evious	Next	Exit (Validate)	Exit (No Validate)	Go To: Ste	p-up #7f Podiatry Services -	Base 3		•		
uthorization	required?									
Yes No										
	ired for Podia	trist Services?								
Yes No										
liatry Service	s Notes									
		nformation to des	cribe benefit in t	his service categ	ory. Do not repeat informa	ion captured in data entr	y.			
es:										
							*			

Step-up #10b Transportation Services – Base 1

	Go To: Step-up #10b Transportation Servi t (No date)	ces - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Dees the plan provide Transportation Services as a supplemental benefit under Part C? Yes No Select enhanced benefit: Plan-approved Location Select type of benefitor Plan-approved Location: Onandatory Optional Is this benefit unlimited for number of trips for Plan -approved Location? Ves No Select Plan-approved Location Trips periodicity: Every three years Every six months Other, Describe Ventor Service Other, Describe	Select Type of Transportation for Plan-approved Location: One-way Days Other, Describe Select Mode of Transportation for Plan-approved Location: Taxi Select Mode of Transportation for Plan- approved Location: Taxi Select Mode of Transportation for Plan- approved Location: Taxi Select Mode of Transportation for Plan- approved Location: Select type of benefit for Any Health-related Location: Mandatory Optional Is this benefit unlimited for number of trips for Any Health-related Location? Yes No	Indicate number of trips for Any Health-related Location: Select Any Health-related Location Trips periodicity: C Every three years C Every year C Every year C Every six months C Other, Describe Select Type of Transportation for Any Health- related Location: O Other, Describe Indicate number of days for Any Health- related Location: Select Mode of Transportation for Any Health- related Location: O ther, Describe	

Step-up #10b Transportation Services – Base 2

BP Data Entry System - Section D, Help Add Variable	contract x0001, Plair 001, Segi		<u>-</u>
	Go To: Step-up #10b Transportati	inn Saruinan, Rasa 2	
	t (No		
vious Next (Validate) Valid	date)		_
ere a service-specific Maximum Plan Benefit	Is there a service-specific Maximum	Is there an enrollee Coinsurance?	
erage amount?	Enrollee Out-of-Pocket Cost?	C Yes	
Yes	C Yes	C No	
No	C No		
icate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of-	Indicate Minimum Coinsurance percentage:	
	Pocket Cost amount:		
	1	Indicate Maximum Coinsurance percentage:	
ect Maximum Plan Benefit Coverage periodicity:	Select Maximum Enrollee Out-of-		
Every three years	Pocket Cost periodicity:		
Every two years	C Every three years	Is there an enrollee Deductible?	
Every year	O Every two years	C Yes	
Every six months Every three months	C Every year	C No	
Other, Describe	C Every six months		
Other, Describe	C Every three months	Indicate Deductible Amount:	
	C Other, Describe		

Step-up #10b Transportation Services – Base 3

revious Next (Validate) Go To: Ualidate)	Step-up #10b Transportation Services - Base 3	
there an enrollee Copayment? No ndicate Minimum Copayment amount per trip: ndicate Maximum Copayment amount per trip: authorization required? Yes No a referral required for Transportation Services? Yes No	Transportation Services Notes Note may include additional information to describe benefit in this service actegory. Do not repeat information captured in data entry. Note: Image: Image	

Help Add Variable	Go To: Step-up #16a Preventive Denta	- Base 1	
	xit (No alidate)		
CLICK FOR DESCRIPTION OF BENEFIT Dees the plan provide Preventive Dental Items as a spplemental benefit under Part C? Yes Oral Exams Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays Select type of benefit for Oral Exams: O Mandatory O Optional Is this benefit unlimited for Oral Exams: O Yes No, indicate number Indicate number of visits for Oral Exams: O Yes	Select the Oral Exams periodicity:	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 three years Every three months Other, Describe Other, Describe	

Help Add Variable	D, Contract X0001, Plan 001, Segment 000	
Exit	Go To: Step-up #16a Preventive Dental - Base 2 Exit (No	
evious Next (Validate)	/alidate)	
lect type of benefit for Dental X-Rays:	Is there a service-specific Maximum Plan Benefit Coverage amount?	
Mandatory Optional	C Yes C No	
his benefit unlimited for Dental X-Rays? Yes	Does the Maximum Plan Benefit Coverage amount apply to In- network services only OR does it apply to both In-network and Out-	
No, indicate number	of-network services?	
dicate number of visits for Dental X-Rays:	C In-network services only C Both In-network and Out-of-network services	
Select the Dental X-Rays periodicity:	Indicate Maximum Plan Benefit Coverage amount:	
Every three years Every two years	Select the Maximum Plan Benefit Coverage periodicity:	
⊖ Every year ⊖ Every six months	C Every three years C Every two years C Every year	
C Every three months C Other, Describe	C Every six months C Every three months	
	C Other, Describe	

Help Add Variable	Go To: Step-up #16a Preventive Dental - Base 3		
Exit Exit (No	Go To: Step-up # toa Preventive Demai - Base 3	<u>Ľ</u>	
evious Next (Validate) Validate)			
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here a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes	Is there a combination of services included in a single cost per Office Visit?	Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):	
No	O Yes		
dicate Maximum Enrollee Out-of-Pocket Cost amount:	C No		
	Select which combination of services are	Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):	
	included in a single cost per Office Visit: Oral Exams		
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Prophylaxis (Cleaning)		
○ Every three years ○ Every two years	Fluoride Treatment	Indicate Minimum Coinsurance percentage for Fluoride Treatment:	
O Every year	Dental X-Rays		
C Every six months		Indicate Maximum Coinsurance percentage	
C Every three months O Other, Describe	Indicate Coinsurance percentage for Office Visit:	for Fluoride Treatment:	
here an enrollee Coinsurance?			
Yes		Indicate Minimum Coinsurance percentage for	
No	Indicate Minimum Coinsurance percentage for Oral Exams:	Dental X-Rays:	
Select which Preventive Dental Services have a Coinsurance			
Select all that apply):	Indicate Maximum Coinsurance percentage for Oral	Indicate Maximum Coinsurance percentage for Dental X-Rays:	
Oral Exams Prophylaxis (Cleaning)	Exams:		
Fluoride Treatment			
Dental X-Rays			

Help Add Variable		
Exit Exit (No Next (Validate)	D To: Step-up #16a Preventive Dental - Base 4	
nere an enrollee Deductible?	Indicate Copayment amount for Office Visit	
Yes No		
Indicate Deductible Amount:	Indicate Minimum Copayment amount for Oral Exams:	
here an enrollee Copayment?	Indicate Maximum Copayment amount for Oral Exams:	
Yes No	Indicate Minimum Copayment amount for Prophylaxis (Cleaning):	
elect which Preventive Dental Services have a Copayment Select all that apply): Oral Exams	Indicate Maximum Copayment amount for Prophylaxis (Cleaning):	
Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays	Indicate Minimum Copayment amount for Fluoride Treatment.	
there a combination of services included in a single cost per ffice Visit?	Indicate Maximum Copayment amount for Fluoride Treatment:	
) Yes) No	Indicate Minimum Copayment amount for Dental X-Rays:	
Select which combination of services are included in a single cost per Office Visit:] Oral Exams	Indicate Maximum Copayment amount for Dental X-Rays:	
Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays		

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revious	Next	Exit (Validate)	Exit (No Validate)	Go To: S	tep-up #16a Preventive Dental - B	ase 5	×		
authorization Yes	required?								
No				2					
a referral requ Yes	iired for Preve	ntive Dental Serv	ices?						
No									
eventive Dent	al Services No	tes							
te may includ egory. Do no	e additional in t repeat inform	formation to desc lation captured in	cribe benefit in t data entry.	his service					
tes:									
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PBP Data Entry System - Section D, Contract X(0001, Plan 001, Segment 000			- 8 >
Eile Help Add Variable	o: Step-up #16b Comprehensive Dental - Ba	ace 1	-	
Previous Next (Validate) Go T	0. Step-up # 100 comprehensive Dental - Da		-	
CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Non-routine Services:	Select type of benefit for Diagnostic Services:	Select type of benefit for Restorative Services:	
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	C Mandatory C Optional	C Mandatory C Optional	C Mandatory C Optional	
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Is this benefit unlimited for Non-routine Services?	Is this benefit unlimited for Diagnostic Services?	Is this benefit unlimited for Restorative Services?	
C Yes C No	C Yes C No, indicate number	C Yes C No, indicate number	O Yes O No, indicate number	
Select enhanced benefits:	Indicate number of visits for Non- routine Services:	Indicate number of visits for Diagnostic Services:	Indicate number of visits for Restorative Services:	
Diagnostic Services Restorative Services				
Endodontics Periodontics	Select the Non-routine Services periodicity:	Select the Diagnostic Services periodicity:	Select the Restorative Services periodicity:	
Extractions Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services	C Every three years C Every two years C Every year	C Every three years C Every two years C Every year	 Every three years Every two years Every year 	
	C Every six months C Every three months	C Every six months C Every three months	C Every six months C Every three months C Other, Describe	
	C Other, Describe	C Other, Describe	O Other, Describe	

Help Add Variable			_
Exit	Go To: Step-up #16b Comprehensiv Exit (No	e Dental - Base 2	•
evious Next (Validate)	Validate)		
lect type of benefit for Endodontics:	Select type of benefit for Periodontics:	Select type of benefit for Extractions:	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:
Mandatory Optional	 Mandatory Optional 	C Mandatory C Optional	O Mandatory
Optional	O Optional	Optional	O Optional
this benefit unlimited for Endodontics?	Is this benefit unlimited for Periodontics?	Is this benefit unlimited for Extractions?	
Yes	O Yes	C Yes	Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?
No, indicate number	C No, indicate number	O No, indicate number	C Yes
ndicate number of visits for Endodontics:	Indicate number of visits for Periodontics:	Indicate number of visits for Extractions:	C No, indicate number
			Indicate number of visits for Prosthodontics, Other
lect the Endodontics periodicity:	Select the Periodontics periodicity:	Select the Extractions periodicity:	Oral/Maxillofacial Surgery, Other Services:
Every three years	C Every three years	C Every three years	
Every two years	C Every two years	C Every two years	Select the Prosthodontics/Other Oral/Maxillofacial
Every year	C Every year	C Every year	Surgery/Other Services periodicity:
Every six months Every three months	 Every six months Every three months 	C Every six months C Every three months	C Every three years C Every two years
Other, Describe	O Other, Describe	O Other, Describe	O Every year
			C Every six months
			C Every three months C Other, Describe

PBP Data Entry System - Section D, Contract X00	01, Plan 001, Segment 000	_
Help Add Variable	Step-up #16b Comprehensive Dental - Base 3	
there a service-specific Maximum Plan Benefit Coverage amount? 7 Yes 7 No Select the Maximum Plan Benefit Coverage type:	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes No Select the Maximum Enrollee Out-of-Pocket Cost type:	
C Covered under Preventive Dental Category 16a Plan-specified amount per period Does the Maximum Plan Benefit Coverage amount apply to In-network rervices only OR does it apply to both In-network and Out-of-network	C Govered under Preventive Dental Category 16a C Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
ervices? C In-network services only C Both In-network and Out-of-network services Indicate Maximum Plan Benefit Coverage amount:	Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe	
Select the Maximum Plan Benefit Coverage periodicity: C Every three years C Every year C Every year C Every six months C Every three months O Other, Describe		

evious Next	Exit Exit (Validate) Valid	Go To: Step-up #16b Cor (No late)	prehensive Dental - Base 4	
here an enrollee Coinsurand	ce?		Is there an enrollee Deductible?	
Yes			C Yes	
No			C No	
lect which Comprehensive E t apply):	ental Services have a C	oinsurance (Select all		
Medicare-covered Benefits			Indicate Deductible Amount:	
Non-routine Services				
Diagnostic Services				
Restorative Services				
Endodontics				
Periodontics				
Extractions				
Prosthodontics, Other Oral/	Maxillofacial Surgery, Ot	her Services		
Mi dicare-covered Benefits	nimum Coinsurance	Maximum Coinsurance		
dicare-covered benefits				
n-routine Services				
agnostic Services				
storative Services				
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osthodontics, Other al/Maxillofacial Surgery, her Services:				

Fu Associates, Ltd.

Previous Next	Exit E (Validate) Va	💥 Go To: 🛿 xit (No alidate)	Step-up #16b Comprehensive Dental - Base 5	
there an enrollee Copayme	nt?			
O Yes			7	
O No				
elect which Comprehensive nat apply):	Dental Services have a	a Copayment (Select all		
Medicare-covered Benefits	1			
Non-routine Services				
Diagnostic Services				
Restorative Services				
Endodontics				
Periodontics				
Extractions				
Prosthodontics, Other Ora	I/Maxillofacial Surgery,	Other Services		
c	opayment Minimum	Copayment Maximu	um	
ledicare-covered Benefits			1	
Ion-routine Services			1	
ton-routine Services				
Diagnostic Services]	
Restorative Services				
ndodontics				
Periodontics				
	·			
xtractions				
Prosthodontics, Other Dral/Maxillofacial Surgery, Dther Services:				

Fu Associates, Ltd.

e <u>H</u> elp Add Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: 🛽	p-up #16b Comprehensive	: Dental - Base 6			
authorization	equired?								
O Yes O No									
	ired for Comp	rehensive Dental	Services?						
O Yes O No									
Comprehensive lote may includ ategory. Do no	e additional in	es Notes formation to desc lation captured in	cribe benefit in ti n data entry.	his service					
otes:	. span mon	en esplored fr							
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Step-up #17a Eye Exams – Base 1

e Help Add Variable Previous Next Exit (No Validate) Go To: Step-up #17a Eye Exams - Base 1 CLICK FOR DESCRIPTION OF BENEFIT Is there a service-specific Maximum Plan Benefit Coverage amount? Is there a service-specific Maximum Plan Benefit Coverage amount? Obes the plan provide Eye Exams as a supplemental enefit or Other Service: Select type of benefit for Other Service: Is there a service-specific Maximum Plan Benefit Coverage amount? Is there a service-specific Maximum Enrolle out-of-Pocket C amount? Yes Optional Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services? Indicate Maximum Enrollee Out-of-Pocket C amount. Routine Eye Exams Is this benefit unlimited for Other Service? In In-network services only Select the Maximum Enrollee Out-of-Pocket C amount.
Octor of recedent intervention of recedent intervention Coverage amount? of-Pocket Cost? Dees the plan provide Eye Exams as a supplemental nefit under Part C? C Yes C Yes Select type of benefit for Other Service: Does the Maximum Plan Benefit Coverage amount? Indicate Maximum Enrollee Out-of-Pocket Cost? Yes O Mandatory Does the Maximum Plan Benefit Coverage amount? Indicate Maximum Enrollee Out-of-Pocket Cost? elect enhanced benefit: C optional Does the Maximum Plan Benefit Coverage amount? Indicate Maximum Enrollee Out-of-Pocket Cost? Routine Eye Exams Is this benefit unlimited for Other Service? C In-network services only Indicate Maximum Enrollee Out-of-Pocket Cost?
Other C Yes Both In-network and Out-of-network services Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Both In-network and Out-of-network services Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Both In-network and Out-of-network services Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years Select the Other Service: Select the Other Service: Select the Maximum Plan Benefit Coverage amount: C Every three years Select the Other Service: Select the Maximum Plan Benefit Coverage periodicity: C Every three years Select the Other Service: Select the Maximum Plan Benefit Coverage periodicity: C Every three years Select the Other Service: Select the Maximum Plan Benefit Coverage periodicity: C Every three years Select the Maximum Plan Benefit Coverage periodicity: C Every three years Select the Maximum Plan Benefit Coverage periodicity: C Every three years Select the Maximum Plan Benefit Coverage periodicity: C Every three years C Every

Step-up #17a Eye Exams – Base 2

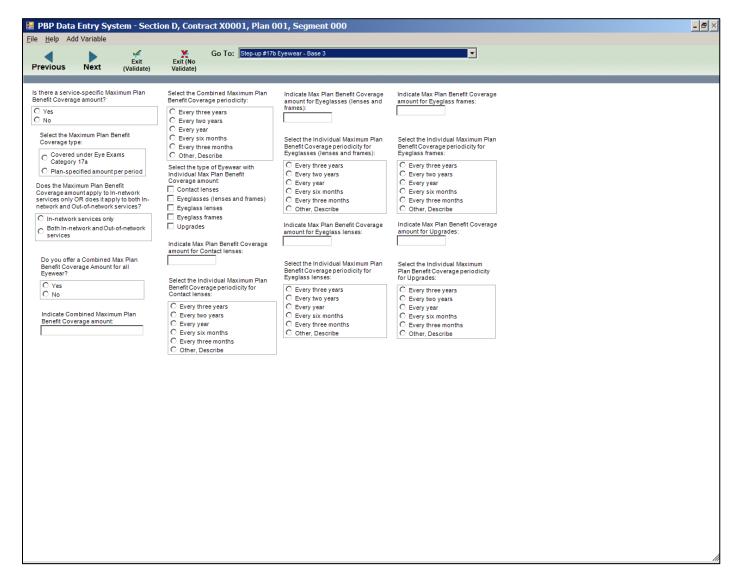
evious Next (Validate) Go To	Step-up #17a Eye Exams - Base 2		
nere an enrollee Coinsurance? Yes No	Is there an enrollee Copayment? C Yes C No	Is there an enrollee Deductible? C Yes C No	
ect which Eye Exams have a Coinsurance (Select all that apply): vledicare-covered Benefits Routine Eye Exams Dther	Select which Eye Exams have a Copayment (Select all that apply): Medicare-covered Benefits Routine Eye Exams Other	Indicate Deductible Amount:	
dicate Minimum Coinsurance percentage for Medicare-covered enefits:	Indicate Minimum Copayment amount for Medicare-covered Benefits:		
dicate Maximum Coinsurance percentage for Medicare-covered enefits:	Indicate Maximum Copayment amount for Medicare-covered Benefits:		
dicate Minimum Coinsurance percentage for Routine Eye Exams:	Indicate Minimum Copayment amount for Routine Eye Exams:		
dicate Maximum Coinsurance percentage for Routine Eye Exams:	Indicate Maximum Copayment amount for Routine Eye Exams:		
dicate Minimum Coinsurance percentage for Other Service:	Indicate Minimum Copayment amount for Other Service:		
dicate Maximum Coinsurance percentage for Other Service:	Indicate Maximum Copayment amount for Other Service:		

Step-up #17a Eye Exams – Base 3

is authorization required 7 C Yes C	e <u>H</u> elp Add Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: Ste	⊢up #17a Eye Exams - Base	3			
C No s a referral required for Eye Exams? C Yes No Seve Exams Notes Note may include additional information to describe benefit in this service sategory. Do not repeat information captured in data entry. Notes:	authorization	required?								
Yes No ye Exams Notes ote may include additional information to describe benefit in this service ategory. Do not repeat information captured in data entry. otes:										
No ve Exams Notes otemay include additional information to describe benefit in this service lategory. Do not repeat information captured in data entry.		ired for Eye E	Exams?							
ote may include additional information to describe benefit in this service itegory. Do not repeat information captured in data entry. Detes:	Ves No									
ites:	e Exams Note	S								
tes:	te may includ	e additional in	nformation to des	cribe benefit in t	his service					
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evious Next (Validate) Valid	jate)		
CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Contact lenses:	Select type of benefit for Eyeglasses (lenses and	
		frames):	
en if you do not offer enhanced benefits, you must mplete this section for your Medicare-covered nefits.	C Mandatory C Optional	C Mandatory C Optional	
es the plan provide Eyewear as a supplemental refit under Part C?	Is this benefit unlimited for Contact lenses? C Yes	Is this benefit unlimited for Eyeglasses (lenses and frames)?	
	C No, indicate number	C Yes	
Yes No		C No, indicate number	
elect enhanced benefits: Contact lenses	Indicate quantity (number of pairs) for Contact lenses:	Indicate quantity for Eyeglasses (lenses and frames):	
Eyeglasses (lenses and frames)			
Eyeglass lenses	Colort Contact lances and distant	Select Eyeglasses (lenses and frames)	
Eyeglass frames	Select Contact lenses periodicity:	periodicity:	
Upgrades	C Every three years C Every two years	C Every three years	
	C Every year	C Every two years	
	C Every six months	C Every year	
	C Every three months	C Every six months C Every three months	
	C Other, Describe	C Other, Describe	

evious Next (Validate)	Go To: Step-up #17b Eyewear - Base 2	
ect type of benefit for Eyeglass lenses:	Select type of benefit for Eyeglass frames:	
Mandatory Optional	C Mandalory C Optional	
this benefit unlimited for Eyeglass lenses?	Is this benefit unlimited for Eyeglass frames?	
Yes No, indicate number	C Yes C No, indicate number	
dicate quantity (number of pairs) for Eyeglass lenses:	Indicate quantity for Eyeglass frames:	
Select Eyeglass lenses periodicity:	Select Eyeglass frames periodicity:	
C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months O Other, Describe	
	Select type of benefit for Upgrades:	



PBP Data Entry System - Section D, Contract >	(0001, Plan 001, Segment 000		_
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revious Next (Validate) Go	TO: Step-up #170 Eyewear - base +	<u>v</u>	
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:	
elect 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:	
ndicate 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: C Every three years C Every two years	Indicate Maximum Coinsurance percentage for Contact lenses:	Indicate Maximum Coinsurance percentage for Upgrades:	
C Every year C Every year C Every six months C Every three months C Other, Describe	Indicate Minimum Coinsurance percentage for Eyeglasses (lenses and frames):		
here an enrollee Coinsurance? Yes No	Indicate Maximum Coinsurance percentage for Eyeglasses (lenses and frames):		
elect which Eyewear Benefits have a Coinsurance (Select all that oply): Medicare-covered Benefits Contact lenses	Indicate Minimum Coinsurance percentage for Eyeglass lenses:		
Eveglasses (lenses and frames) Eyeglasses lenses Eyeglass frames	Indicate Maximum Coinsurance percentage for Eyeglass lenses:		
Upgrades			

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Eile Help Add Variable	To: Step-up #17b Eyewear - Base 5	Y	
Previous Next (Validate) Go	,		
Is there an enrollee Deductible?			
C Yes C No	Indicate Minimum Copayment amount for Contact lenses:	Indicate Minimum Copayment amount for Eyeglass frames:	
O No Indicate Deductible Amount:	Indicate Maximum Copayment amount for Contact lenses:	Indicate Maximum Copayment amount for Eyeglass frames:	
Is there an enrollee Copayment?	Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):	Indicate Minimum Copayment amount for Upgrades:	
C Yes C No			
Select which Eyewear Benefits have a Copayment (Select all that apply):	Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):	Indicate Maximum Copayment amount for Upgrades:	
Medicare-covered Benefits Contact lenses	Indicate Minimum Copayment amount for Eyeglass lenses:		
☐ Eyeglasses (lenses and frames) ☐ Eyeglass lenses ☐ Eyeglass frames			
Upgrades	Indicate Maximum Copayment amount for Eyeglass lenses:		
Indicate Minimum Copayment amount for Medicare-covered Benefits:			
La diaste Maximum Canadama and anno untita Madiana anuarad			
Indicate Maximum Copayment amount for Medicare-covered Benefits:			
			//

	4	ld Variable	Exit (Validate)	Exit (No Validate)	Go To:	p-up #17b Eyewear - Base 6	
Yes	evious	Next	(Validate)	Validate)			
No referral required for Eyewear? Yes No wear Notes may include additional information to describe benefit in this service gory. Do not repeat information captured in data entry. IS:		required?					
referral required for Eyewear? Yes No wear Notes emay include additional information to describe benefit in this service gory. Do not repeat information captured in data entry. es:	Yes						
Yes No wear Notes emay include additional information to describe benefit in this service ggory. Do not repeat information captured in data entry. es:					9		
vear Notes may include additional information to describe benefit in this service gory. Do not repeat information captured in data entry. s:		uired for Eyew	ear?				
wear Notes emay include additional information to describe benefit in this service gory. Do not repeat information captured in data entry. es:							
gory. Do notrepeat information captured in data entry. s:			formation to desc	cribe benefit in t	hisservice		
	egory. Do n	ot repeat inforr	nation captured in	n data entry.	113 361 1106		
	otes:						
					<u>×</u>		

Help Add Variable	Go To: Step-up #18a Hearing Exams - Base 1	
	Select Routine Hearing Exams periodicity:	
LICK FOR DESCRIPTION OF BENEFIT	C Every three years C Every two years C Every year C Every six months C Every three months	
es the plan provide Hearing Exams as a supplemental efit under Part C?	C Other, Describe Select type of benefit for Fitting/Evaluation for Hearing Aid:	
Yes No	C Mandatory C Optional	
ect enhanced benefits: Routine Hearing Exams Fitting/Evaluation for Hearing Aid	Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	
Select type of benefit for Routine Hearing Exams:	C Yes C No, indicate number	
C Mandatory C Optional	Indicate number for Fitting/Evaluation for Hearing Aid:	
s this benefit unlimited for Routine Hearing Exams?	Select Fitting/Evaluation for Hearing Aid periodicity:	
C No, indicate number Indicate number for Routine Hearing Exams:	C Every three years C Every two years C Every year C Every year C Every three months C Every three months C Other, Describe	

e <u>H</u> elp Add Variable	, Contract X0001, Plan 001, Seg		
Exit E	Go To: Step-up #18a Hearing Exa xit (No	ams - Base 2	
revious Next (Validate) Va	alidate)		_
there a service-specific Maximum Plan Benefit overage 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 and Out-of-network services andicate Maximum Plan Benefit Coverage amount: Select the Maximum Plan Benefit Coverage periodicity: Every three years Every three years Every three months Every three months Other, Describe Is there an enrollee Deductible?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C Yes Select Maximum Enrollee Out-of-Pocket Cost amount C Every three years C Every three years C Every three years C Every three months C Other, Describe Is there an enrollee Colinsurance? Yes No Select Which Hearing Exam Benefits have a Coinsurance Celectal that apply): C Goinsurance Celectal that apply): C Fitting/Evaluation for Hearing Aid	Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate the Maximum Coinsurance percentage for Routine Hearing Exams: Indicate Maximum Coinsurance percentage for Routine Hearing Exams: Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Ald: Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Ald:	

PBP Data Entry System - Section D, Contract Help Add Variable	t X0001, Plan 001, Segment 000	<u>-</u>
	Go To: Step-up #18a Hearing Exams - Base 3	
there an enrollee Copayment?	Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	
Yes No		
lect which Hearing Exam Benefits have a Copayment (Select that apply): Medicare-covered Benefits Routine Hearing Exams	Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	
Fitting/Evaluation for Hearing Aid	Is authorization required?	
dicate Minimum Copayment amount for Medicare-covered nefits:	C Yes C No	
dicate Maximum Copayment amount for Medicare-covered mefits:		
	Is a referral required for Hearing Exams? C Yes	
dicate Minimum Copayment amount for Routine Hearing	C No	
ams:		
dicate Maximum Copayment amount for Routine Hearing ams:		

ous	Next	Exit (Validate)	Exit (No Validate)	Go To: Step-up #18a Hear	ring Exams - Base 4		
I Exams Nr		formation to desc	cribe benefit in	this service category. Do not rep	peat information captured in data en	try.	
						v	

PBP Data Entry System - Section	D, Contract X0001, Plan 001,	Segment 000	<u> </u>
e <u>H</u> elp Add Variable	🧏 Go To: Step-up #18b Heari	na Aida - Bana 4	
Exit	Exit (No	ig Alds - base i	
Previous Next (Validate)	Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Select Hearing Aids (all types) periodicity		
oes the plan provide Hearing Aids as a	C Every three years C Every two years	C Every three years C Every two years	
upplemental benefit under Part C?	C Every year C Every six months	C Every year C Every six months	
O Yes	O Every three months	C Every three months	
O No	O Other, Describe	O Other, Describe	
Select enhanced benefits: Hearing Aids (all types)	Select type of benefit for Hearing Aids -	Select type of benefit for Hearing Aids - Outer Ear:	
Hearing Aids - Inner Ear	Inner Ear:	C Mandatory	
Hearing Aids - Outer Ear	C Mandatory	C Optional	
Hearing Aids - Over the Ear	C Optional	In this has affected in the fact the size Aids - Only 7 - O	
Select type of benefit for Hearing Aids (all types):	Is this benefit unlimited for Hearing Aids -	Is this benefit unlimited for Hearing Aids - Outer Ear?	
C Mandatory	Inner Ear?	O No, indicate number	
C Optional	C Yes C No, indicate number	Indicate quantity for Hearing Aids - Outer Ear:	
Is this benefit unlimited for Hearing Aids (all types)?	Indicate quantity for Hearing Aids - Inner Ear:		
C Yes		Select Hearing Aids - Outer Ear periodicity:	
C No, indicate number	,	C Every three years	
Indicate quantity for Hearing Aids (all types):		C Every two years C Every year	
		C Every six months	
		C Every three months	
		C Other, Describe	
		L	

evious Next (Validate)	Go To: Step-up #18b Hearing Aids - Base 2	
ect type of benefit for Hearing Aids - Over the Ear: Mandatory Optional this benefit unlimited for Hearing Aids - Over the Ear? Yes No, indicate number dicate quantity for Hearing Aids - Over the Ear: Select Hearing Aids - Over the Ear periodicity: Every two years Every two years Every year Other, Describe there a service-specific Maximum Plan Benefit verage amount? Yes No	Does the Maximum Plan Benefit Coverage Amount apply per ear of for both ears combined? C Pre rar C Deer find the Amount Benefit Coverage type: C Covered under Hearing Exams Category - 18 Plan-specified amount per period Does the Maximum Plan Benefit Coverage amount apply to In-network and Out-of-network services? C In-network and Out-of-network services Indicate Maximum Plan Benefit Coverage periodicity: C Struct the years C Every three years C Every three years C Every three years C Every three months C Other, Describe	

	stem - Section D), Contract X0001, Plan 001, Segme		<u>- </u> t
Help Add Variable	Exit E	Go To: Step-up #18b Hearing Aids - E	Base 3	
revious Next	Exit Exit (Validate) Va	xit (No alidate)		
there a service-specific M cket Cost? Yes	aximum Enrollee Out-of-	Indicate Minimum Coinsurance percentage Hearing Aids (all types):	for Indicate Minimum Coinsurance percentage for Hearing Alds - Over the Ear:	
No				
elect the Maximum Enroll		Pe: Indicate Maximum Coinsurance percentage Hearing Aids (all types):	e for Indicate Maximum Coinsurance percentage for Hearing Aids - Over the Ear:	
D Plan-specified amount				
Indicate Maximum Enrolle	e Out-of-Pocket Cost am	nount: Indicate Minimum Coinsurance percentage Hearing Aids - Inner Ear:	for	
Select Maximum Enrolle periodicity:	Out-of-Pocket Cost	Indicate Maximum Coinsurance percentage ————————————————————————————————————	9 for	
C Every three years C Every two years C Every year				
C Every six months		Indicate Minimum Coinsurance percentage Hearing Aids - Outer Ear:	for	
C Every three months C Other, Describe		Hearing Alds - Outer Ear.		
there an enrollee Coinsu	irance?	Indicate Maximum Coinsurance percentage	ə for	
) Yes) No		Hearing Aids - Outer Ear:		
Select which Hearing Aids Select all that apply): Hearing Aids - Inner Ea Hearing Aids - Outer Ei Hearing Aids - Over th	ır ar	ance		

PBP Data Entry System - Section D, Contrac	t X0001, Plan 001, Segment 000		-
Help Add Variable	Go To: Step-up #18b Hearing Aids - Base 4	•	
evious Next (Validate) Validate)			
here an enrollee Copayment?			
Yes No	Indicate Minimum Copayment amount per Hearing Aid - Outer Ear:	Is there an enrollee Deductible? C Yes C No	
lect which Hearing Aids Benefits have a Copayment (Select that apply): Hearing Aid - Inner Ear	Indicate Maximum Copayment amount per Hearing Aid - Outer Ear:	Indicate Deductible Amount:	
Hearing Aid - Outer Ear Hearing Aids - Over the Ear	Indicate Minimum Copayment amount per two Hearing Aids - Outer Ear:		
dicate Minimum Copayment amount per Hearing Aid I types):	Indicate Maximum Copayment amount per two Hearing Aids - Outer Ear:		
dicate Maximum Copayment amount per Hearing Aid types):	Indicate Minimum Copayment amount per Hearing Aid - Over the Ear:		
dicate Minimum Copayment amount per Hearing Aid - ner Ear:	Indicate Maximum Copayment amount per Hearing Aid - Over the Ear:		
licate Maximum Copayment amount per Hearing Aid - er Ear:	Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear:		
licate Minimum Copayment amount per two Hearing Aids - er Ear:	Indicate Maximum Copayment amount per two Hearing Aids - Over the Ear:		
dicate Maximum Copayment amount per two Hearing Aids -			
er Ear:			

Help Ad	d Variable	Exit	X	Go To: Step	up #18b Hearing	Aids - Base 5]			
evious	Next	Exit (Validate)	Exit (No Validate)										
uthorization Yes	required?												
Yes No									ą.				
Yes	uired for Heari	ing Aids?											
No									2				
ring Aids N													
es:	de additional n	niormation to des	scribe benefit in	h <mark>is service catego</mark>	ry. Do not repeat	. mormation cap	tured in data en	uy.					
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