# CY 2024 PBP Data Entry System Screens

#### Cost Share Groups – Out of Network Groups

Plan Characteristics - Completed	Out-of-Networ (Maximum of 25 groups)		ups Setup				
Standard Bid - Completed	(maximum or Eo Broabo)				+	- Add New OON Gro	oup
Benefit Offerings - Completed					_		
Plan Level Cost Share-Completed	OON Group Name	Copayment	Coinsurance	Deductible	Maximum Plan benefit Coverage amount	Periodicity	
Fran Level obst Share-Completed	Group 1	\$20	5%-10%	\$200	\$10000	Every 1 year	10
Prior Authorization/Referrals-Completed	Group 2	\$23	10%	\$230	\$20000	Every 6 months	10
nor Additionation Referrate-completed	Group 3	\$25	5%-10%	\$250	No	N/A	/ 0
Visitor Travel - Completed	Group 4	\$20	10%	\$200	No	N/A	/ 0
Out of Network Groups - In Progress							
Point of Service Groups - Not started							
Combined Supplemental Benefits - Not started							
Reduction in Cost Sharing - Not started							
Optional Supplemental Packages -Not started							
<ul> <li>VBID, MA Uniformity, SSBCI-Not started</li> </ul>							

Out of Network Groups – Add New OON Group – page 1

	A 0 0	L.	् ∋
Health Plan Management System	Add New Out of Network Group	Contact Us	Search Log Out
Plan Benefit Package 🔤 HPMS > Pl		-	
B Dashboard PBP CY	Group Name Sample Group Name		
	Is there a maximum plan benefit coverage amount?	- (5) Re	wiew 6 Submit
B PBP CY 2023 C Reports Groups S	Yes No		
Documentation Do you have Ou	Maximum plan benefit coverage amount 4		
Yes No	Periodicity Every 6 Months		
Out of Netv	Is there coinsurance?		+ Add New Group
OON Group 1	Yes Yes with a minimum & maximum No	unt	Periodicity
Group 1	Minimum percentage Maximum percentage		Every 1 year
Group 2	4% 8%		Every 6 months
Group 3 Group 4	· · · · · · · · · · · · · · · · · · ·		N/A N/A
	Is there copayment?		
Do you have Po	Cancel Save		
Yes No			
About HPMS   Website Accessibility   Web Pc			(CMS

Out of Network Groups – Add New OON Group – page 2

HPMS	Add New Out of Network Group	A	8	6 ×	Contact Us		→ g Out
Plan Benefit Package 🔤 HPMS 🗲 Pl							
Dashboard     PBP CY     Plan Benefit Packages	Is there copayment?						
PBP CY 2024     Plan Level	Yes Yes with a minimum & maximum No				5 Rev	iew 👘 🚯 Subn	nit
PBP CY 2023     Reports     Groups S     Documentation     Do you have Out	Minimum amount \$400	Maximum amount – \$ <b>800</b>					
Yes No	Is there a deductible? Yes No						
Out of Netv	Deductible amount     4				unt	+ Add New Group Periodicity	
Group 1 Group 2 Group 3 Group 4	+ Add Notes					Every 1 year Every 6 months N/A N/A	
Do you have Po Yes No			Cancel	Save			
About HPMS   Website Accessibility   Web Po							CMS

Out of Network Groups – Edit Out of Network Group – page 1

HPMS	Edit Out of Network Group X Contact Us Search Log Out
an Benefit Package = HPMS > 1	Group Name Group 1
PBP CY 2024 Plan Leve PBP CY 2023	Is there a maximum plan benefit coverage amount?
Reports     Groups       Documentation     Do you have	Maximum plan benefit coverage amount
Yes	Periodicity Every 6 Months
Out of Ne	Yes Yes with a minimum & maximum No
Group 1 Group 2 Group 3	Minimum percentage     Maximum percentage     Every 1 year       4%     8%     Every 0 months
Group 3 Group 4	Is there copayment?
Do you have	
out HPMS Website Accessibility Web	

Out of Network Groups – Edit Out of Network Group – page 2

Plan Benefit Package	Edit Out of Network Group X	Contact Us	Q Search Log Out
Dashboard     DBP CY	Yes Yes with a minimum & maximum No		
<ul> <li>PBP CY 2024</li> <li>Plan Level I</li> <li>PBP CY 2023</li> <li>C Reports</li> <li>✓ Groups S</li> </ul>	Minimum amount     Maximum amount       \$400     \$800	— 5 Rev	view 6 Submit
Documentation Do you have Ou Yes No	Is there a deductible? Yes No		
Out of Netv	Deductible amount 4		+ Add New Group
OON Group 1 Group 2 Group 3 Group 4	Service categories that are mapped to this group: Inpatient Hospital Services(1) Inpatient Hospital-Acute(1a) Inpatient Hospital Psychiatric(1b) Skilled Nursing Facility (SNF)(2) Cardiac and Pulmonary Rehabilitation Services(3) Cardiac Rehabilitation Services(3-1)	unt	Periodicity Every 1 year Every 6 months N/A N/A
Do you have Po Yes No	Cancel Save		
			(CMS

Out of Network Groups – Edit Out of Network Group – page 3

Plan Benefit Package	Edit Out of Network Group	Contact Us Search L	og Out
Bashboard     PBP CY 2024     PBP CY 2024     PBP CY 2023     Reports     Croups S	Is there a deductible?       Yes     No   Deductible amount       4	— 5 Review 6 Sub	mit
Do you have Ou Yes No Out of Netw Group 1 Group 2 Group 3 Group 4	Service categories that are mapped to this group: Inpatient Hospital Services(1) Inpatient Hospital Psychiatric(1b) Skilled Nursing Facility (SNF)(2) Cardiac and Pulmonary Rehabilitation Services(3) Cardiac Rehabilitation Services(3-2) Pulmonary Rehabilitation Services(3-3) SET for PAD Services(3-4) + Add Notes	unt Periodicity Every 1 year Every 6 months N/A N/A	
Do you have Po Yes No About HPMS Website Accessibility Web Po	Cancel Save		(CMS

# CY 2024 PBP Data Entry System Screens

#### Cost Share Groups – Point of Service (POS) Groups

Plan Characteristics - Completed	Point of Servic (Maximum of 25 groups)		ips Setup				
Standard Bid - Completed					+	• Add New POS Gro	up
Benefit Offerings - Completed	POS Group Name	Copayment	Coinsurance	Deductible	Maximum Plan benefit Coverage	Periodicity	
Plan Level Cost Share - Completed	Group 1	\$20	10%	\$200	amount \$10000	Every 1 year	/0
	Group 2	\$23	5%-10%	\$230	\$20000	Every 6 months	/0
Prior Authorization/Referrals-Completed	Group 3	\$25	10%	\$250	No	N/A	/ 0
	Group 4	\$20	5%-10%	\$200	No	N/A	/ 0
Cost Share Groups - In Progress Out of Network Groups - Completed							
Point of Service Groups - In Progress							
Out of Network Groups-Completed							
Out of Network Groups-Completed Point of Service Groups - In Progress Combined Supplemental Benefits-							
Out of Network Groups - Completed Point of Service Groups - In Progress Combined Supplemental Benefits - Not started							

Point of Service Groups – Add New POS Group – page 1

HPMS	Add New Point of Service Group X Contact Us Search Log Out
Plan Benefit Package     ➡     HPMS > Plan	Group Name Sample Group Name Is there a maximum plan benefit coverage amount? Yes No
C Reports - Groups S Documentation Do you have Ou Yes No	Maximum plan benefit coverage amount 4 Periodicity Every 6 Months
Out of Network	Is there coinsurance?          Yes       Yes with a minimum & maximum       No         Minimum percentage       Maximum percentage       Every 1 year         4%       Every 6 menths       N/A
Group 3 Group 4 Do you have Po Yes No	Is there copayment?

Point of Service Groups – Add New POS Group – page 2

HPMS	Add New Point of Service Group	A	8	6 ×	Contact Us	Q Search	Log Out
Plan Benefit Package 🔤 HPMS 🗲 Pl	- 10	• 70					
Dashboard Plan Benefit Packages	Is there copayment?						
Plan Level	Yes Yes with a minimum & maximum No				G Rev	iew 🛛 🌀	Submit
PBP CY 2023     Reports      Groups S     Do you have Or	\$400	Maximum amount – \$800					
Yes No	Is there a deductible? Yes No						
Out of Netv	- Deductible Amount						up
OON Group	4				unt	Periodicity	
Group 1						Every 1 year	
Group 2 Group 3 Group 4	+ Add Notes					Every 6 months N/A N/A	
Do you have Po			Cancel	Save			
Yes No							
							(CMS

01/13/2023

# CY 2024 PBP Data Entry System Screens

#### Cost Share Groups – Combined Supplemental Benefits

Plan Characteristics - Completed	Combined Su	pplemental Benefits			
Standard Bid - Completed	(max 5 groups)			nbined Benefits Gro	
Benefit Offerings - Completed				ibilied benefits dit	Jup
Plan Level Cost Share-Completed	Group Name	Mode of delivery	Maximum Plan benefit Coverage amount	Periodicity	
Prior Authorization/Referrals-Completed	Group 1	Debit Card	\$10000	Every 1 year	/ 0
Phot Authorization/Referrats-Completed	Group 2	Reimbursement	\$20000	Every 6 months	/ 0
Visitor Travel - Completed	Group 3 Group 4	Other, described other Debit Card	No	N/A N/A	/ 0
Out of Network(OON) Groups-Completed Point of Service(POS) Groups-Completed					
Reduction in Cost Sharing -Completed					
Combined Supplemental Benefits - In Progress					
Optional Supplemental Packages - Not					
started					

Combined Supplemental Benefits – Add New Combined Benefits Group – page 1

PBP CY 2024 -	Add New Combined Benefits Group (j)		×		×
Plan Characterist	Group Name *		Î	Plan Characteristics	
Standard Bld - Co	What is your combined supplemental benefits mode of delivery? *			ental Benefits Group	
✓ Benefit Offerings	Catalogue Purchase				
✓ Plan Level Cost S	Claims Processing				
	Debit Card				
✓ Prior Authorizatio	Reimbursement				
Visitor Travel - Co	Other				
▲ Cost Share Group	Select which Non-Medicare covered benefits are included in your Combined Supple	mental Benefit group: *			
Point of Service	Available	Selected			
Combined Sup Progress	Q		Q		
	Additional Days for Inpatient Hospital-Acute(1a1)				
Reduction in Co	Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		-		
			Cancel Save	lose Save and N	Vext

Combined Supplemental Benefits – Add New Combined Benefits Group – page 2

PBP CY 2024 -	Add New Combined Benefits Group ()	×		×
Plan Characteris	Additional Intensive Cardiac Rehabilitation Services (3-7)	•		
Plan Characteris	Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance? () *		Plan Characteristics	
Standard Bid - Co	Yes No		intal Benefits Group	
✓ Benefit Offerings	Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount? () *		intat benefits Group	
✓ Plan Level Cost €	Maximum plan benefit coverage amount @*			
✓ Prior Authorization	Periodicity () *			
Visitor Travel - Co				
∧ Cost Share Group	Do you offer Combined Supplemental Benefits with a shared visit/trips limits? () *	_		
Point of Servic	r Indicate number of shared visits/trips 💽*	_		
Combined Sup Progress	Periodicity () *	_		
Reduction in C		- 1		
-	+ Add Notes	÷		
	Canc	el Save	lose Save and	Next

#### Cost Share Groups – Reduction in Cost Sharing (RICS) Groups

Plan Characteristics - Completed		ost Sharing Groups Setup			
Standard Bid - Completed	(Max 5 groups)			Add New RIC Grou	
Benefit Offerings - Completed				Add New RIC Gro	up
Plan Level Cost Share - Completed	RIC Group Name	Mode of delivery	Maximum Plan benefit Coverage amount	Periodicity	
	Group 1	Debit Card	\$10000	Every 1 year	/ 0
Prior Authorization/Referrals-Completed	Group 2	Reimbursement	\$20000	Every 6 months	/ 0
Visiter Trevel, Osmalated	Group 3	Other, described other	No	N/A	/ 0
Visitor Travel - Completed	Group 4	Debit Card	No	N/A	/ 0
Out of Network(OON) Groups-Completed Point of Service(POS) Groups-Completed					
Point of Service(POS) Groups-Completed					
Point of Service(POS) Groups-Completed Reduction in Cost Sharing-In Progress Combined Supplemental Benefits-					

Health Plan Man       Add New Reduction in Cost Sharing Group         Plan Benefit Package       Image: Comp Name         Image: Dashboard       Group Name         Image: Plan Benefit Packages       Select the type of benefit:         Image: Plan CY 2024       Select the type of benefit:         Image: Plan CY 2023       Image: Medicare services         Image: Plan Benefit Package       Image: Plan CY 2024         Image: Plan CY 2023       Image: Plan CY 2023         Image: Plan CY 2023       Image: Plan CY 2023         Image: Plan CY 2023       Image: Plan CY 2023         Image: Plan CY 2024       Image: Plan CY 2024         Image: Plan CY 2023       Image: Plan CY 2024         Image: Plan CY 2024       Image: Plan CY 2024         Image: Plan CY 20				;	K Search	Log Out
Select the Medicare service categories that have Reduction Available Search by terms Inpatient Hospital-Acute(1a) Inpatient Hospital Psychiatric(1b) Skilled Nursing Facility (SNF)(2) Cardiac Rehabilitation Services(3-1) Intensive Cardiac Rehabilitation Services(3-2) Pulmonary Rehabilitation Services(3-3)	> >> < «	: Search by terms Partial Hospitalization(5) Chiropractic Services(7b Individual Sessions for O Nursing Home Services(1 Glaucoma Screening(14e	) utpatient Substance A 3h6)	Q Abuse(9c1)	Add New Gr riodicity ery 1 year ery 6 months	roup
Select the Non-Medicare service categories that have Rec         Yes       No         About HPMS       Website Accessibility       Web Policies       File Formats and Plug-ins       Rules of B	_	aring: Requirements	Cancel	Save	A	(CMS

Plan Benefit Package Ec	Add New Reduction in Cost Sharing Group Select the Non-Medicare service categories that have Reduc	ction in Cost Sharing:
<ul> <li>Dashboard</li> <li>Plan Benefit Packages </li> <li>PBP CY 2024</li> <li>PBP CY 2023</li> <li>Reports </li> <li>Documentation</li> </ul>	Available         Search by terms         Inpatient Hospital-Acute(1a)         Inpatient Hospital Psychiatric(1b)         Skilled Nursing Facility (SNF)(2)         Cardiac Rehabilitation Services(3-1)         Intensive Cardiac Rehabilitation Services(3-2)         Pulmonary Rehabilitation Services(3-3)	<ul> <li>Selected</li> <li>Search by terms</li> <li>Partial Hospitalization(5)</li> <li>Chiropractic Services(7b)</li> <li>Individual Sessions for Outpatient Substance Abuse(9c1)</li> <li>Nursing Home Services(13h6)</li> <li>Glaucoma Screening(14e1)</li> </ul>
	Is there a maximum plan benefit coverage amount? Yes No Maximum plan benefit coverage amount 4 Periodicity Every 6 Months	Add New Group riodicity ary 1 year ary 6 months A A
About HPMS Vebsite Acca	Yes No	Cancel Save

Add New Reduction in Cost Sharing Group ()				X
Periodicity () * Every 6 Months				^
Is your Reductions in Cost Sharing Max Plan Benefit amount of the second state of the	int shared wi	th a Combined Benefits package? () *		
Available		Selected		
Search by terms Q		Search by terms	Q	
NCBG 1 Oncology Benefits Group 1 Dental Benefits Group 2 Eye Care Group 1	> >> < ~			v
			Cancel	Save

Add New Reduction in Cost Sharing Group (	)	×
Eye Care Group 1	<<	^
Can the reduction in cost sharing be applied to a deduction in Cost sharing be applied to a deduction of the state of the	ible?*	
What is your Reductions in Cost Sharing mode of deliver	y? *(j)	
Debit Card		
Reimbursement		
Other		
+ Add Notes		~
		Cancel Save

#### Cost Share Groups – Optional Supplemental Packages

Plan Characteristics - Completed	Optional Supple (Maximum of 15 packages)	mental Pa	ckages Setup				
Standard Bid - Completed						+ Add New Packa	ge
Benefit Offerings - Completed	Optional Supplemental Package Name	Package ID	Package Description	Deductible	Maximum Plan benefit Coverage amount	Periodicity	
Plan Level Cost Share - Completed	Package 1	12345	Lorem Ipsum Do	\$200	\$10000	Every 1 year	10
	Package 2	23453	Lorem Ipsum Do	\$230	\$20000	Every 6 months	10
Prior Authorization/Referrals-Completed	Package 3	43534	Lorem Ipsum Do	\$250	No	N/A	10
	Package 4	83474	Lorem Ipsum Do	\$200	No	N/A	10
Point of Service(POS) Groups - Completed							
Completed Combined Supplemental Benefits - Not started							

# Optional Supplemental Packages – Add New Package – page 1

Optional Supplemental Package - Package 1-In Progress V Health Care Professional Services(7) - In	Package ID 001	
Progress     Step-up Chiropractic Services(7b)-In     Progress     Step-up Routine Foot Care(7f)-In     Progress	Package Name Package 1 Package Description Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eius incididunt ut labore et dolore magna aliqua. Ut enim ad minim venia nostrud exercitation ullamco laboris nisi ut aliquip ex ea commodo	iam, quis
	Select the service categories included in this package that have optic Non-medicare section	ional/both supplemental benefits declared in Benefit offerings-
	Select the service categories included in this package that have optic	ional/both supplemental benefits declared in Benefit offerings- Selected
	Select the service categories included in this package that have optic Non-medicare section	

# Optional Supplemental Packages – Add New Package – page 2

PBP CY 2024 - Contract ID , Very long Plan Name	/ Plan ID / Segment ID - In Patient Ho	ospital Se	ervices	×
Optional Supplemental Package - Package 1 - In Progress	ls there a Maximum Plan Benefit Coverage Amount for this	package?		
<ul> <li>Health Care Professional Services(7) - In Progress</li> </ul>	Yes No	package?		
Step-up Chiropractic Services(7b) - In Progress	Maximum plan benefit coverage amount			
Step-up Routine Foot Care(7f)-In Progress	Periodicity			
	Do the Optional Supplemental benefits in this package app	oly to the MOOP	for this plan?	
	Yes No			
	Is there an enrollee Deductible for this package?			
	Yes No			
	Indicate deductible amount: \$400			
	Select the benefits to which the deductible applies:			
	Available		Selected	
	Search by terms Q		Search by terms	
	Inpatient Hospital-Acute(1a)	>	Partial Hospitalization(5)	
	Inpatient Hospital Psychiatric(1b)	»	Chiropractic Services(7b)	
			Close Save and Close	Save and Next

# Optional Supplemental Packages – Add New Package – page 3

ptional Supplemental Package - Package In Progress	Do the Optional Supplemental benefits in this package apply to	the MOOP for this plan?
Health Care Professional Services(7) - In         Progress         Step-up Chiropractic Services(7b) - In         Progress         Step-up Routine Foot Care(7f) - In         Progress	Yes No Is there an enrollee Deductible for this package? Yes No Indicate deductible amount: \$400 Select the benefits to which the deductible applies:	
	Available         Search by terms         Inpatient Hospital-Acute(1a)         Inpatient Hospital Psychiatric(1b)         Skilled Nursing Facility (SNF)(2)         Cardiac Rehabilitation Services(3-1)         Intensive Cardiac Rehabilitation Services(3-2)         Pulmonary Rehabilitation Services(3-3)	Selected       Search by terms       Partial Hospitalization(5)       Chiropractic Services(7b)       Individual Sessions for Outpatient Substance Abuse(9c1)       Nursing Home Services(13h6)       Glaucoma Screening(14e1)

### Optional Supplemental Packages- Edit Package - page 1

tional Supplemental Package - Package In Progress	Package ID 002	
OON Optional Transportation Services(10b In Progress	Package Name Package Description Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiu incididunt ut labore et dolore magna aliqua. Ut enim ad minim veni nostrud exercitation ullamco laboris nisi ut aliquip ex ea commodo	iam, quis
	555	/ Tubu Characters
	Select the service categories included in this package that have opti Benefit offerings-Non-medicare section	
	Select the service categories included in this package that have opti Benefit offerings-Non-medicare section	ional/both or not offered supplemental benefits declared in
	Select the service categories included in this package that have optil Benefit offerings-Non-medicare section           Available           Search by terms           Inpatient Hospital-Acute(1a)           Inpatient Hospital Psychiatric(1b)	ional/both or not offered supplemental benefits declared in Selected Search by terms Partial Hospitalization(5)
	Select the service categories included in this package that have optil Benefit offerings-Non-medicare section           Available           Search by terms           Inpatient Hospital-Acute(1a)	ional/both or not offered supplemental benefits declared in Selected Search by terms Partial Hospitalization(5) Chiropractic Services(7b) Routine Foot Care(7f)

# Optional Supplemental Packages – Edit Package – page 2

PBP CY 2024 - Contract ID Very long Plan Name	/ Plan ID / Segment ID - In Patient He	ospital Se	ervices	×
Optional Supplemental Package - Package 2-in Progress OON Optional Transportation Services(10b) - In Progress	Is there a Maximum Plan Benefit Coverage Amount for this          Yes       No         Maximum plan benefit coverage amount       \$2800         Pariodicity       •         6 Months       •         Do the Optional Supplemental benefits in this package apply         Yes       No         Is there an enrollee Deductible for this package?         Yes       No         Is there an enrollee Deductible for this package?         Yes       No         Select the benefits to which the deductible applies:		for this plan?	
	Available		Selected	
	Search by terms Q		Search by terms	
	Inpatient Hospital-Acute(1a)	<b>`</b>	Partial Hospitalization(5)	
	Inpatient Hospital Psychiatric(1b)	»	Chiropractic Services(7b)	
			Close Save and Close Save and Nex	t

#### Optional Supplemental Packages – Edit Package – page 3

Optional Supplemental Package - Package 2 - In Progress	Do the Optional Supplemental benefits in this package apply to the MOC	DP for this plan?
OON Optional Transportation Services(10b) - In Progress	Yes No Is there an enrollee Deductible for this package? Yes No Indicate deductible amount: \$400 Select the benefits to which the deductible applies:	
	Available         Search by terms         Inpatient Hospital-Acute(1a)         Inpatient Hospital Psychiatric(1b)         Skilled Nursing Facility (SNF)(2)         Cardiac Rehabilitation Services(3-1)         Intensive Cardiac Rehabilitation Services(3-2)         Putmonary Rehabilitation Services(3-3)	Selected         Search by terms         Partial Hospitalization(5)         Chiropractic Services(7b)         Individual Sessions for Outpatient Substance Abuse(9c1)         Nursing Home Services(13h6)         Glaucoma Screening(14e1)