CHAPTER 4: DETAILED PBP DATA ENTRY

PBP FEATURES & CLARIFICATIONS

PBP Variables Used in the Summary of Benefits

NEW FOR 2007:

Given the need to comply with the 508 regulations within the PBP screens, users are now provided with the ability to choose whether or not to utilize the question variable colors (red and blue - variables used in the Summary of Benefits are red, while all other variables are blue).

By default, users get the all-black setup (i.e., the red/blue is OFF by default). Tool-tips are provided on all of the SB variables indicating they are used in the SB. This information is also included in the variable help.

There is an option to enable the red/blue colors by going to the Options, Preferences menu. The setting is saved in the PBP INI file, so it will be "remembered" the next time PBP is started. The variables will then be displayed on the PBP screens in either red or blue.

Part D Payment Demonstration Plans

NEW FOR 2007:

In CY 2006, certain organizations were able to designate Part D Payment demonstration plans under their contract in HPMS during Bid upload. In CY 2007, this data will be collected in the PBP.

Organizations wanting to participate in the Part D Payment demo program must apply to CMS by submitting specific information in a cover letter that accompanies their application. Organizations approved to participate in the Part D Payment demo program will indicate which plans are in this program and which option the plan has selected in the PBP.

An organization offering an Enhanced Alternative Part D drug benefit that is approved to participate in the Part D Payment Demo may select one of three options, based on organization type:

- Flexible Capitated option - Can be selected by any non-employer plan offering Part D under the following org types: Local CCP, PFFS, Demo, 1876 Cost, PDP, and Regional CCP.
- Fixed Capitated option - Can be selected by any non-employer plan offering Part D under the following org types: Local CCP, PFFS, Demo, 1876 Cost, PDP, and Regional CCP.
- Flexible MA rebate option - Can be selected by any non-employer plan offering Part D under the following org types: Local CCP, PFFS, 1876 Cost, Demo, and Regional CCP.

Out-of-Network Benefits, Point-of-Service Option, Visitor/Travel Program

NEW FOR 2007:

In CY 2006, section C was utilized by certain plans to enter detailed data entry to describe Out-of-Network (OON) benefits. For CY 2007, section C will also allow certain plans to enter detailed data entry to describe cost sharing reduction (CSR) for OON benefits, Point-of-Service (POS) benefits, and Visitor/Travel (V/T) benefits (U.S. and/or Foreign). The rules dictating which plan types have access to the OON, CSR, POS, and V/T subsections are detailed in Table 4-1 below.

Table 4-1: CY 2007 HPMS Plan PBP Data Entry Matrix

PLAN TYPE	SECTION A	SECTION B	B B-15	SECTION C – OON	SECTION C – POS	SECTION C – CSR	SECTION C – V/T U.S.	SECTION C – V/T FOREIGN	SECTION D	SECTION RX
HMO	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Part D = Yes No Part D = No
HMOPOS	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Part D = Yes No Part D = No
CCOTH	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Local PPO	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Part D = Yes No Part D = No
PSO (State License)	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Part D = Yes No Part D = No
PSO (Fed. Waiv. State Lns)	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Part D = Yes No Part D = No
MSA	Yes	Yes	Yes	No	No	No	No	Yes	Yes	No
RFB	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PFFS	Yes	Yes	Yes	No (Network: Yes)	No	No	Yes (Network: No)	Yes	Yes	Part D = Yes No Part D = No
SHMO	Yes	Yes	Yes	No	Yes[2]	No	Yes	Yes	Yes	Part D = Yes No Part D = No
Other	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MN Disability Health Options	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Part D = Yes No Part D = No
MN Senior Health Options	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Part D = Yes No Part D = No
WI Partnership Program	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Part D = Yes No Part D = No
MA Health Senior Care Options	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Part D = Yes No Part D = No
CCRC	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Part D = Yes No Part D = No
ESRD I	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	Part D = Yes No Part D = No
ESRD II	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Part D = Yes No Part D = No
MSA Demo	Yes	Yes	Yes	No	No	No	No	Yes	Yes	No
1876 Cost	Yes	Yes[1]	Part D = B15[1] No Part D = B20	No	No	No	Yes	Yes	Yes[1]	Part D = Yes No Part D = No
HCPP - 1833 Cost	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
National PACE	Yes	No	No	No	No	No	No	No	No	No
Chronic Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicare Prescription Drug	Yes	No	No	No	No	No	No	No	No	Yes

PLAN TYPE	SECTION A	SECTION B	B B-15	SECTION C – OON	SECTION C – POS	SECTION C – CSR	SECTION C – V/T U.S.	SECTION C – V/T FOREIGN	SECTION D	SECTION RX
Plan										
Regional PPO	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Part D = Yes No Part D = No
Fallback	Yes	No	No	No	No	No	No	No	No	Yes
Employer Sponsored PDP	Yes	No	No	No	No	No	No	No	No	Yes
Employer Direct PFFS	Yes	Yes	Yes	No (Network: Yes)	No	No	Yes (Network: No)	Yes	Yes	Part D = Yes No Part D = No

1) 1876 Cost employer-only plans may only offer Part D benefits; therefore, the PBP shall disable Sections B and D for an 1876 Cost employer-only plan.

2) Only SHMO II plan types are allowed to describe POS benefits.

MSA plan data entry

NEW FOR 2007:

MSA and MSA Demo plans may now enter an Annual MSA Deductible amount and also indicate the Annual amount CMS will deposit into the enrollee MSA in Section D of the PBP.

Part A/B Plans versus Part B Only Plans

In PBP Section A, the MA plan indicates the plan's Medicare beneficiary coverage criteria as either Part A/B or Part B Only. Beneficiaries who elect Medicare Part A/B coverage are entitled to Medicare-covered benefits that include Inpatient hospital, SNF, HHA, and Outpatient services. Medicare does not cover inpatient hospital and SNF services for beneficiaries who elect Part B Only coverage. Therefore, the data collected in the PBP Section B benefit categories for the Part B Only plans differs from the data collected for the Part A/B plans.

Minimum and Maximum Cost Share Values

Throughout the PBP, minimum and maximum (min/max) cost sharing amounts are collected. Min/Max cost sharing questions exist in certain categories because the cost sharing for an item or service could vary based on certain plan-specific criteria. These criteria should be further explained in the applicable notes section of the PBP. When a min/max cost share is required, the SB sentence that is generated will display either the range of cost sharing values or the single cost share amount entered. For example, if the min/max fields are completed as $0 and $5, respectively, the SB sentence generated will read, "You pay $0 to $5 for….". If the min/max fields both contain $5, the SB sentence generated will read, "You pay $5 for….".

Zero Cost Share Values

If there is no cost sharing for benefits in a category, i.e., no coinsurance and no copayment, the questions "Is there an enrollee Coinsurance?" and "Is there an enrollee Copayment?" should both be answered "No". By answering "No" to both of these

questions, or entering a "0" for the coinsurance and/or copayment amount, the PBP will generate the SB sentence, "There is no copayment for [particular service]".

Periodicity

Periodicity within the PBP is generally presented as five or six options, including every six months, every year, every two years, etc. Although this set of options accommodates many plan benefit structures, it may not accommodate all structures. Therefore, CMS has provided for an "Other, describe" periodicity to be entered. If the benefit plan periodicity is not specifically listed, i.e., every 18 months, the option "Other, describe" should be selected and explained in the Notes. CMS has made changes in the SB sentences when the option "Other, describe" is selected so that appropriate language is provided. Please refer to the PBP-SB Crosswalk for this language.

Referral versus Authorization

The question, "Is a referral required for …?" is in most service categories, and the SB sentences concerning referrals are generated from these questions. Generally, a referral is defined as an **actual** document obtained from a provider in order for the beneficiary to receive additional services, whereas authorization is defined as approval from the organization (can be verbal or written) to receive a service. These definitions vary between organizations, so no hard and fast definition exists.

Drug Tiers

Drug tiers are definable by the plan. The option "tier" was introduced in the PBP to allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs.

Optional Supplemental Step-up Benefits

If a plan offers multiple levels of a benefit, i.e., a basic benefit and an enhanced version (a.k.a. "step-up"), then information on Optional Supplemental Step-up Benefits may be entered in Section D for nine selected service categories. These nine categories contain the same data entry screens and questions as those provided in Section B.

Specifically, if an enhanced benefit is offered as a Mandatory Supplemental benefit and also as an Optional Supplemental benefit, the Mandatory Supplemental benefit should be described in the data fields within the PBP service category in Section B. For nine selected categories, the Optional Supplemental Step-up benefit should be described entirely in Section D. For other categories, the Step-up benefit should be described in the Notes field for that service category in Section B.

NOTE: The MA plan should NOT describe or enter Step-up benefits in PBP Service Categories B-13c, B-13d, or B-13e.

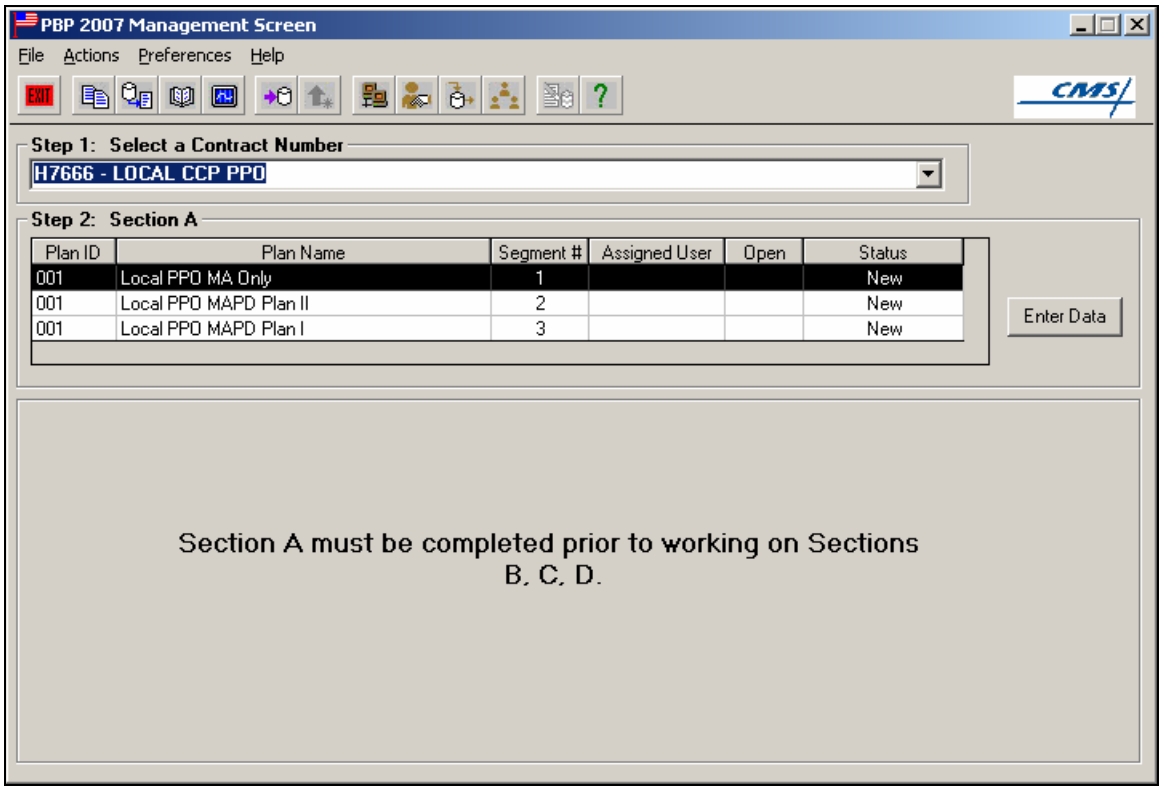
Example: Preventive dental services are offered as a Mandatory Supplemental benefit with a maximum limit of $100 per year. The MA also offers Preventive dental services as an Optional Supplemental benefit with a limit of $500 per year. To describe these two benefits, the MA should complete the Section B Preventive dental screens describing the $100 limit. The Optional Supplemental dental benefit with a $500 limit should be entered in Section D. Section D also collects information on packaging and pricing the Optional Supplemental benefits.

The nine Optional step-up benefit categories are:

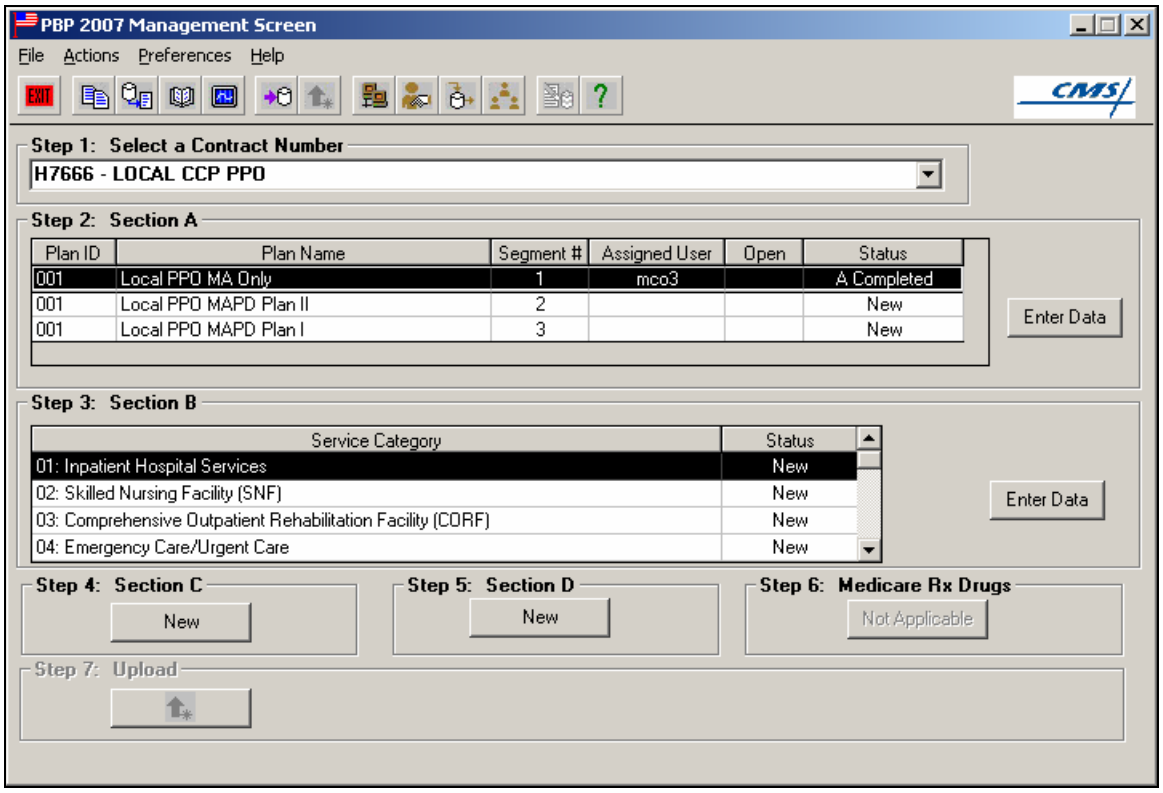
- Chiropractic Services (7b)
- Podiatrist Services (7f)
- Transportation Services (10b)
- Dental - Preventative Services (16a)
- Dental - Comprehensive Services (16b)
- Vision - Eye Exams (17a)
- Vision - Eye Wear (17b)
- Hearing - Hearing Exams (18a)
- Hearing - Hearing Aids (18b)

MANAGEMENT SCREEN

From the PBP 2007 Management Screen, the user can select a Contract Number from the Select a Contract Number Section. This will display the corresponding plans under the Section A area. The Contract Numbers and plans associated with each CMS User ID are included in the download of the PBP plan-specific information from HPMS.


PBP 2007 Management Screen
File
Actions
Preferences
Help
EXIT
CMS
Step 1: Select a Contract Number
H7666 - LOCAL CCP PPO
Step 2: Section A
Plan ID
Plan Name
Segment #
Assigned User
Open
Status
001
Local PPO MA Only
1
New
001
Local PPO MAPD Plan II
2
New
001
Local PPO MAPD Plan I
3
New
Enter Data
Section A must be completed prior to working on Sections
B, C, D.

Once data entry has been completed and validated for Section A, the Status displays, "A Completed"**.** Sections B, C, D, and Rx will then be enabled and displayed for data entry as applicable. As these sections are completed, the status will also change to indicate they are completed.



HELPFUL HINT:

Please refer to Table 4-1 CY 2007 Plan PBP Data Entry Matrix for guidance on what sections of the PBP are required for your plan to compete. Additionally, the PBP software is programmed to only allow users to access those sections that are required, so the software will guide users through the process.

SECTION A

Section A is where an organization views plan-specific information which has been downloaded from HPMS plan creation. Section A also defines certain plan-specific data characteristics in the PBP. Information contained in Section A consists primarily of high level Plan information, including the Contract number, Plan ID, plan type, name of the plan, and geographic service area of the plan. For some plans, this section requires that the user enter a variety of plan characteristics that will uniquely identify the benefit packages offered by an organization. Once a plan is defined in Section A, its characteristics will correspond with subsequent data entry in Sections B, C, D, and Rx.

For Local MA plans, Section A will display information in the Segment ID and Segment Name fields. For Regional MA plans, the segment will be displayed as '0' and the Segment Name will be blank.

For all MA plan types, a Special Needs Plan indicator will be displayed, as well as the Special Needs Plan Type, if applicable. These data are entered in HPMS as part of the plan creation process.

There are four status types available for Section A. These represent data entry progress and include:

- **New** -- Section A has not been opened for data entry.
- **Incomplete** -- Data entry has begun and has not been completed.
- **A Completed** -- Data entry has been completed for Section A.
- **Plan Completed** -- Data entry has been completed for Sections A, B, C, and D.

To begin data entry, click on <Enter Data> located to the right of Section A.

Many data elements in Section A are downloaded from HPMS after the organization has "created" a plan. These data elements are disabled ("grayed out") in the PBP. If changes need to be made to these data, please refer to "Editing Plan Specific Information" in the Downloading section (Chapter 1) of these instructions.

For MA Regional plans and PDPs, the service area will display the region covered. For Local MA plans, a Service Area can represent a county in several ways. These include:

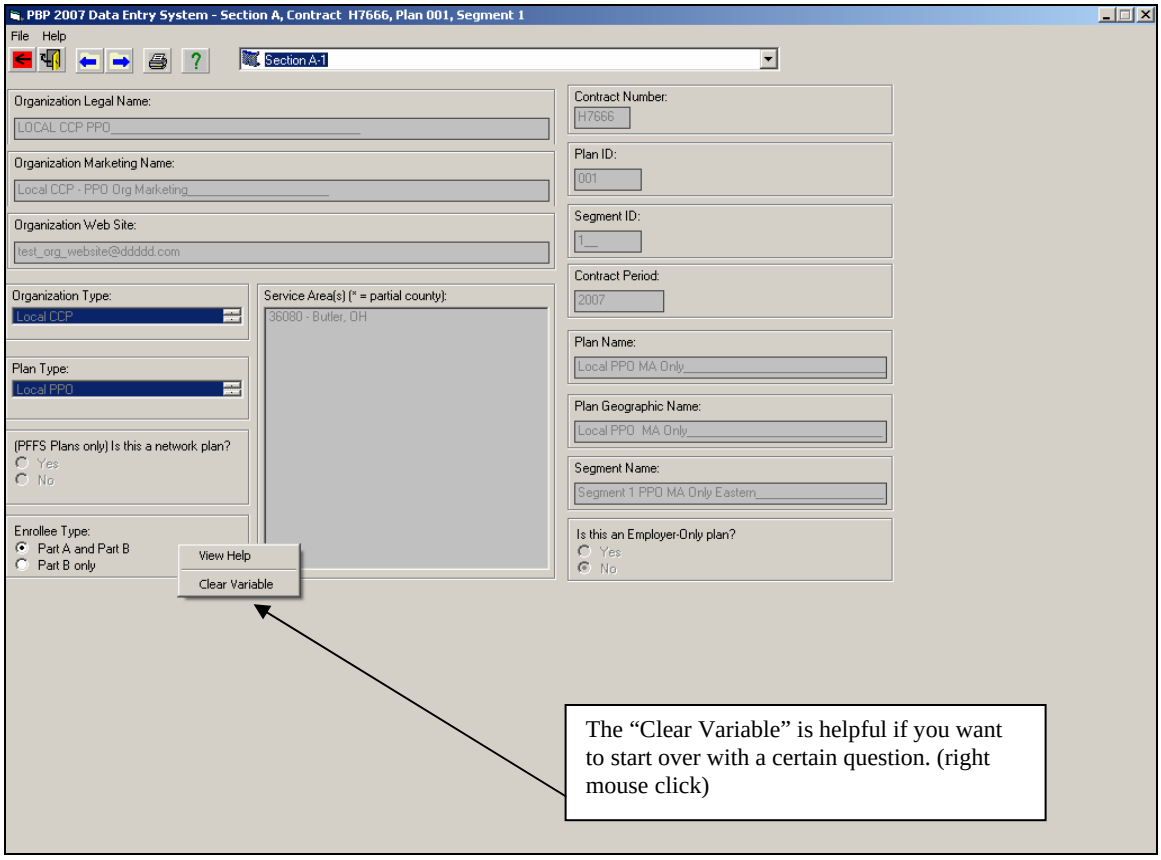
- An asterisk (*) indicates that the Service Area is for a partial county.
- [Pending] indicates that the county is pending approval.
- An asterisk (*) with [pending] indicates that a partial county is pending approval.
- [Emp-Only] indicates an Employer-Only county.

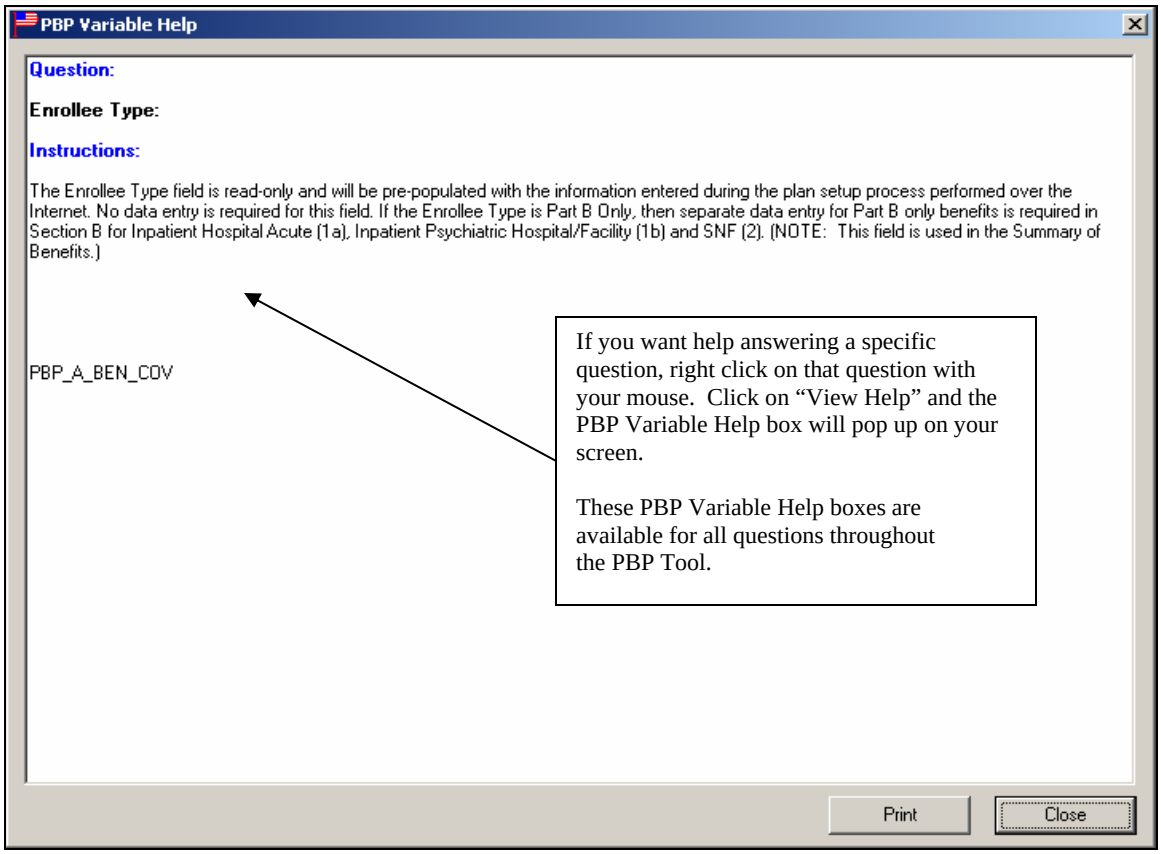
There are two questions that an MA plan must enter in Section A: Enrollee Type [Part A/B; Part B Only] and Continuation area [Yes/No; describe].

NOTE: PDPs are not required to perform any data entry in Section A. Fallback Plans only have to enter the estimated monthly enrollment.

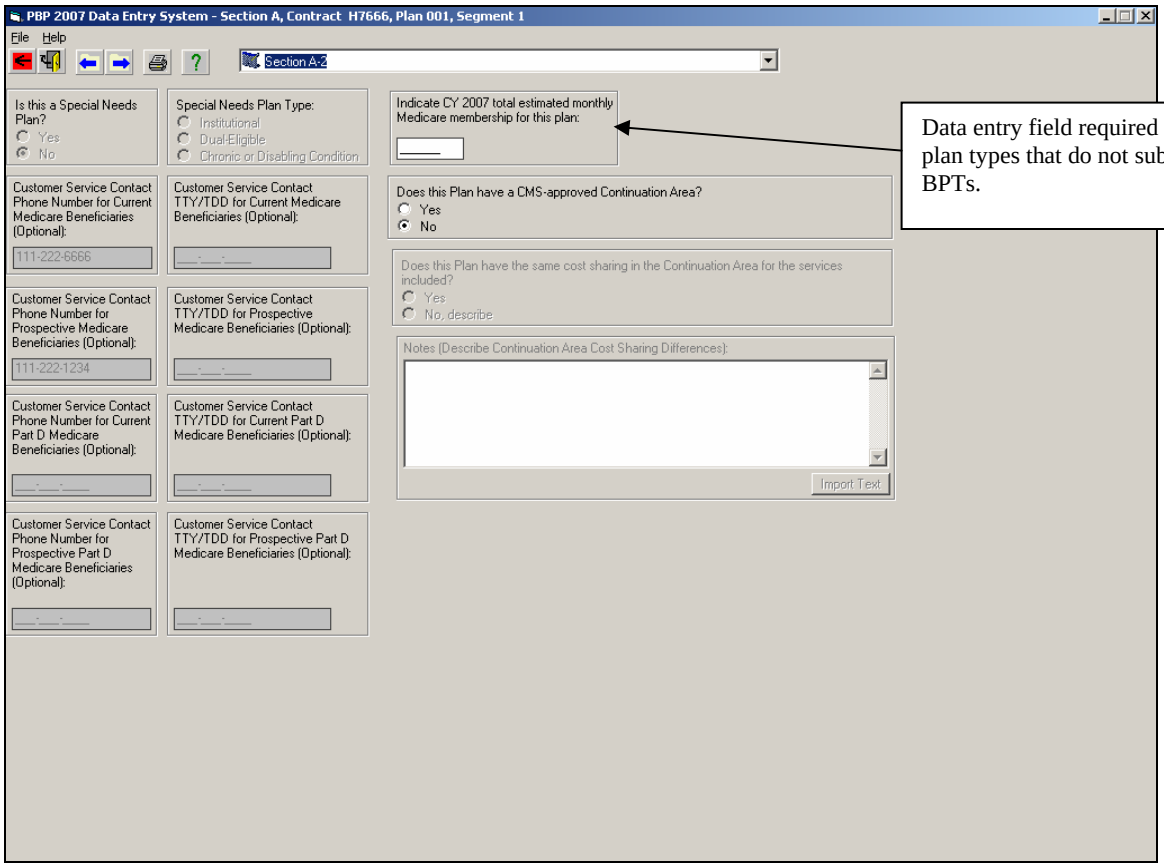
NOTE: Based on whether the beneficiaries to be enrolled in the plan have Part A/B coverage or Part B Only coverage, different data entry screens are enabled in Section B for Inpatient hospital and SNF benefits.

HELPFUL HINT:

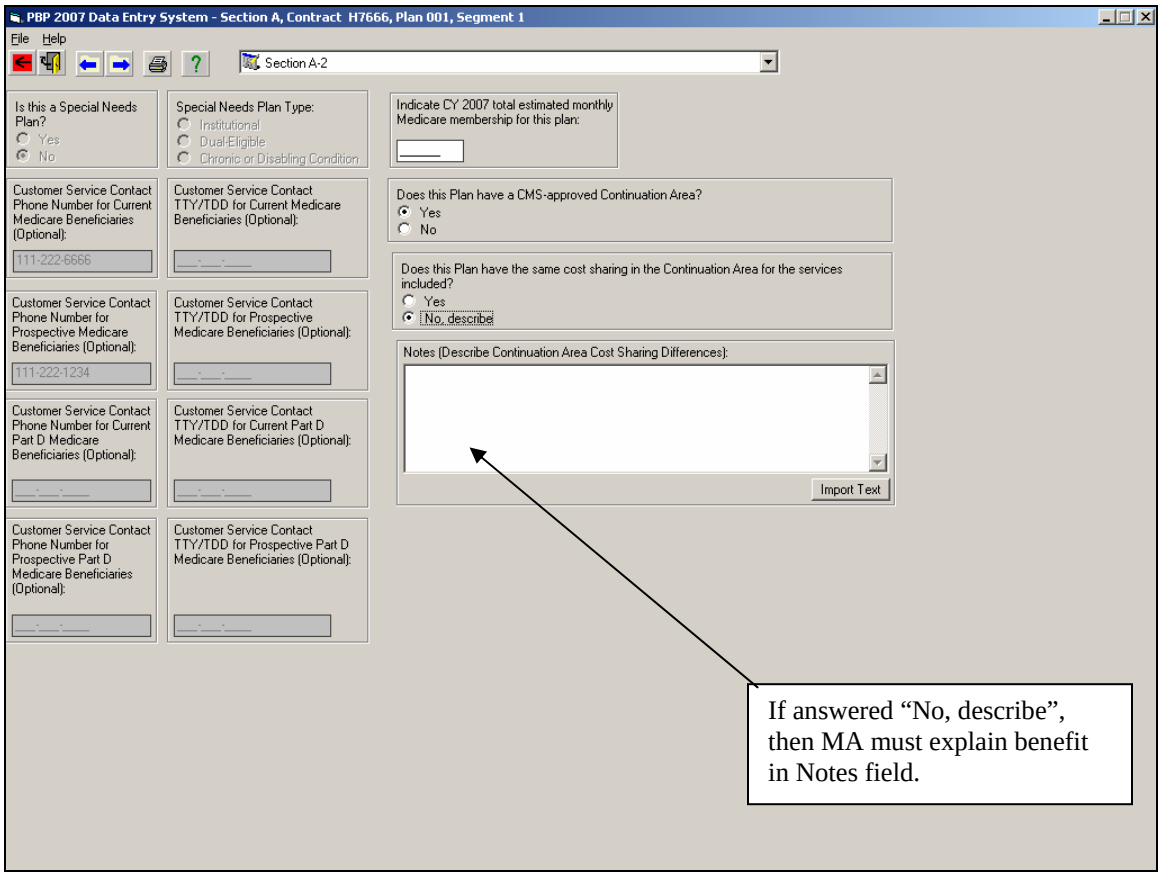



PBP Variable Help
Question:
Enrollee Type:
Instructions:
The Enrollee Type field is read-only and will be pre-populated with the information entered during the plan setup process performed over the Internet. No data entry is required for this field. If the Enrollee Type is Part B Only, then separate data entry for Part B only benefits is required in Section B for Inpatient Hospital Acute (1a), Inpatient Psychiatric Hospital/Facility (1b) and SNF (2). (NOTE: This field is used in the Summary of Benefits.)
PBP_A_BEN_COV
If you want help answering a specific question, right click on that question with your mouse. Click on "View Help" and the PBP Variable Help box will pop up on your screen.
These PBP Variable Help boxes are available for all questions throughout the PBP Tool.
Print
Close

In Section A-2, users indicate the CY 2007 total estimated monthly Medicare membership for the plan. Please note that this field is ONLY required for those plans not submitting a BPT with the PBP submission.



In addition, Section A-2 is where the MA plan indicates and is asked to describe if the plan has an approved Continuation area in which the costs for plan benefits are the same or different. Section A-3 is an optional Notes field for the plan to enter any additional information not captured in the data entry fields pertaining to Section A.



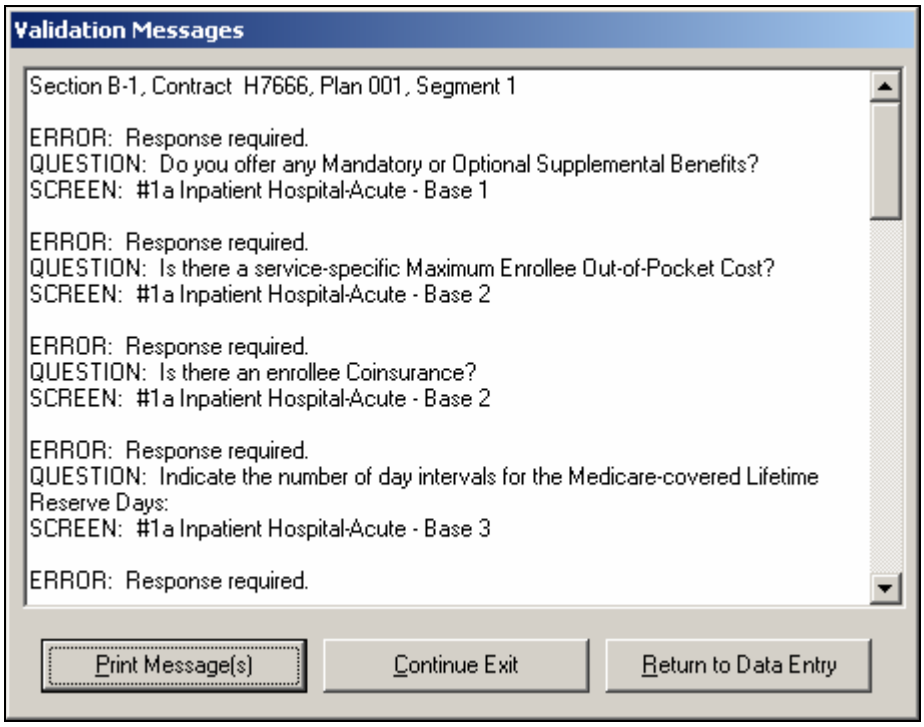
There are two exit options available when leaving data entry:

1. **Return Without Validation** - - If user exits by selecting *Return Without Validation (the yellow door)*, the system will not validate any of the rules that pertain to that section or category, and the user does not encounter warning messages alerting of invalid or missing data. This feature allows the user to exit a section quickly in the middle of data entry. If data entry has not been completed entirely for a service category, the user may wish to postpone validation until completion. The status of plans exited using *Return Without Validation* will be *Incomplete*.
2. **Return to Management Screen** - - To mark a section or service category as *Completed*, the user must use the *Return to Management Screen* option (the red arrow).

HELPFUL HINT:

When the user selects the *Return to Management Screen* option and the PBP Tool detects an unanswered question or data entry error, the Validation Message Screen will appear (as shown below). The user has the option to

- Print the message,
- Continue with the exit, ignoring the message at this time; the user will have to correct the error prior to upload,
- Return to Data Entry in order to fix the issue.



Once data entry has been completed and validated for Section A, the Status displays "A Completed"**.** Sections B, C, D, and Rx will then be enabled and displayed for data entry as applicable. As these sections are completed, the status of the sections will also change to indicate they are completed.

SECTION B

Section B collects information at the service category level on the specific benefits being offered by a plan. This information includes: benefit description; maximum plan benefit coverage; maximum enrollee out-of-pocket costs; coinsurance; deductible; copayment; authorization; and referral. An optional Notes field is also provided for the plan to enter any additional information not captured in the data entry fields.

The 18 service categories are further disaggregated into 50 subcategories that enable an MA to describe plan benefits in greater detail.

NOTE: There is a category that is only available for Cost plans that are not offering the Medicare Part D benefit to describe their enhanced drug benefits. This data entry is listed in category B-20.

Table 4-2 displays a list of the PBP service categories with their respective Medicare and enhanced benefits.

Table 4-2: PBP 2007 Service Categories and Benefits

SERVICE CATEGORY #1: Inpatient Hospital Services
#1a: Inpatient Hospital Services including Acute - Medicare covered stay - Additional Days - Non-Medicare Covered Stay - Upgrades
#1b: Inpatient Psychiatric Hospital Services - Medicare covered stay - Additional Days - Non-Medicare Covered Stay - Upgrades
SERVICE CATEGORY #2: Skilled Nursing Facility (SNF)
#2: SNF - Medicare covered stay - Additional Days - Non-Medicare Covered Stay - Upgrades
SERVICE CATEGORY #3: Comprehensive Outpatient Rehabilitation Facility (CORF)
#3: CORF - Medicare covered benefits
SERVICE CATEGORY #4: Emergency Care/Post Stabilization/Urgent Care
#4a: Emergency Care - Medicare covered benefits - Worldwide care

#4b: Urgent Care - Medicare covered benefits - Worldwide care
SERVICE CATEGORY #5: Partial Hospitalization
#5: Partial Hospitalization - Medicare covered benefits
SERVICE CATEGORY #6: Home Health
#6: Home Health Services - Medicare covered benefits - Custodial care - Respite care
SERVICE CATEGORY #7: Health Care Professional Services
#7a: Primary Care Physician Services - Medicare covered benefits
#7b: Chiropractic Services - Medicare covered benefits - Routine care
#7c: Occupational Therapy Services - Medicare covered benefits
#7d: Physician Specialist Services - Medicare covered benefits
#7e: Mental Health Specialty Services - Non-Physician - Medicare covered benefits
#7f: Podiatrist Services - Medicare covered benefits - Routine care
#7g: Other Health Care Professional Services - Medicare covered benefits
#7h: Psychiatric Services - Medicare covered benefits
#7i: Physical Therapy and Speech-Language Pathology Services - Medicare covered benefits
SERVICE CATEGORY #8: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services
#8a: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services - Clinical/diagnostic Medicare covered benefits - Therapeutic Medicare covered benefits
#8b: Outpatient X-Rays - Medicare covered benefits
SERVICE CATEGORY #9: Outpatient Hospital Services
#9a: Outpatient Hospital Services - Medicare covered benefits
#9b: Ambulatory Surgical Center (ASC) Services - Medicare covered benefits
#9c: Outpatient Substance Abuse Services

- Medicare covered benefits
#9d: Cardiac Rehabilitation Services - Medicare covered benefits
SERVICE CATEGORY #10: Ambulance/Transportation Services
#10a: Ambulance Services - Medicare covered benefits
#10b: Transportation Services - Plan-approved / Any location
SERVICE CATEGORY #11: Durable Medical Equipment-Prosthetics, Orthotics, and Other Medical Supplies (DMEPOS)
#11a: DME - Medicare covered benefits
#11b: Medical Supplies - Medicare covered Prosthetic devices - Medicare covered Medical Supplies
#11c: Diabetes Monitoring Supplies - Medicare covered benefits
SERVICE CATEGORY #12: Renal Dialysis
#12: Renal Dialysis - Medicare covered benefits
SERVICE CATEGORY #13: Other
#13a: Outpatient Blood - Medicare covered benefits
#13b: Acupuncture - Treatments
#13c: Other1 - Service
#13d: Other2 - Service
#13e: Other3 - Service
SERVICE CATEGORY #14: Preventive Services
#14a: Health Education/Wellness Programs - Written health education materials, including newsletters - Nutritional Training - Nutritional Benefit - Smoking Cessation - Alternative Medicine Program - Membership in Health Club, Fitness Classes - Nursing Hotline - Other, describe
#14b: Immunizations - Medicare covered benefits - Hepatitis B - Other Immunizations

#14c: Routine Physical Exams - Medicare covered services - Visit
#14d: Pap Smears and Pelvic Exams Screening - Medicare covered Pap Smears - Additional Pap Smears - Medicare covered Pelvic Exams - Additional Pelvic Exams
#14e: Prostate Cancer Screening - Medicare covered benefits - Additional Screenings
#14f: Colorectal Screening - Medicare covered benefits - Additional Screenings
#14g: Bone Mass Measurement - Medicare covered benefits
#14h: Mammography Screening - Medicare covered benefits - Additional Screenings
#14i: Diabetes Monitoring - Medicare covered benefits
SERVICE CATEGORY #15: Medicare Part B Rx Drugs
#15: Medicare Part B Rx Drugs - Medicare covered benefits
SERVICE CATEGORY #16: Dental
#16a: Preventive Dental - Oral Exams - Prophylaxis (Cleaning) - Fluoride treatment - Dental X-rays
#16b: Comprehensive Dental - Medicare covered benefits - Emergency services - Diagnostic services - Restorative services - Endodontics/Periodontics/Extractions - Prosthodontics/Other Oral/Maxillofacial surgery/Other
SERVICE CATEGORY #17: Eye Exams/Wear
#17a: Eye Exams - Medicare covered benefits - Routine eye exams
#17b: Eye Wear - Contact lenses - Eye glasses - Lenses - Frames

- Upgrades
SERVICE CATEGORY #18: Hearing Exams/Aids
#18a: Hearing Exams - Medicare covered benefits - Routine Hearing Tests - Fitting/Evaluation for Hearing Aid
#18b: Hearing Aids - All Types - Inner ear - Outer ear - Over the ear
NOTE: **SERVICE CATEGORY #19: POS was moved to Section C**
SERVICE CATEGORY #20: Outpatient Drugs and Biologicals/Prescription Drugs
#20: Outpatient Drugs and Biologicals/Prescription Drugs - Medicare covered benefits - Drug Groups 1-5

Within these service categories, three types of statutory benefit categories exist: Medicare-covered, Mandatory Supplemental, and Optional Supplemental. These are described below in greater detail.

Statutory Benefit Categories:

- ✧ Medicare-covered
  - Health services required by law
- ✧ Mandatory Supplemental

  Non-Medicare Covered Benefits that:
  - Plan can offer, but is not required to,
  - Enrollee must buy if offered by plan
  - Plan can charge premium and/or cost sharing
- ✧ Optional Supplemental

  Non-Medicare Covered Benefits that:
  - Plan can offer, but is not required to,
  - Enrollee can buy or reject if offered by plan
  - Plan can charge premium and/or cost sharing

All supplemental benefits that were designated Optional in Section B must be associated with an Optional Benefits Package in Section D before completing a plan's PBP. In addition, Section D requests that the user define the services and premiums for both individual and grouped optional supplemental benefits. A special set of screens is provided in each Optional Supplemental Benefit package for data entry of step-up benefits for nine selected subcategories:

- 7b-Chiropractic Services,
- 7f-Podiatry Services,

- 10b-Transportation,
- 16a-Preventive Dental,
- 16b-Comprehensive Dental,
- 17a-Eye Exams,
- 17b-Eye Wear,
- 18a-Hearing Exams, and
- 18b-Hearing Aids.

If a plan's optional benefits package includes a step-up benefit for which there are no special step-up screens in Section D (not one of the nine selected subcategories), these step-up benefits must be described in the corresponding Notes field of the service category in Section B.

PBP and SB

The data collected in the PBP is used to populate the sentences in the SB, which is displayed on MPPF. Table 4-3 displays a crosswalk between the SB Categories that display the sentences describing the benefits offered by the plan, and the PBP Service Categories that collect and provide the data. A more detailed version of the PBP/SB Crosswalk is provided in the PBP software (Help > SB Crosswalk).

Table 4-3: PBP-SB 2007 Category Crosswalk
(Ordered by SB Category)

PBP		**SUMMARY OF BENEFITS**	
Section/ Category #	*Title*	*Category #*	*Title*
A D Rx C-OON	General Org & Plan Information Plan-level costs Medicare Part D Out-of-Network	1	Premium and Other Important Information
A B-1 (a-b) B-7 (b-i) B-8 (a-b) B-13b B-14 (b, d-i) B-16 (a-b) B-17 (a-b) B-18 (a-b) C-POS C-OON C-CSR C-V/T	General Org & Plan Information Inpatient Hospital Services Health Care Prof. Services Outpatient Lab, Rad., & X-ray Acupuncture Services Preventive Services Dental Services Vision Services Hearing Services POS Out-of-Network Cost Share Reduction Visitor/Travel benefit	2	Doctor and Hospital Choice
B-1a C-OON	Inpatient Hospital – Acute Out-of-Network	3	Inpatient Hospital Care
B-1b	Inpatient Psych Hospital	4	Inpatient Mental Health

C-OON	PPO Out-of-Network		Care
B-2 C-OON	SNF Out-of-Network	5	Skilled Nursing Facility
B-6 C-OON	Home Health Services Out-of-Network	6	Home Health Care
N/A		7	Hospice
B-7a B-7d B-14c C-OON	Primary Care Physician Svcs Physician Specialist Svcs Routine Care Out-of-Network	8	Doctor Office Visits
B-7b C-OON	Chiropractic Services Out-of-Network	9	Chiropractic Services
B-7f C-OON	Podiatry Services Out-of-Network	10	Podiatry Services
B-7e B-7h C-OON	Mental Health Services Psychiatric Services Out-of-Network	11	Outpatient Mental Health Care
B-9c C-OON	Substance Abuse Services Out-of-Network	12	Outpatient Substance Abuse Care
B-9a B-9b C-OON	Outpatient Hospital Services ASC Services Out-of-Network	13	Outpatient Services
B-10a C-OON	Ambulance Services Out-of-Network	14	Ambulance Services
B-4a	ER Care	15	Emergency Care
B-4b	Urgent Care	16	Urgently Needed Care
B-7c B-7i C-OON	Occupational Therapy PT/Speech Therapy Out-of-Network	17	Outpatient Rehabilitation Services
B-11a C-OON	DME Out-of-Network	18	Durable Medical Equipment
B-11b C-OON	Prosthetics/Orthotics Out-of-Network	19	Prosthetic Devices
B-11c B-14i C-OON	Diabetes Monitoring Supplies Diabetes Monitoring Training Out-of-Network	20	Diabetes Self-Monitoring Training and Supplies
B-8a B-8b C-OON	Outpatient Rad. & Lab Svcs. X-rays Out-of-Network	21	Diagnostic Tests, X-Rays, and Lab Services
B-14b C-OON	Bone Mass Measurement Out-of-Network	22	Bone Mass Measurement
B-14f C-OON	Colorectal Screening Exam Out-of-Network	23	Colorectal Screening Exams
B-14b C-OON	Immunizations Out-of-Network	24	Immunizations
B-14h	Mammography Screening	25	Mammograms (Annual

C-OON	Out-of-Network		Screening)
B-14d C-OON	Pap Smears/Pelvic Exams Out-of-Network	26	Pap Smears and Pelvic Exams
B-14e C-OON	Prostate Cancer Screening Out-of-Network	27	Prostate Cancer Screening Exams
B-15 Rx	Medicare Part B Rx Drugs Medicare Part D Rx drugs	28	Outpatient Prescription Drugs
B-16a B-16b C-OON	Preventive Dental Comprehensive Dental Out-of-Network	29	Dental Services
B-18a B-18b C-OON	Hearing Exams Hearing Aids Out-of-Network	30	Hearing Services
B-17a B-17b C-OON	Eye Exams Eye Wear Out-of-Network	31	Vision Services
B-14c C-OON	Routine Physical Exams Out-of-Network	32	Physical Exams
B-14a	Health/Wellness Education	33	Health/Wellness Education
B-10b C-OON	Transportation Out-of-Network	34	Transportation
B-13b C-OON	Acupuncture Out-of-Network	35	Acupuncture
C-POS	POS	36	Point of Service
D	Optional Supplemental Benefit packages	Optional Benefits	Package Premium
B-7b D-Step-up 7b	Chiropractic Services (Opt.) Chiropractic Services	Optional Benefits	Chiropractic Services
B-7f D-Step-up 7f	Podiatry Services (Opt.) Podiatry Services	Optional Benefits	Podiatry Services
 Rx	(Cost Plans only) Medicare Part D Rx drugs	Optional Benefits	Outpatient Prescription Drugs
B-16a B-16b D-Step-up 16a D-Step-up 16b	Preventive Dental (Opt.) Comprehensive Dental (Opt.) Preventive Dental Comprehensive Dental	Optional Benefits	Dental
B-18a B-18b D-Step-up 18a D-Step-up 18b	Hearing Exams (Opt.) Hearing Aids (Opt.) Hearing Exams Hearing Aids	Optional Benefits	Hearing

B-17a B-17b D-Step-up 17a D-Step-up 17b	Eye Exams (Opt.) Eye Wear (Opt.) Eye Exams Eye Wear	Optional Benefits	Vision
B-10b D-Step-up 10b	Transportation (Opt.) Transportation	Optional Benefits	Transportation

NOTE: Sub-network rules -- If the rules provided in given answers to Section B do not cover ALL Plan (network) providers, but only a portion of network providers, then provide clarification of these rules in the **Notes** field for the applicable service category. For example, if self-referral for a screening mammography is limited to a specific provider or a specific set of providers (provider networks), then provide this information in the Notes field for Mammography (14h).

The sections of the PBP are highly interdependent; data entered into one section can impact the data entry requirements for another section. This is particularly true of Section B. For example, specifying a benefit as Optional in Section B forces the user to include that benefit in an Optional Supplemental Benefit package when filling out Section D.

What may potentially be confusing to some users is the impact to the status of Section D when changes are made to Section B after data entry has been completed for Section D. In the above example, if data entry for Section D had previously been completed but changes are made to Section B, then the status for Section D would have automatically changed to "Incomplete". The PBP tool is designed this way in order to require the user to reopen Section D and make the necessary changes.

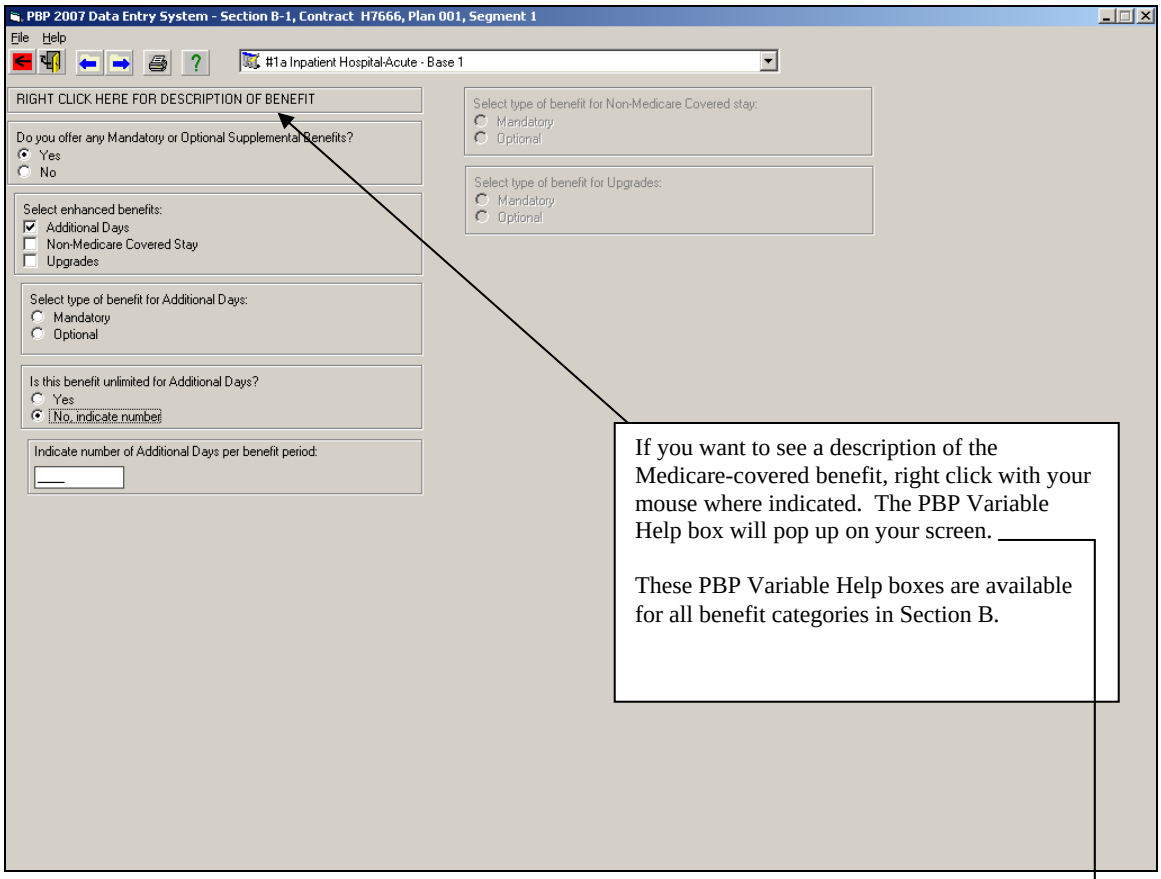
However, if the change to Section B had been made in error, reopening Section B and correcting the error will not automatically change the Section D status back to "Complete". In this case, the user would have to reopen Section D and should exit with validation in order to change the status back to "Complete". The reason for this is that the checks for data entry completion are only performed on the exit of a certain section or service category.

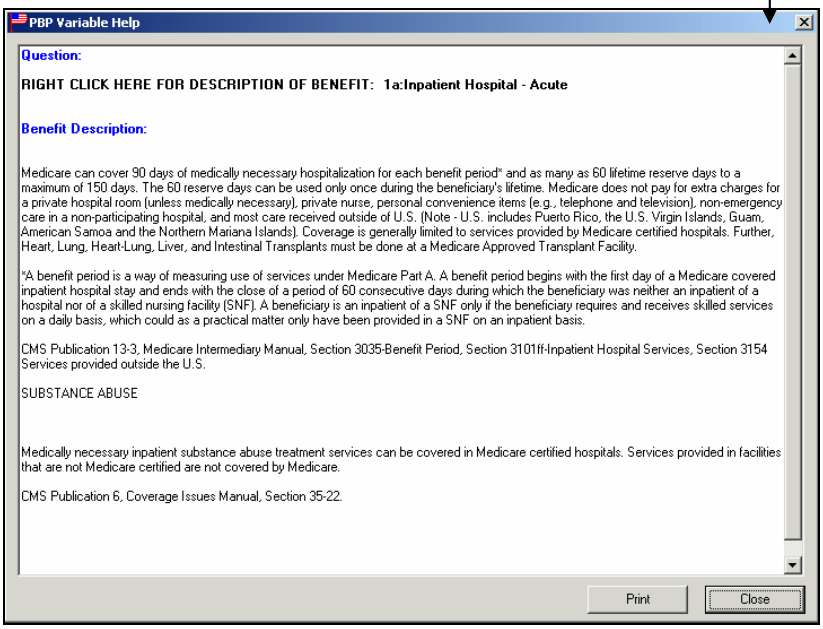
There are three status types available for **each** Service Category in Section B. These represent data entry progress and include:

- **New** -- Service Category has not been opened for data entry.
- **Incomplete** -- Data entry has begun and has not been completed.
- **Completed** -- Data entry has been completed and validated.

Once data entry has been completed and validated for all service categories in Section B, the Status for each will display Completed**.**

HELPFUL HINT:





SERVICE CATEGORY SPECIFIC INSTRUCTIONS

PBP B-1a: Inpatient Hospital—Acute

SB 3: Inpatient Hospital Services

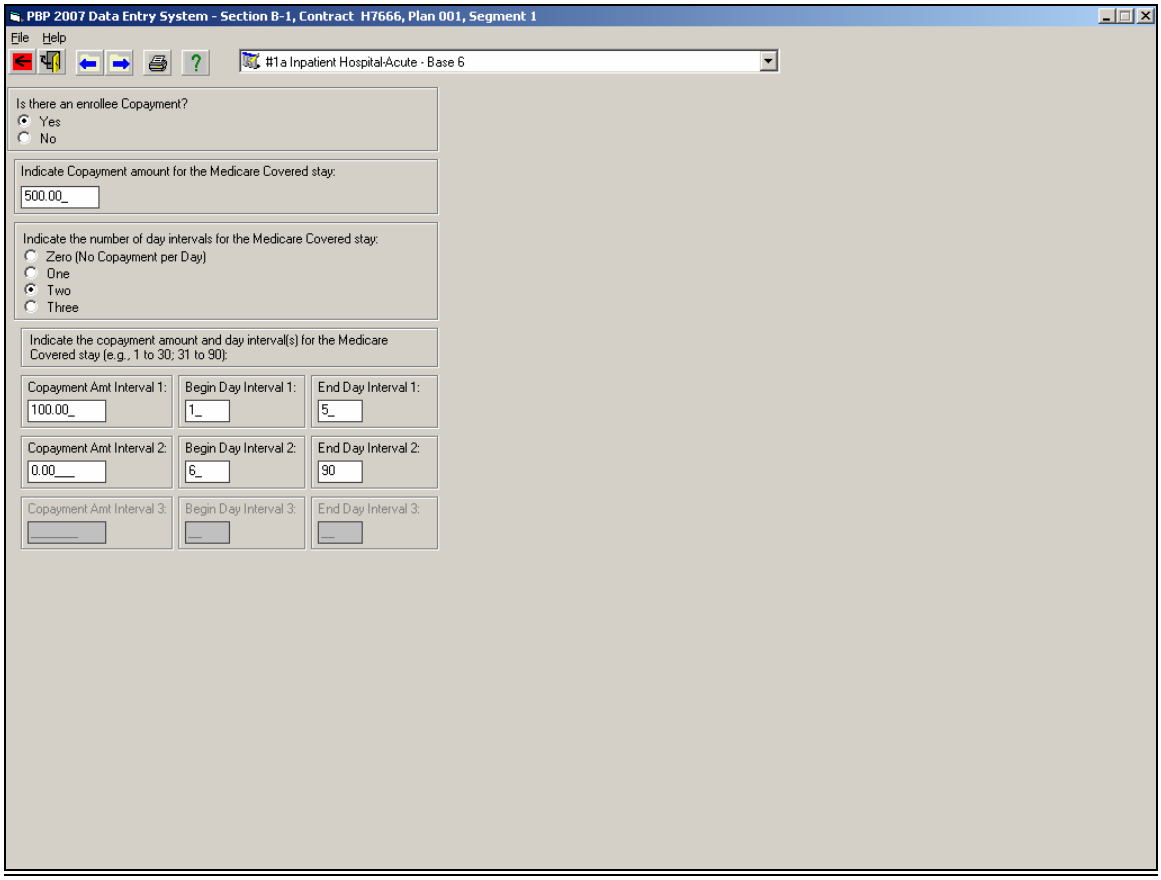
This category collects information on Medicare-covered and non-Medicare-covered inpatient hospital – acute services.

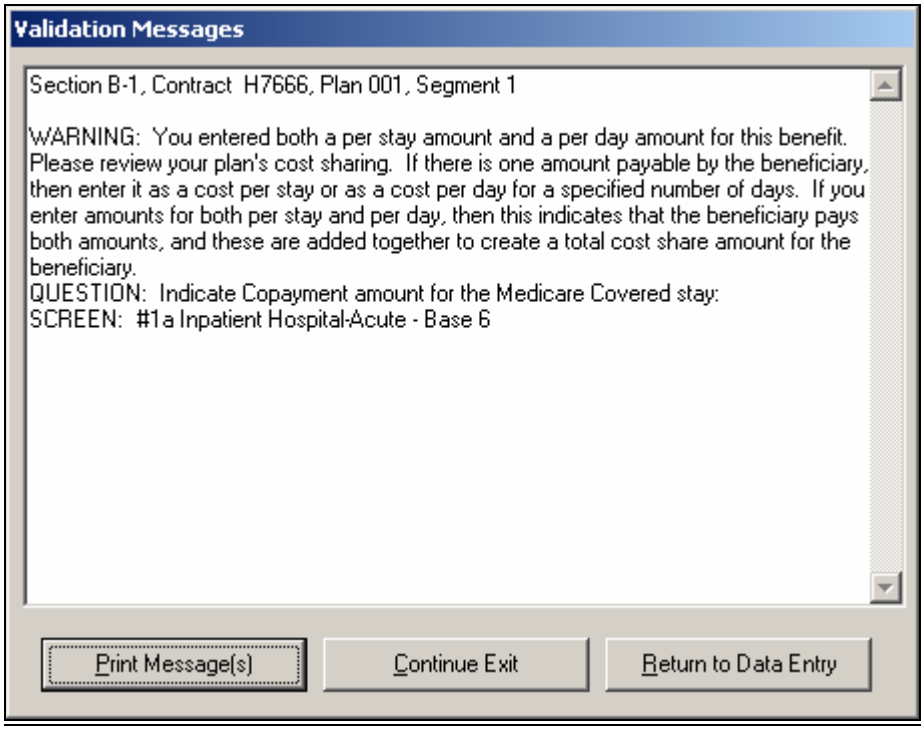
NEW FOR 2007:

Medicare-covered Lifetime Reserve Days Cost share fields (Coinsurance and Copayment intervals) have been added for the 60 Medicare-covered lifetime reserve days. The plan must explicitly price the 60 lifetime reserve days covered by Medicare. The software requires the user to enter a start day equal to '1' in the first interval, and an end day equal to '60' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost share structure.

Coinsurance and copayment amounts may be entered on a per stay and/or a per day basis.

A warning message will appear whenever a per stay amount and a per day amount are the same value. For example, MAs charge $500 per stay and $100 per day for days 1-5. This means the beneficiary is charged $500 for each entry to the hospital and $100 for each day 1-5. Therefore, if a beneficiary goes to the hospital for 5 days they end up paying $1,000, or $500 + ($100*5). If an MA plan intends to charge a per stay amount and a per day amount, this is fine; however, CMS has seen that this is commonly a data entry error so we have implemented the warning message as an alert. See the illustration below for this example.


PBP 2007 Data Entry System - Section B-1, Contract H7666, Plan 001, Segment 1
File Help
#1a Inpatient Hospital-Acute - Base 6
Is there an enrollee Copayment?
Yes
No
Indicate Copayment amount for the Medicare Covered stay:
500.00_
Indicate the number of day intervals for the Medicare Covered stay:
Zero (No Copayment per Day)
One
Two
Three
Indicate the copayment amount and day interval(s) for the Medicare Covered stay (e.g., 1 to 30; 31 to 90):
Copayment Amt Interval 1:
100.00_
Begin Day Interval 1:
1_
End Day Interval 1:
5_
Copayment Amt Interval 2:
0.00___
Begin Day Interval 2:
6_
End Day Interval 2:
90
Copayment Amt Interval 3:
Begin Day Interval 3:
End Day Interval 3:

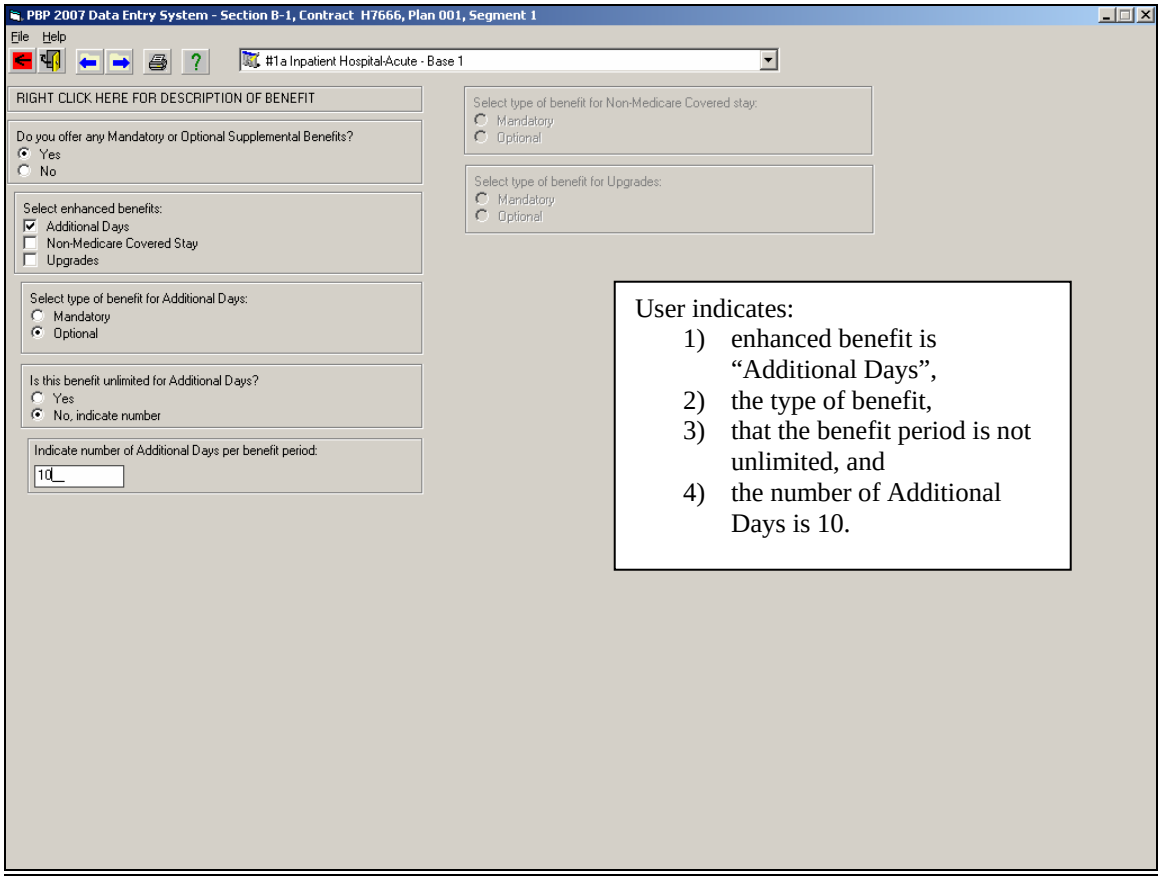

Validation Messages
Section B-1, Contract H7666, Plan 001, Segment 1
WARNING: You entered both a per stay amount and a per day amount for this benefit. Please review your plan's cost sharing. If there is one amount payable by the beneficiary, then enter it as a cost per stay or as a cost per day for a specified number of days. If you enter amounts for both per stay and per day, then this indicates that the beneficiary pays both amounts, and these are added together to create a total cost share amount for the beneficiary.
QUESTION: Indicate Copayment amount for the Medicare Covered stay:
SCREEN: #1a Inpatient Hospital-Acute - Base 6
Print Message(s)
Continue Exit
Return to Data Entry

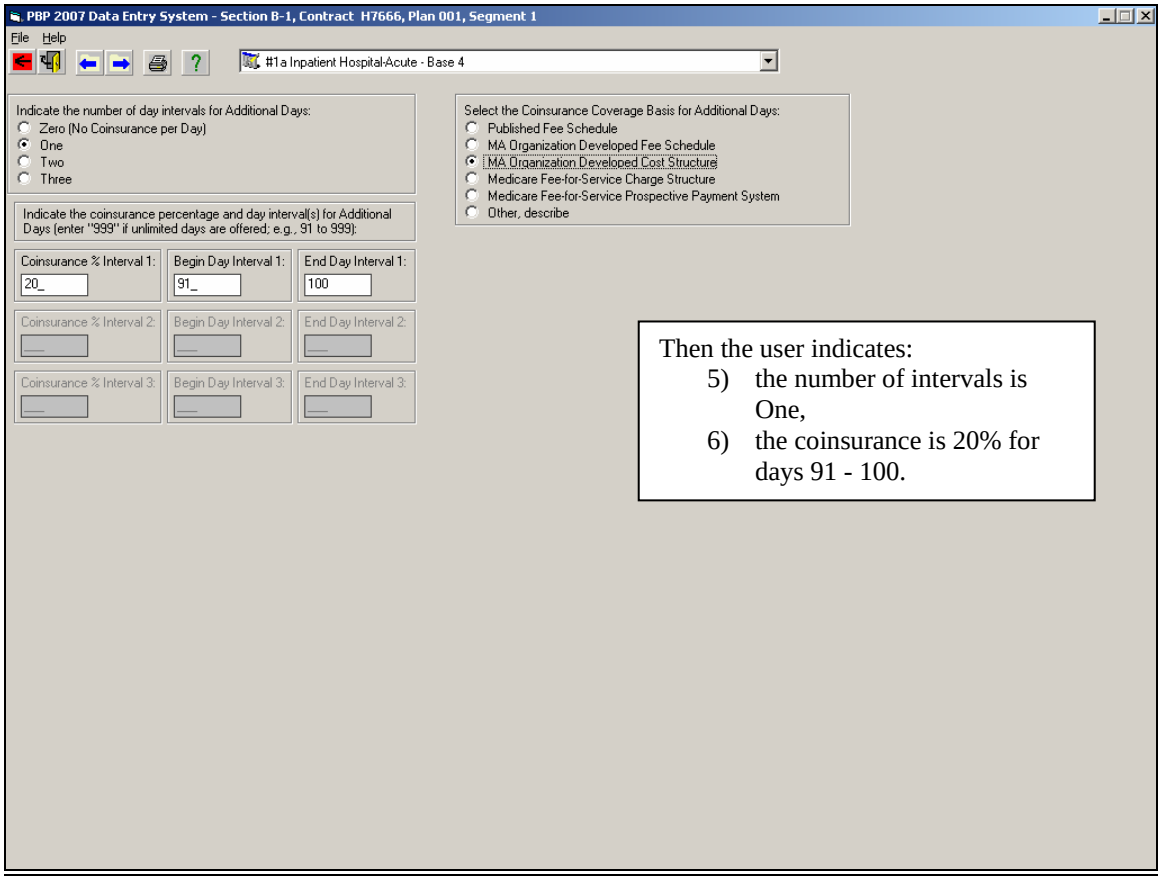
Below are the instructions for entering data if a plan has cost sharing on a per day basis.

Medicare Covered Stay Cost Shares: If a plan has a per day cost structure for Medicare-covered stays, the plan must explicitly price the 90 days covered by Medicare during a benefit period. To ensure this pricing structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '90' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost sharing structure.

Additional Days Cost Shares: Additional days are defined as days covered by the plan after the 90 Medicare-covered days per benefit period. Additional days for Inpatient Hospital Acute should always start at day 91. The number of additional days offered will determine the end day.

Example: If 10 additional days per benefit period are offered at 20% coinsurance, then the cost share structure should specify additional days 91 through 100. See below.

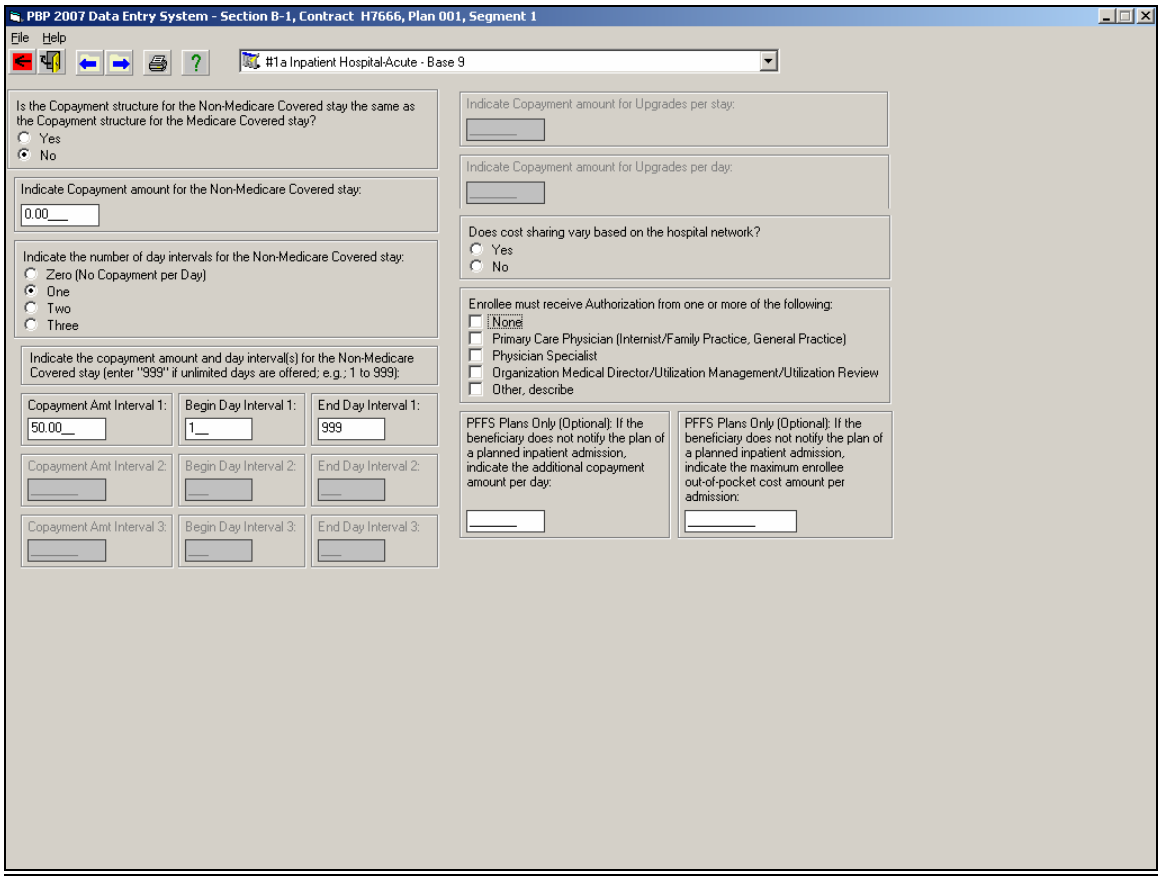




However, if an unlimited number of additional days are offered at 10% coinsurance, "999" should be used to notate the end day of the pricing structure. By using "999", the SB will generate a sentence that states "You pay $x (or x% of the cost) for additional days 91 and beyond."

Non-Medicare Covered Stay Cost Shares: A non-Medicare-covered stay is a stay that is not medically necessary and reasonable according to Medicare coverage guidelines, or is provided in a facility not certified by Medicare. If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the non-Medicare covered stay, if a per day cost share structure exists.

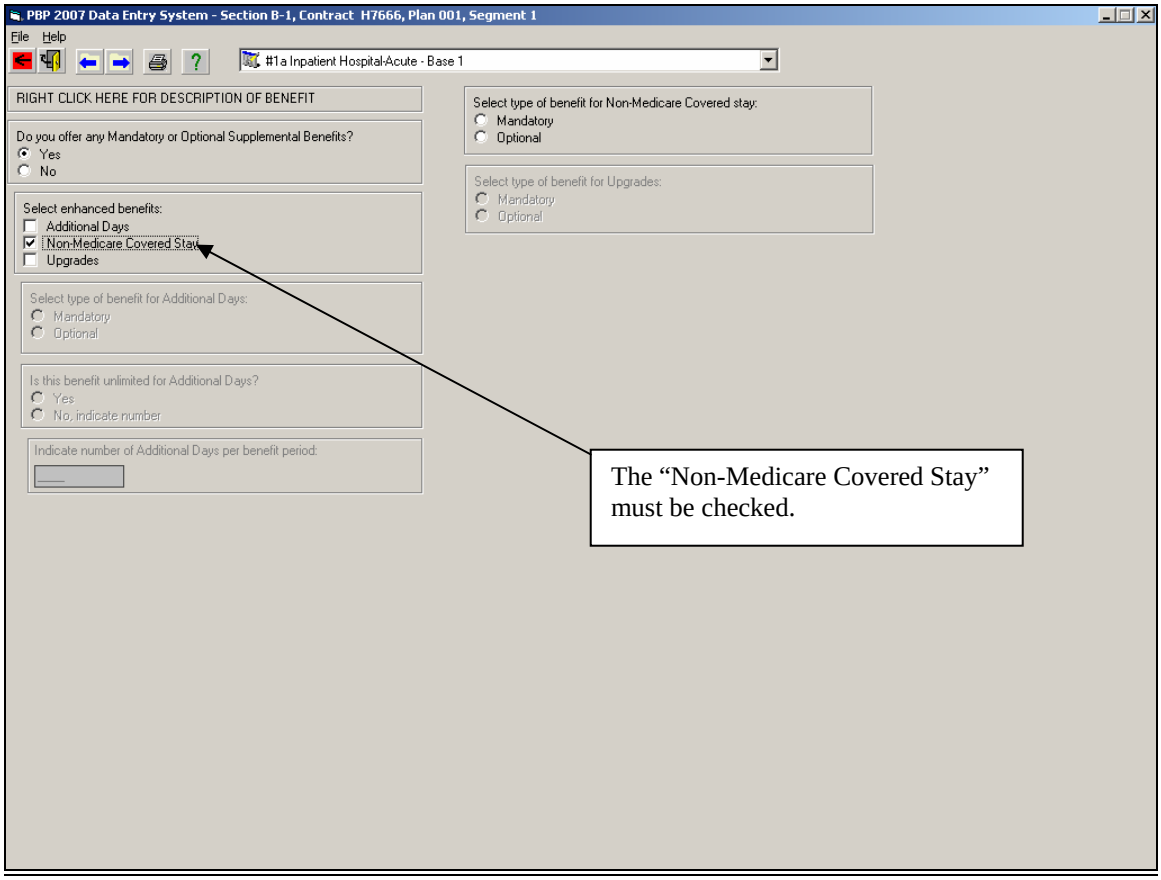
Example: If the plan charges $50 per day for an unlimited Non-Medicare-covered Stay, then the MA plan should declare one interval and enter $50 for days 1 through 999.



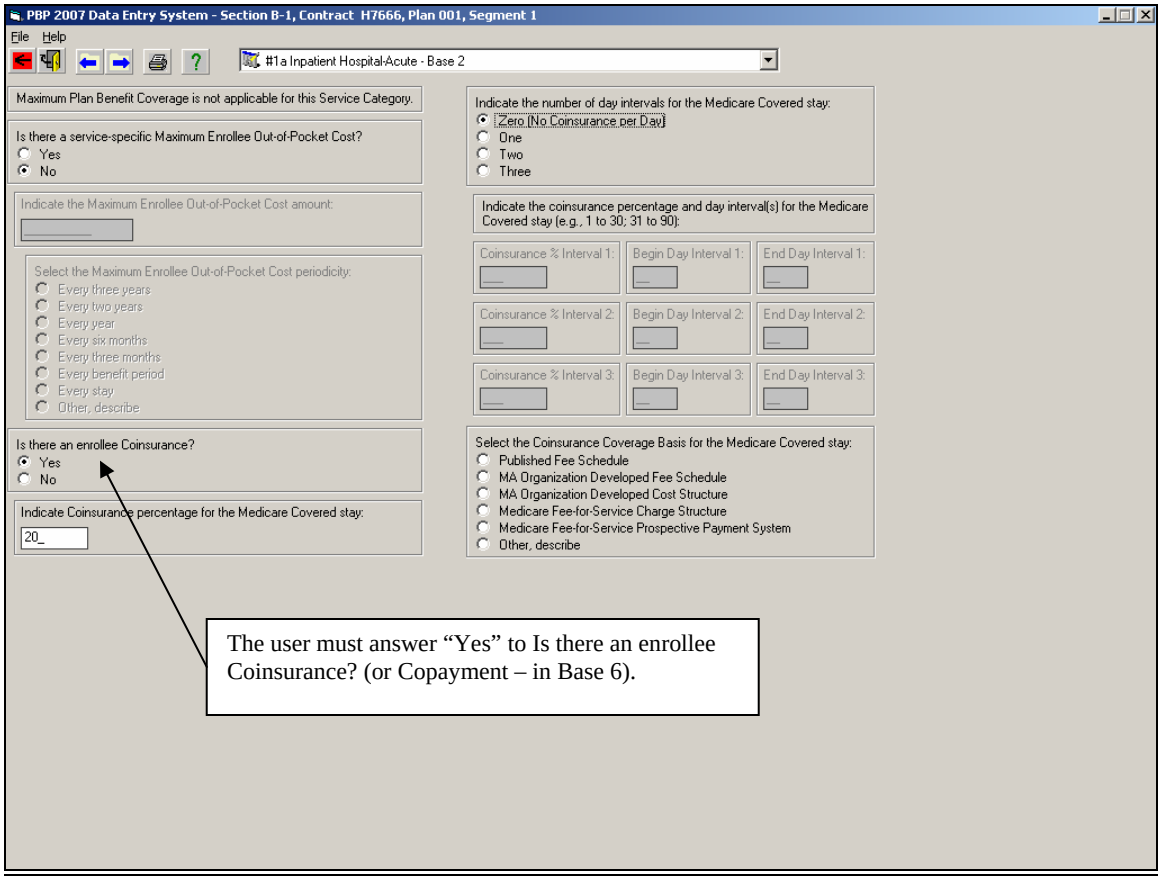
HELPFUL HINT:

If the Medicare Covered cost-sharing and Non-Medicare Covered cost sharing are the same amounts, answer "Yes" to the question, “Is the Copayment [Coinsurance] structure for the Non-Medicare Covered stay the same as the Copayment [Coinsurance] structure for the Medicare Covered stay?” By answering, “Yes”, the correct SB sentences will be produced, eliminating unneeded duplication of sentences. In order to enable this question, see the PBP screen shots below:

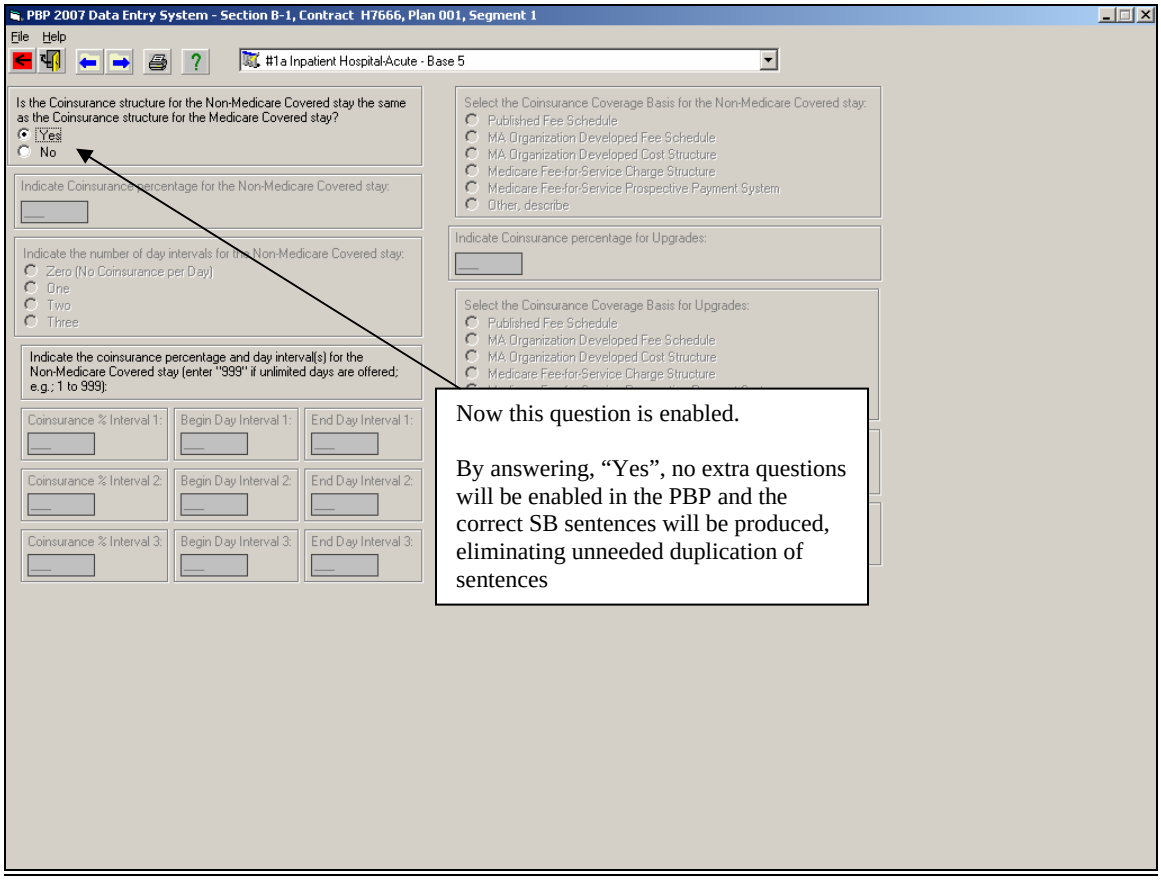
Step 1:


PBP 2007 Data Entry System - Section B-1, Contract H7666, Plan 001, Segment 1
File Help
#1a Inpatient Hospital-Acute - Base 1
RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT
Do you offer any Mandatory or Optional Supplemental Benefits?
Yes
No
Select enhanced benefits:
Additional Days
Non-Medicare Covered Stay
Upgrades
Select type of benefit for Additional Days:
Mandatory
Optional
Is this benefit unlimited for Additional Days?
Yes
No, indicate number
Indicate number of Additional Days per benefit period:
Select type of benefit for Non-Medicare Covered stay:
Mandatory
Optional
Select type of benefit for Upgrades:
Mandatory
Optional
The “Non-Medicare Covered Stay” must be checked.

Step 2:


PBP 2007 Data Entry System - Section B-1, Contract H7666, Plan 001, Segment 1
File Help
#1a Inpatient Hospital-Acute - Base 2
Maximum Plan Benefit Coverage is not applicable for this Service Category.
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Yes
No
Indicate the Maximum Enrollee Out-of-Pocket Cost amount:
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Every benefit period
Every stay
Other, describe
Is there an enrollee Coinsurance?
Yes
No
Indicate Coinsurance percentage for the Medicare Covered stay:
20_
Indicate the number of day intervals for the Medicare Covered stay:
Zero [No Coinsurance per Day]
One
Two
Three
Indicate the coinsurance percentage and day interval(s) for the Medicare Covered stay (e.g., 1 to 30; 31 to 90):
Coinsurance % Interval 1:
Begin Day Interval 1:
End Day Interval 1:
Coinsurance % Interval 2:
Begin Day Interval 2:
End Day Interval 2:
Coinsurance % Interval 3:
Begin Day Interval 3:
End Day Interval 3:
Select the Coinsurance Coverage Basis for the Medicare Covered stay:
Published Fee Schedule
MA Organization Developed Fee Schedule
MA Organization Developed Cost Structure
Medicare Fee-for-Service Charge Structure
Medicare Fee-for-Service Prospective Payment System
Other, describe
The user must answer “Yes” to Is there an enrollee Coinsurance? (or Copayment – in Base 6).

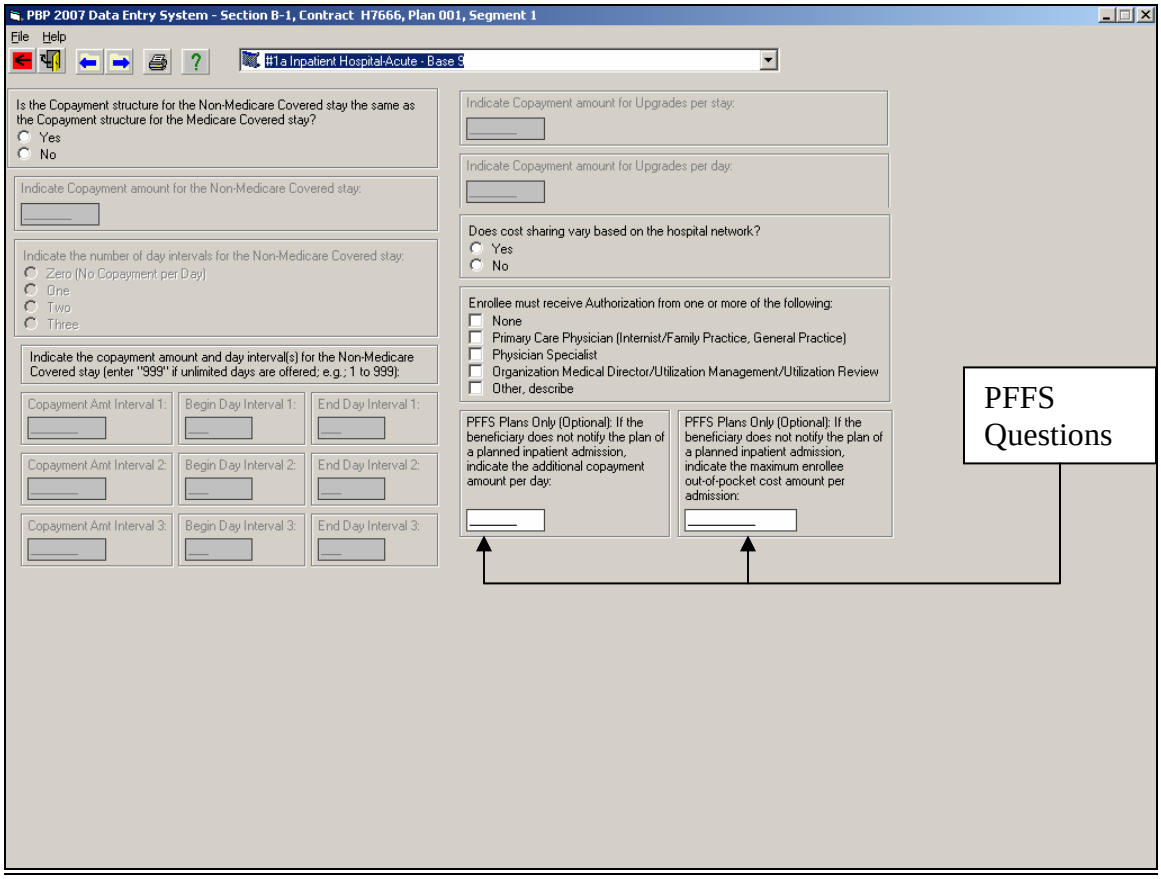
Step 3:



HELPFUL HINT:

An Inpatient Substance Abuse benefit may be covered either under Inpatient Hospital Acute or Inpatient Psychiatric Hospital. The MA Plan may use either subcategory to describe this benefit in the PBP.

In Sections 1a – Inpatient Hospital Service and 1b – Inpatient Psychiatric Hospital Services, a pair of **optional** questions is available for PFFS plan types **ONLY**. These questions appear on the screen for all plan types, but only PFFS plans are permitted to answer them and then perform a successful validation for the section. If a plan type other than PFFS enters information in this section, the non-PFFS plan type would receive the following validation message: *Error – Must be blank for non-PFFS plan types*. If a PFFS plan enters data for these two questions, then a sentence will be generated for the SB. See the PBP/SB Crosswalk for details.



SB Out-of-Network sentences may be generated based on data entered in Section C for Inpatient Hospital out-of-network benefits.

PBP B-1b: Inpatient Psychiatric Hospital

SB 4: Inpatient Mental Health Services

This category collects information on Medicare-covered and non-Medicare-covered inpatient psychiatric hospital services.

NEW FOR 2007:

Medicare-covered Lifetime Reserve Days Cost share fields (Coinsurance and Copayment intervals) have been added for the 60 Medicare-covered lifetime reserve days. The plan must explicitly price the 60 days covered by Medicare. To ensure this pricing structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '60' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

HELPFUL HINT:

See above Section "PBP B-1a: Inpatient Hospital—Acute SB 3: Inpatient Hospital Services" for more detailed information that also pertains to "PBP B-1b: Inpatient Psychiatric Hospital SB 4: Inpatient Mental Health Services."

SB Out-of-Network sentences may be generated based on data entered in Section C for Inpatient Psychiatric Hospital out-of-network benefits.

PBP B-2: Skilled Nursing Facility (SNF)

SB 5: SNF Services

This category collects information on Medicare-covered and non-Medicare-covered SNF services.

Coinsurance and copayment amounts may be entered on a per stay and/or a per day basis. Below are the instructions for entering data if a plan has cost sharing on a per day basis.

Medicare Covered Stay Cost Shares: If a plan has a per day cost structure for Medicare-covered stays, the plan must explicitly price the 100 days covered by Medicare during a benefit period. To ensure this pricing structure, the software requires the user to enter, at a minimum, a start day equal to '1' in the first interval, and an end day equal to '100' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

Additional Days Cost Shares: Additional days are defined to be days covered after the 100 Medicare-covered days per benefit period. Additional days for SNF should always start at day 101. The number of additional days offered will determine the end day.

Non-Medicare Covered Stay Cost Shares: A non-Medicare-covered stay is not medically necessary and reasonable according to Medicare coverage guidelines, or is provided in a

facility not certified by Medicare. If the plan has a per day cost share for the Non-Medicare-covered stay, the first day of the cost share interval must be day 1 and the last day must be the maximum number of days covered under the benefit. As in the case of the Medicare-covered stay, all days must be explicitly priced for the non-Medicare covered stay, if a per day pricing structure exists.

HELPFUL HINT:
See above Section "PBP B-1a: Inpatient Hospital—Acute SB 3: Inpatient Hospital Services" for more detailed information that also pertains to "PBP B-2: Skilled Nursing Facility (SNF) SB 5: SNF Services".

HELPFUL HINT:
Medicare requires a prior 3-day inpatient hospital stay and an admission to a SNF within 30 days of the inpatient discharge, to be a qualifying SNF stay. If the MA Plan admits a beneficiary who does not meet these requirements to a SNF, it is considered a non-Medicare covered SNF stay and must be described and priced accordingly in the PBP and BPT as a Mandatory or Optional Supplemental benefit.

SB Out-of-Network sentences may be generated based on data entered in Section C for SNF out-of-network benefits.

PBP B-3: Comprehensive Outpatient Rehabilitation Facility (CORF)

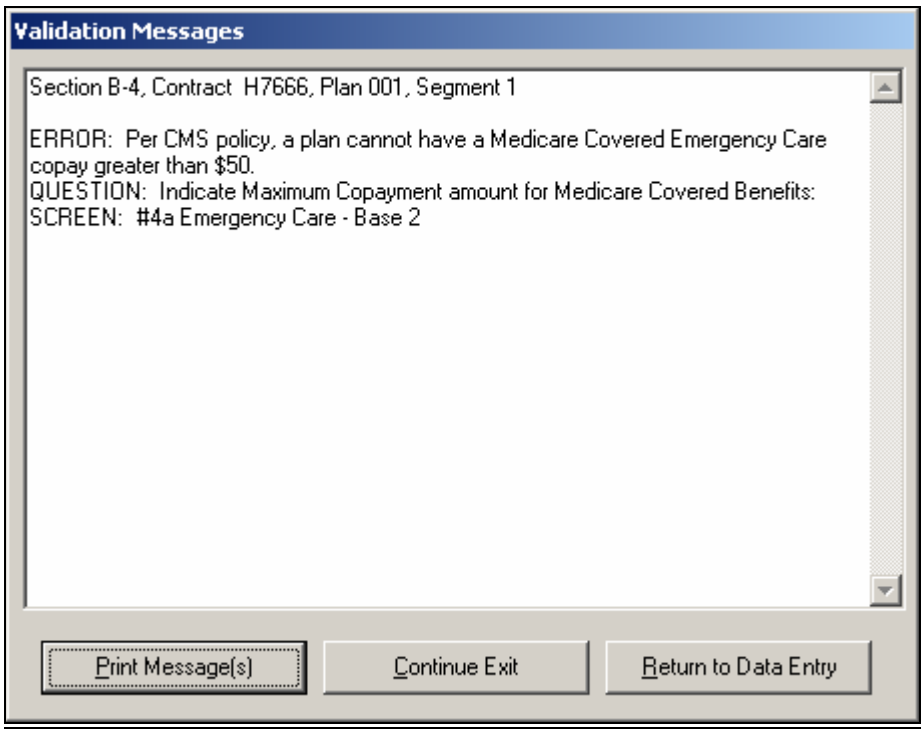
This category collects information on Medicare-covered services provided at a comprehensive outpatient rehabilitation facility.

PBP B-4a: Emergency Care/Post Stabilization Care

SB 15: Emergency Care

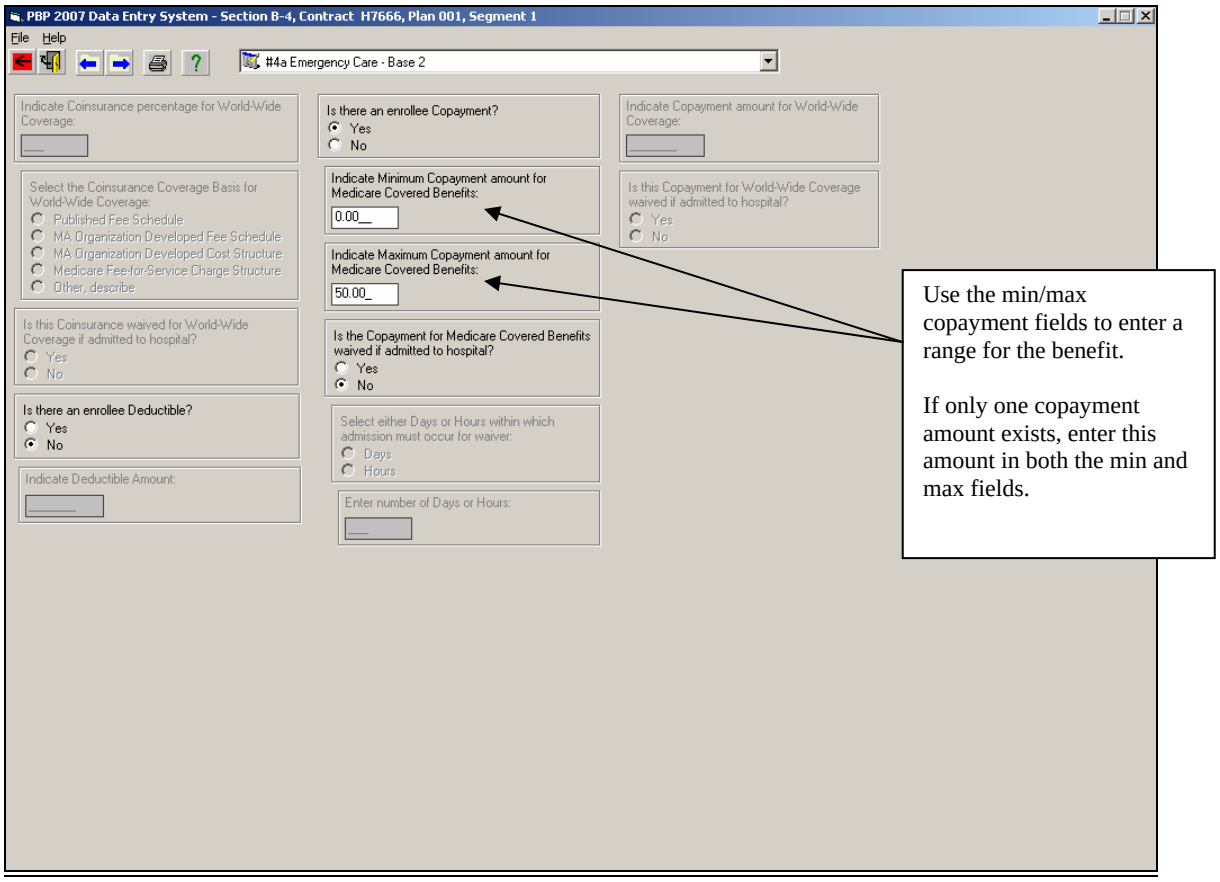
This category collects information on Medicare-covered and non-Medicare-covered emergency room services.

HELPFUL HINT:
There is an edit rule limiting the cost share for an ER visit to $50. Also, the SB sentence for the ER cost share reflects this limit if a coinsurance is charged. If a value greater the $50 is entered, the following validation screen will appear:



HELPFUL HINT:

MAs often waive the coinsurance and/or copayment for the emergency room visit if a beneficiary is admitted to the hospital. If the cost share is waived, the question "Is the Coinsurance [Copayment] for Medicare Covered Benefits waived if admitted to hospital?" should be answered "Yes" and the appropriate days or hours in which the admission must occur for the waiver should be entered. If the waiver is only applicable when the beneficiary is immediately admitted to the hospital, then "hours" should be selected and the number "0" should be entered as the number of hours in which admittance must occur for the cost sharing to be waived. This will produce the sentence, "You do not pay this amount if you are immediately admitted to the hospital." An illustration of this example follows.



There are no SB Out-of-Network sentences for this category. Under current statutory regulations, an MA plan cannot charge more for out of network Emergency services than in network.

PBP B-4b: Urgently Needed Care/Urgent Care Centers

SB 16: Urgently Needed Care

This category collects information on Medicare-covered and non-Medicare-covered urgent care services.

HELPFUL HINT:

See "PBP B-4a: Emergency Care/Post Stabilization Care, SB 15: Emergency Care" for more detailed information regarding the question "Is the Coinsurance [Copayment] for Medicare Covered Benefits waived if admitted to hospital?".

PBP B-5: Partial Hospitalization

This category collects information on Medicare-covered partial hospitalization services. There are no SB sentences associated with this category.

PBP B-6: Home Health Services

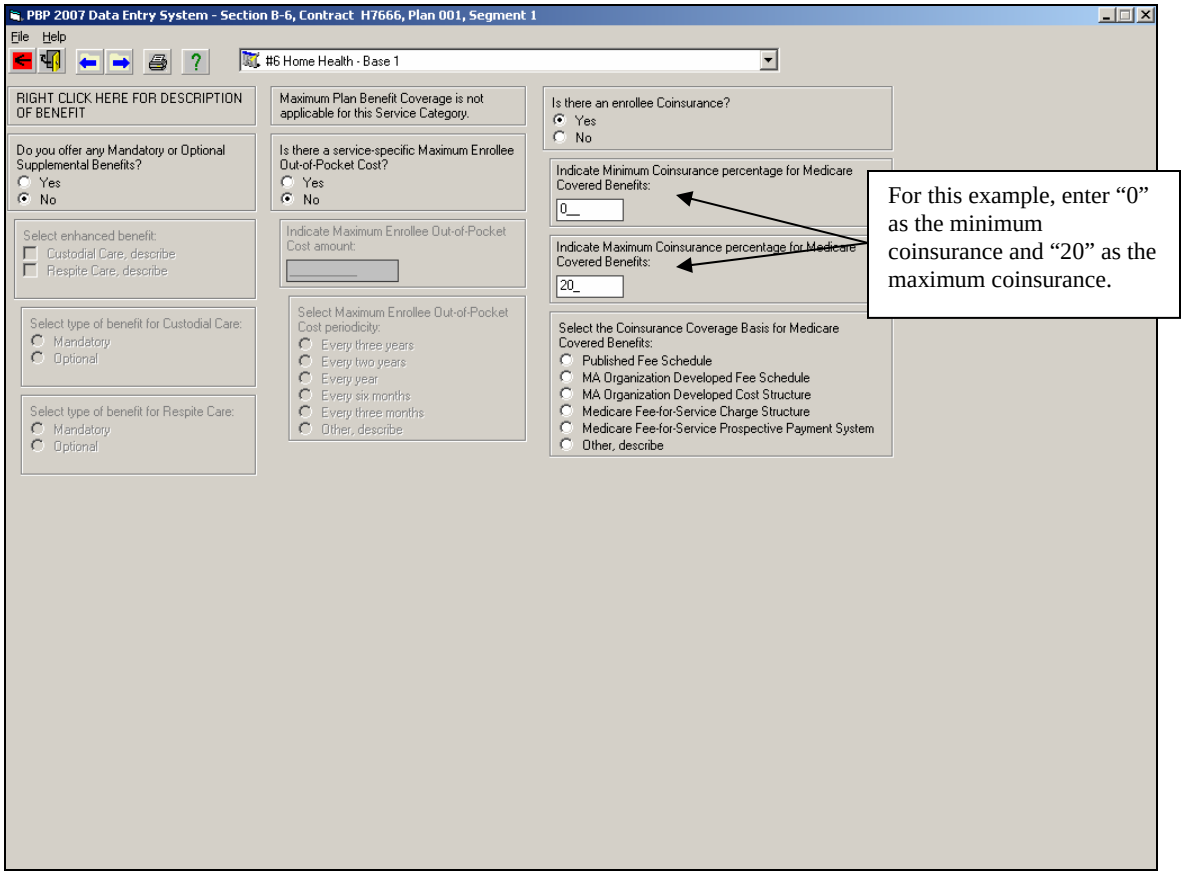
SB 6: Home Health Care

This category collects information on Medicare-covered and non-Medicare-covered home health services.

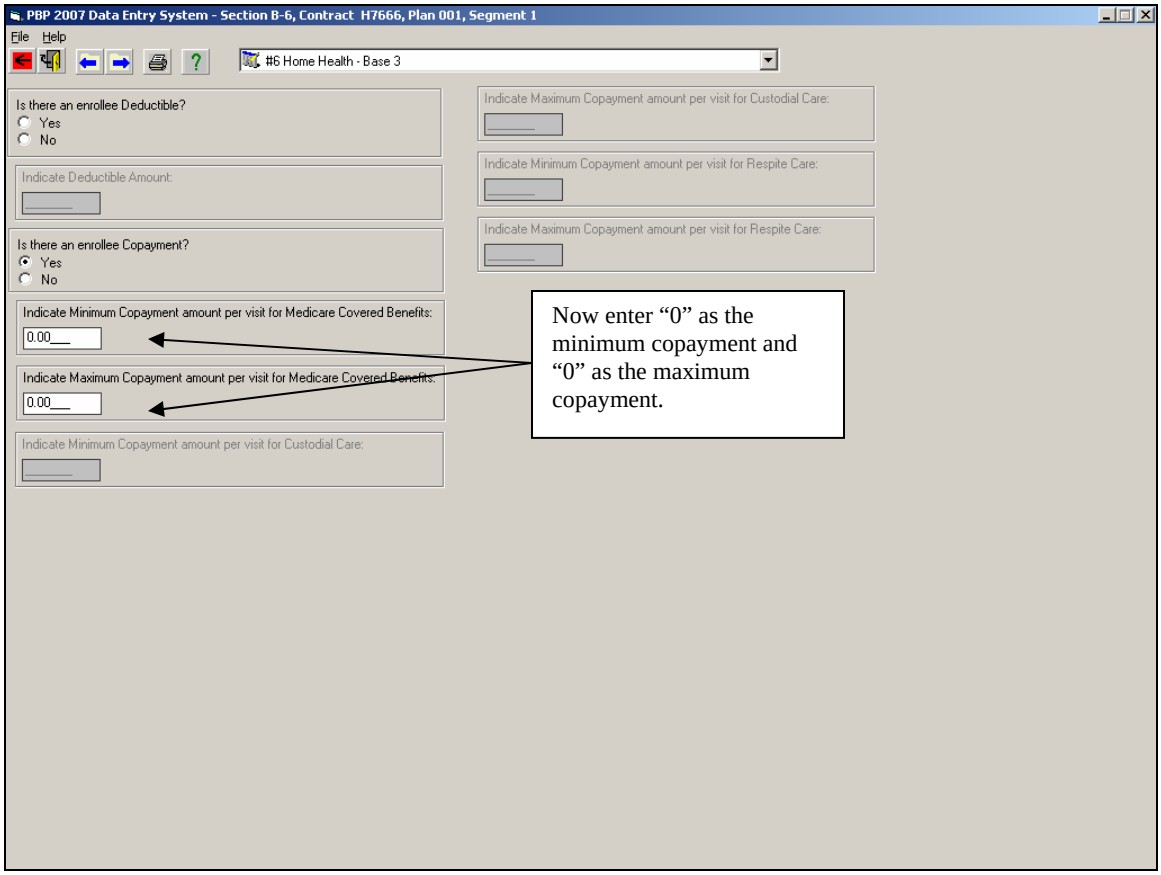
CHANGE FOR 2007:
Homemaker services have been removed as an enhanced benefit. See the CY 2007 Call Letter for guidance on this topic.

HELPFUL HINT:
Currently if an MA plan wants to offer a $0 copay or 20% of the cost for a Medicare covered service, the information must be entered as shown below. The SB will only print copay values greater than $0 for this service. However, by following the example below, the SB will read, "You pay 0% - 20% of the cost for Medicare-covered Home Health visits."

Step 1:


PBP 2007 Data Entry System - Section B-6, Contract H7666, Plan 001, Segment 1
File Help
#6 Home Health - Base 1
RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT
Maximum Plan Benefit Coverage is not applicable for this Service Category.
Is there an enrollee Coinsurance?
Yes
No
Do you offer any Mandatory or Optional Supplemental Benefits?
Yes
No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Yes
No
Indicate Minimum Coinsurance percentage for Medicare Covered Benefits:
0__
Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:
20_
Select enhanced benefit:
Custodial Care, describe
Respite Care, describe
Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Select type of benefit for Custodial Care:
Mandatory
Optional
Select Maximum Enrollee Out-of-Pocket Cost periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select type of benefit for Respite Care:
Mandatory
Optional
Select the Coinsurance Coverage Basis for Medicare Covered Benefits:
Published Fee Schedule
MA Organization Developed Fee Schedule
MA Organization Developed Cost Structure
Medicare Fee-for-Service Charge Structure
Medicare Fee-for-Service Prospective Payment System
Other, describe
For this example, enter “0” as the minimum coinsurance and “20” as the maximum coinsurance.

Step 2:



SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7a: Primary Care Physician Services

SB 8: Doctor Office Visits

This category collects information on Medicare-covered primary care physician services.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7b: Chiropractic Services

SB 9: Chiropractic Services

This category collects information on Medicare-covered and non-Medicare-covered chiropractic services.

Medicare covered chiropractic services only include Manual Manipulation of the Spine to Correct Subluxation. Any other chiropractic services that are offered, such as routine

care, would be classified as either Mandatory Supplemental or Optional Supplemental benefits.

In the SB, Manual Manipulation of the Spine and Chiropractic Services (Routine care) are merged into one category, "Chiropractic Services". The SB sentences will continue to distinguish between the Manual Manipulation of the Spine and Routine Care.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7c: Occupational Therapy Services

SB 17: Outpatient Rehabilitation Services

This category collects information on Medicare-covered occupational therapy services.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7d: Physician Specialist Services

SB 8: Doctor Office Visits

This category collects information on Medicare-covered specialist services.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7e: Mental Health Specialist Services

SB 11: Outpatient Mental Health Care

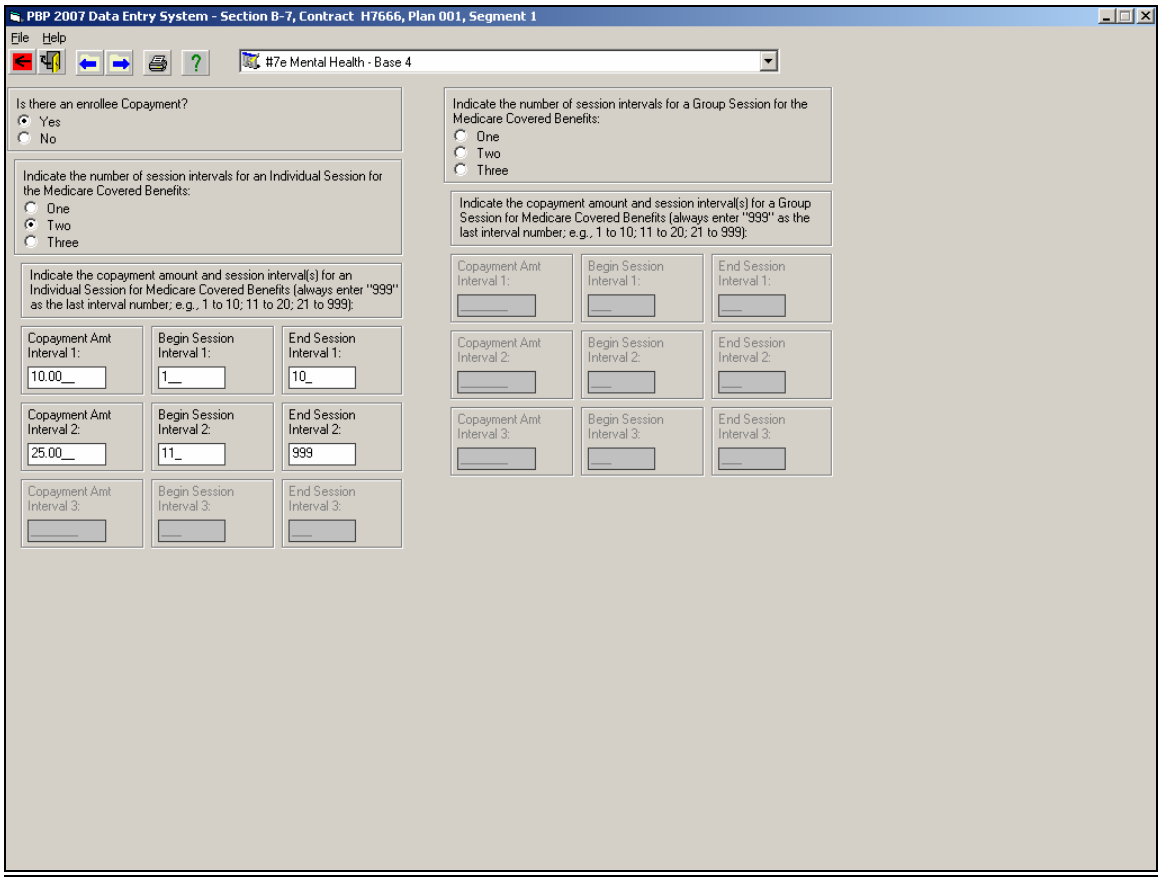
This category collects information on Medicare-covered mental health services, excluding psychiatric services.

Cost sharing allows plans to enter self-designated intervals for costs per visit. Below are the instructions for entering data if a plan has cost sharing on a per visit basis.

Individual/Group Visit Cost Shares: If a plan has a per visit cost structure for individual and/or group visits, the plan should explicitly price these visits. Since the visits are Medicare-covered, the plan should enter a start visit equal to '1' in the first interval, and an end visit equal to '999' in the last interval. Note that the end visit can be entered in the first, second, or third interval, depending upon the plan's cost structure.

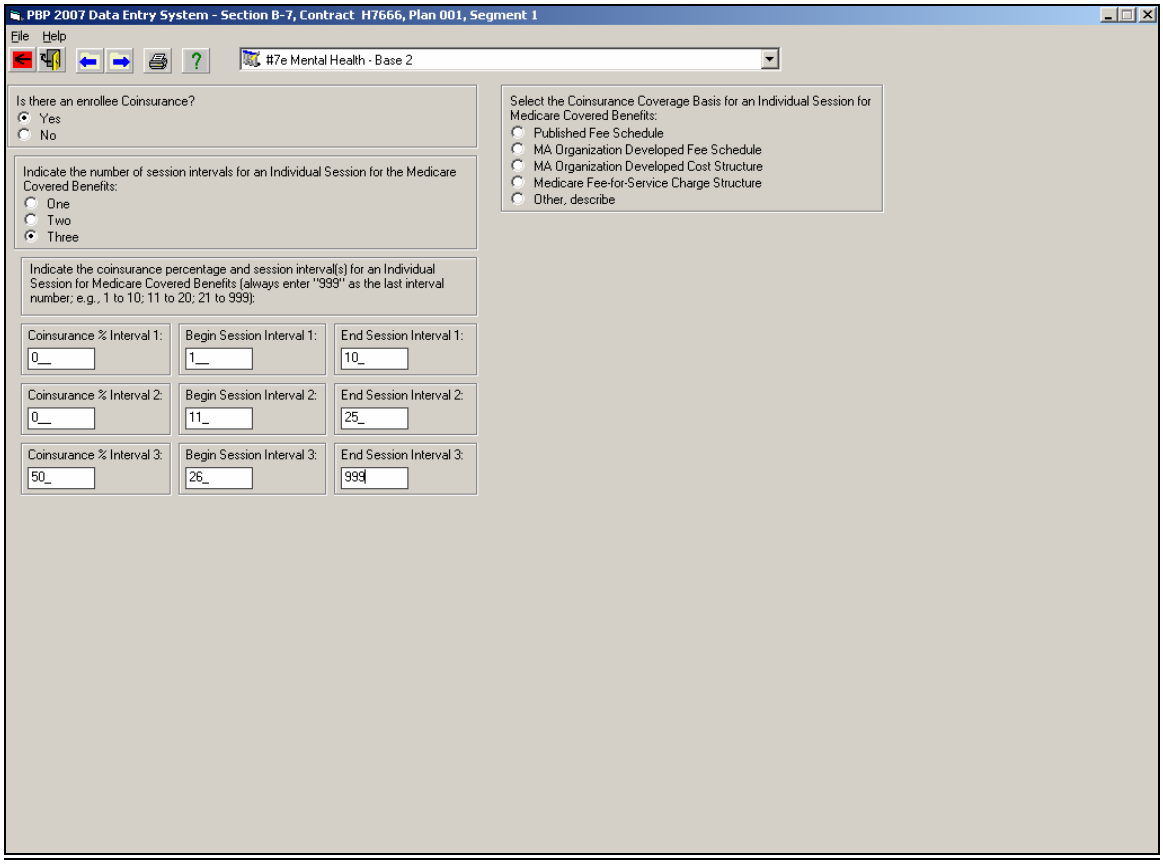
HELPFUL HINT:

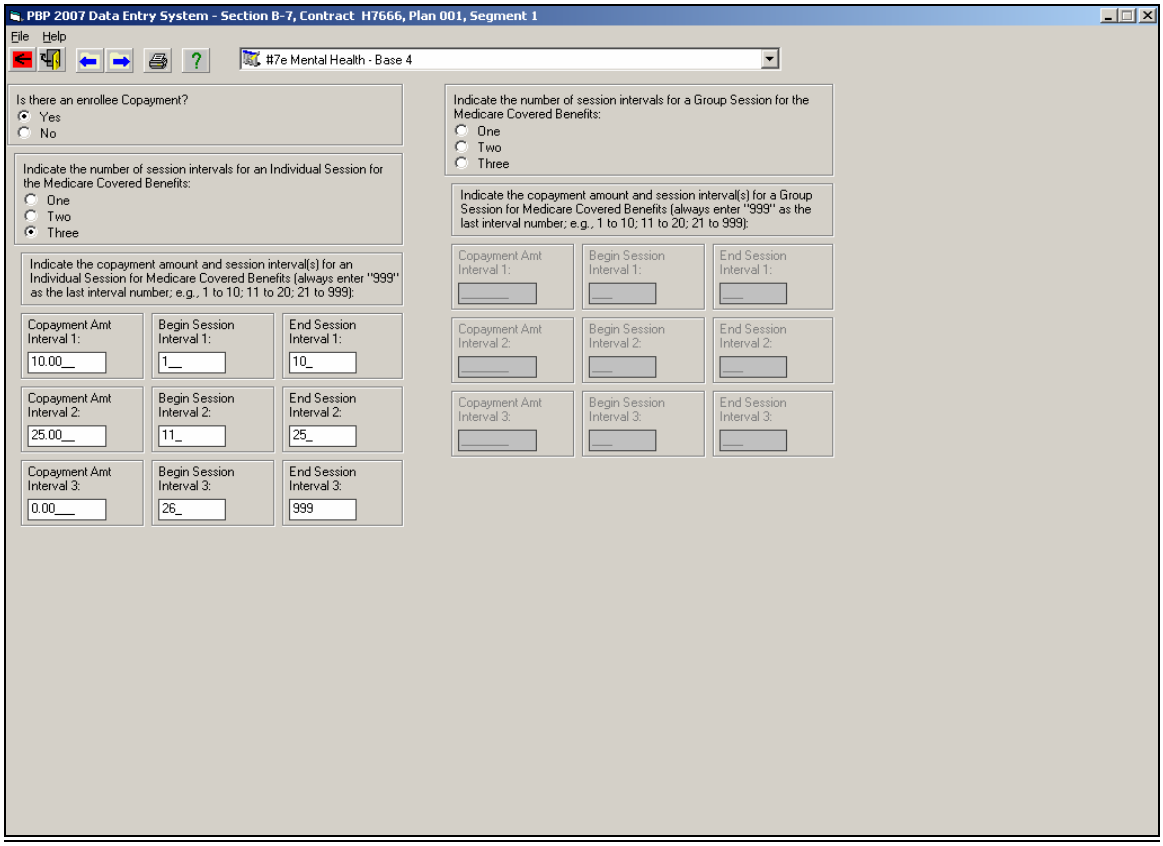
If an MA plan charges $10 per visit for the first 10 visits, then $25 per visit for all visits beyond 10, the MA plan should declare two intervals and enter the copayment as $10 for Visits 1 through 10 and $25 for Visits 11 through 999. See an illustration of this example below.



HELPFUL HINT:

If an MA plan charges $10 per visits for the first 10 visits, then $25 per visits 11-25, then 50% coinsurance for all visits beyond 25, the MA plan should declare three intervals for both copayment and coinsurance. The coinsurance intervals would be 0% for Visits 1 through 10, 0% for Visits 11 through 25, and 50% for Visits 25 through 999. The copayment intervals would be $10 for Visits 1 through 10, $25 for Visits 11 through 25, and $0 for Visits 26 through 999. This structure will ensure proper sentences print out in the SB. See an illustration of this example below.





If the cost sharing for both individual and group visits are the same, ensure that the cost sharing structure is entered exactly the same for both the individual and group visits. By doing so, one SB sentence will be produced for both types of visits, thereby eliminating unnecessary duplication.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7f: Podiatry Services

SB 10: Podiatry Services

This category collects information on Medicare-covered and non-Medicare-covered podiatry services.

Medicare covered podiatry services only include medically necessary and reasonable foot care. Any other podiatry services that are offered, such as routine care, would be classified as either Mandatory Supplemental or Optional Supplemental benefits.

In the SB, Medically Necessary Foot Care and Podiatry Services (Routine care) were merged into one category, "Podiatry Services". The SB sentences will continue to distinguish between the Medically Necessary Foot Care and Routine Care.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-7g: Other Health Care Professional Services

This category collects information on Medicare-covered services provided by other health care professionals.

PBP B-7h: Psychiatric Services

SB 11: Outpatient Mental Health Care

This category collects information on Medicare-covered psychiatric services.

See Section "PBP B-7e: Mental Health Specialist Services, SB 11: Outpatient Mental Health Care" above for more detailed information.

PBP B-7i: Physical Therapy and Speech-Language Pathology Services

SB 17: Outpatient Rehabilitation Services

This category collects information on Medicare-covered physical therapy and speech language pathology services.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-8a: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services

SB 21: Diagnostic Tests, X-rays, and Lab Services

This category collects information on Medicare-covered lab services and radiation therapy.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-8b: Outpatient X-Rays

SB 21: Diagnostic Tests, X-rays, and Lab Services

This category collects information on Medicare-covered X-ray services.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-9a: Outpatient Hospital Services

SB 13: Outpatient Services

This category collects information on Medicare-covered outpatient hospital services.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-9b: Ambulatory Surgical Center (ASC) Services

SB 13: Outpatient Services

This category collects information on Medicare-covered ASC services.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-9c: Outpatient Substance Abuse Services

SB 12: Outpatient Substance Abuse Care

This category collects information on Medicare-covered outpatient substance abuse services.

Cost sharing allows plans to enter self-designated intervals for costs per visit. Below are the instructions for entering the cost share structure if a plan has cost sharing on a per visit basis.

Individual/Group Visit Cost Shares: If a plan has a per visit cost structure for individual and/or group visits, the plan should explicitly price these visits. Since the visits are Medicare-covered, the plan should enter a start visit equal to '1' in the first interval, and an end visit equal to '999' in the last interval. Note that the end day can be entered in the first, second, or third interval, depending upon the plan's cost structure.

HELPFUL HINT:

If the cost sharing for both individual and group visits are the same, ensure that the cost sharing structure is entered exactly the same for both the individual and group visits. By doing so, one SB sentence will be produced for both types of visits, thereby eliminating unnecessary duplication.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-9d: Cardiac Rehabilitation Services

This category collects information on Medicare-covered cardiac rehabilitation services. There are no SB sentences associated with this category.

PBP B-10a: Ambulance Services

SB 14: Ambulance Services

This category collects information on Medicare-covered ambulance services.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-10b: Transportation Services

SB 34: Transportation

This category collects information on non-Medicare-covered transportation services. If transportation services are not offered, the category will not appear on the SB.

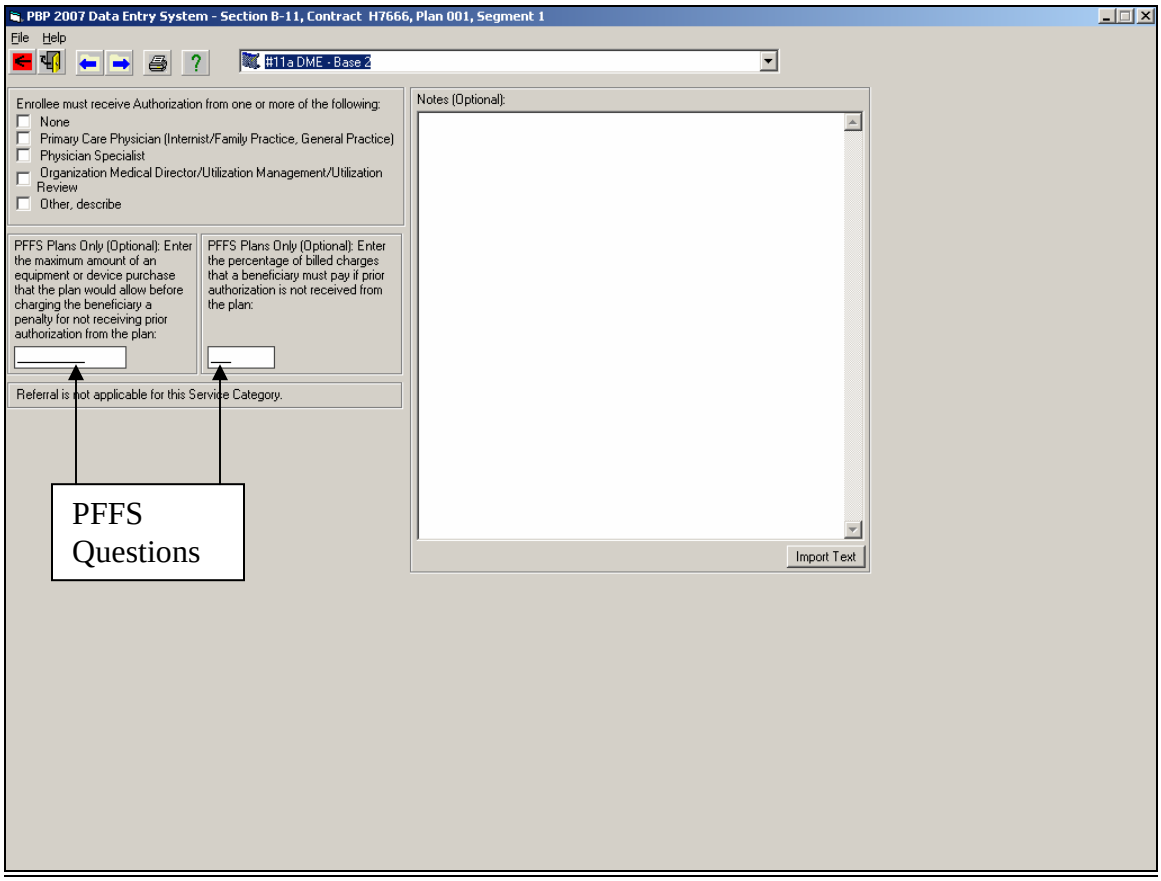
SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-11a: DME

SB 18: Durable Medical Equipment

This category collects information on Medicare-covered durable medical equipment.

In Sections 11a – DME and 11b – Medical Supplies, a pair of **optional** questions is available for PFFS plan types **ONLY**. These questions appear on the screen for all plan types, but only PFFS plans are permitted to answer them and then perform a successful validation for the section. If a plan type other than PFFS enters information in this section, the non-PFFS plan type would receive the following validation message: *Error – Must be blank for non-PFFS plan types*. If a PFFS plan enters data for these two questions, then a sentence will be generated for the SB. See the PBP/SB Crosswalk for details. See an illustration of this example below.



Benefits information contained in the DME Services category includes all DME not related to Diabetes Monitoring Supplies.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-11b: Prosthetics and Medical Supplies

SB 19: Prosthetic Devices

This category collects information on Medicare-covered prosthetics, orthotics, and medical and surgical supplies.

HELPFUL HINT:
Cost sharing data is collected separately for Medicare covered Prosthetic devices compared to Medicare covered Medical Supplies. There is no corresponding sentence for Medical Supplies in the SB.

See Section "PBP B-11a: DME SB 18: Durable Medical Equipment" for more detailed information regarding the two optional PFFS plan questions.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-11c: Diabetes Monitoring Supplies

SB 20: Diabetes Self-Monitoring Training and Supplies

This category collects information on Medicare-covered supplies for diabetes monitoring.

This category distinguishes between Diabetes Monitoring Supplies and other DME, since cost sharing often differs between these two categories. Benefit information for Diabetes Training should continue to be entered in category 14i-Diabetes Monitoring. SB sentences will distinguish between Diabetes Monitoring Training and Diabetes Monitoring Supplies.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-12: Renal Dialysis

This category collects information on Medicare-covered renal dialysis services. There are no SB sentences associated with this category.

PBP B-13a: Outpatient Blood

This category collects information on Medicare-covered blood benefits. There are no SB sentences associated with this category.

PBP B-13b: Acupuncture

SB 35: Acupuncture

This category collects information on non-Medicare-covered acupuncture benefits. If acupuncture services are not offered, the category will not appear on the SB.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-13c: Other1

The category, "Other1" should be used to describe benefits that are not provided for in other areas of the PBP. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category. There are no SB sentences associated with this category.

PBP B-13d: Other2

The category, "Other2" should be used to describe benefits that are not provided for in other areas of the PBP. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category. There are no SB sentences associated with this category.

PBP B-13e: Other3

The category, "Other3" should be used to describe benefits that are not provided for in other areas of the PBP. This category should not be used to provide information on benefits that are listed in other areas such as the Hepatitis B vaccine. In addition, optional supplemental benefits and "step-ups" (see section on policy clarifications and changes for step-ups) should not be described in this category. There are no SB sentences associated with this category.

PBP B-14a: Health Education/Wellness

SB 33: Health/Wellness Education

This category collects information on non-Medicare-covered health education and wellness benefits. If no Health Education/Wellness services are offered, the category will not appear on the SB.

NEW FOR 2007:

The enhanced benefits have been revised as follows:

a. Written health education materials, including newsletters
b. Nutritional Training
c. Nutritional Benefit
d. Smoking Cessation
e. Alternative Medicine Program
f. Membership in Health Club, Fitness Classes
g. Nursing Hotline
h. Other, describe

HELPFUL HINT:

If the plan indicates there is cost sharing for mandatory supplemental benefits, then the SB sentence "Copayments may apply. Contact plan for details." is generated.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14b: Immunizations

SB 24: Immunizations

This category collects information on Medicare-covered and non-Medicare-covered immunization benefits. The Immunization category on the SB includes some automatically generated sentences.

HELPFUL HINT:
If there is no cost sharing for immunizations but a doctor office copayment does or may apply, the coinsurance/copayment questions for immunizations should be marked "No" and the question, "Indicate whether a separate office visit cost share applies for services:" should be marked either "Yes" or "Sometimes, describe". Copay sentences will **not** be generated in the SB as long as the cost sharing for the immunization is marked "No."

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14c: Routine Physical Exam

SB 32: Physical Exams

This category collects information on both Medicare and non-Medicare covered physicals. The one-time Medicare covered physical is included in this category, and a plan may specify a Coinsurance and/or Copayment for the Medicare covered physical.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14d: Pap and Pelvic Exams

SB 26: Pap Smears and Pelvic Exams

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

HELPFUL HINT:
See Section "PBP B-14b: Immunizations, SB 24: Immunizations" above for more detailed information for when a doctor's office copay may apply.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14e: Prostate Cancer Screening

SB 27: Prostate Cancer Screening Exams

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

HELPFUL HINT:

See Section "PBP B-14b: Immunizations, SB 24: Immunizations" above for more detailed information for when a doctor's office copay may apply.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14f: Colorectal Cancer Screening

SB 23: Colorectal Screening Exams

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category.

The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

HELPFUL HINT:

See Section "PBP B-14b: Immunizations, SB 24: Immunizations" above for more detailed information for when a doctor's office copay may apply.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14g: Bone Mass Measurement

SB 22: Bone Mass Measurement

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

NEW FOR 2007:

The Medicare-covered cost share fields (Coinsurance and Copayment) have been changed to allow for a Minimum/Maximum range.

HELPFUL HINT:
See Section "PBP B-14b: Immunizations, SB 24: Immunizations" above for more detailed information for when a doctor's office copay may apply.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14h: Mammography Screening

SB 25: Mammograms

This category collects information about preventive services covered by Medicare and offered by the plan. Diagnostic services that are covered by Medicare are not included in this category. The enhanced benefits in this category reflect preventive services offered by the plan in addition to those covered by Medicare.

HELPFUL HINT:
See Section "PBP B-14b: Immunizations, SB 24: Immunizations" above for more detailed information for when a doctor's office copay may apply.

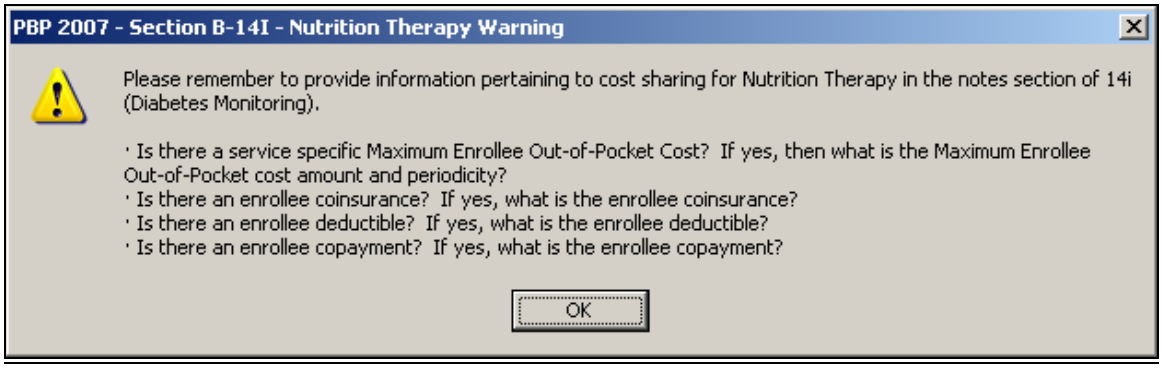
SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-14i: Diabetes Monitoring

SB 20: Diabetes Self-Monitoring Training and Supplies

This category collects information specifically for diabetes monitoring training. Diabetes supplies should be entered in category B-11c, Diabetes Monitoring Supplies.

HELPFUL HINT:
Beginning with the PBP 2003, the plan is required to provide benefit information for Nutrition Therapy in the Notes for this category. A reminder warning will display upon entry into Section B-14, shown below.



SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-15: Medicare Part B Prescription Drugs

SB 28: Outpatient Prescription Drugs

This category collects information ONLY on Medicare Part B prescription drugs benefits offered by the plan.

NEW FOR 2007:

Sentences have been added to the SB to describe the cost sharing for Part B-covered drugs as entered in the PBP.

PBP B-16a: Preventive Dental Services

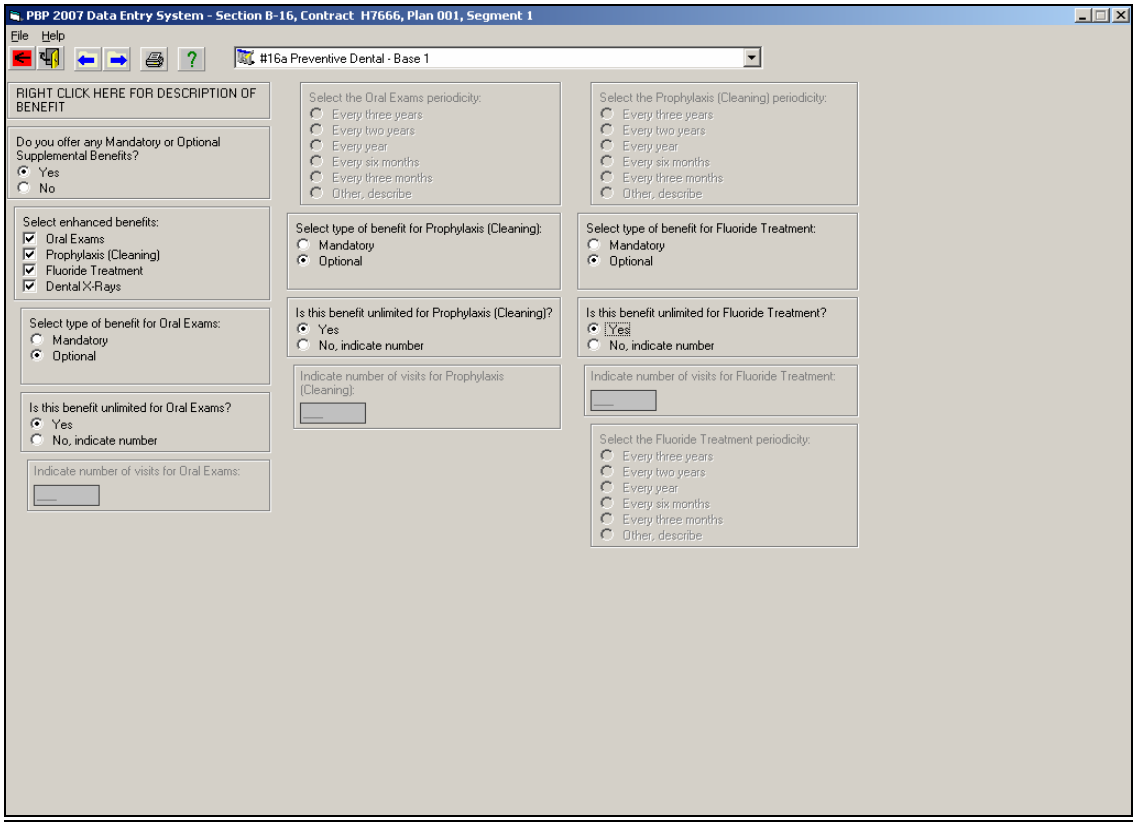
SB 29: Dental Services

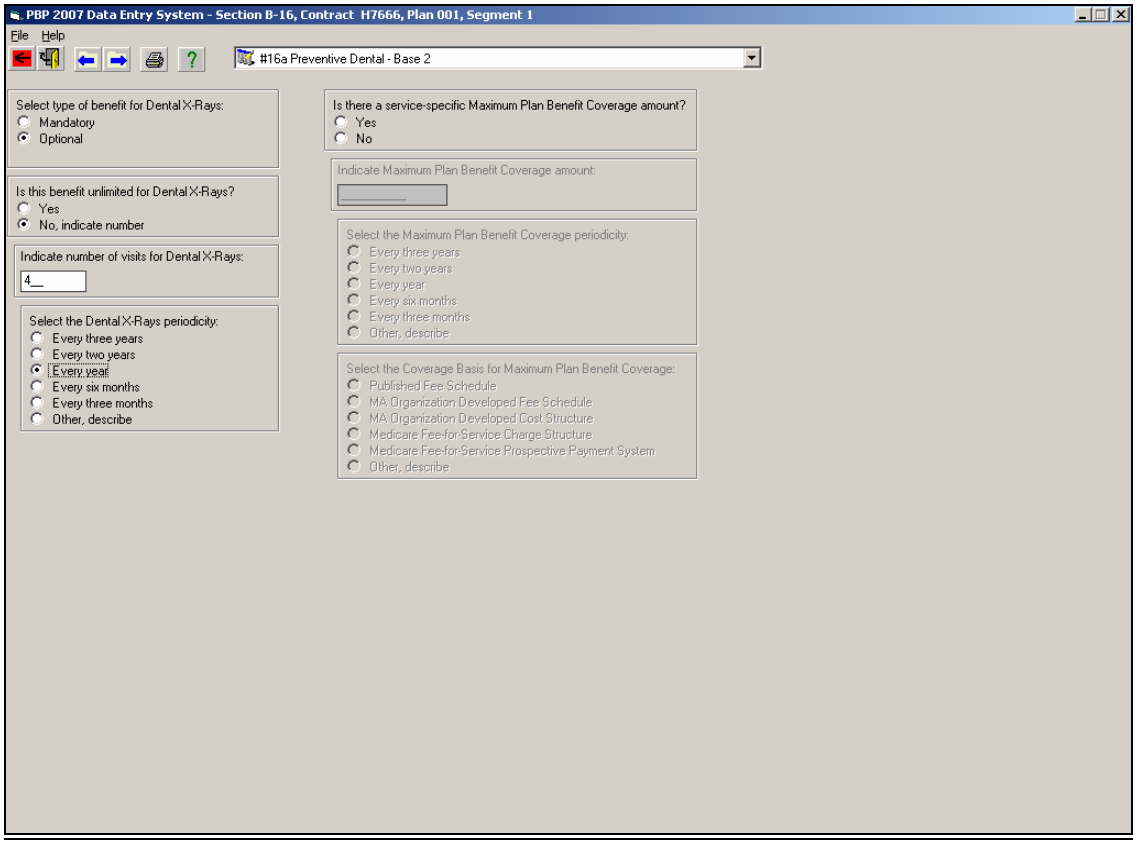
This category collects information on enhanced dental benefits offered by the plan.

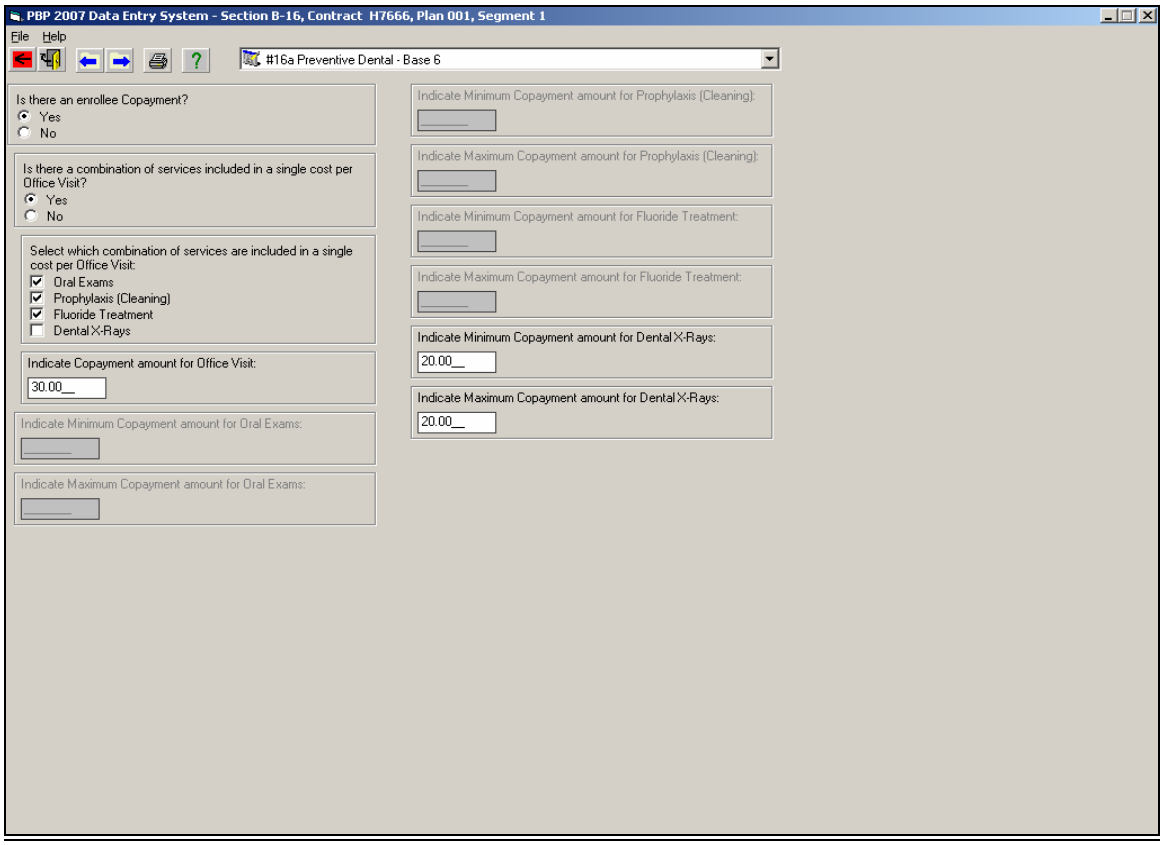
The MA plan can have a single cost share for an Office Visit and designate the enhanced benefits that are included in that Office Visit.

HELPFUL HINT:

If the plan offers Oral Exams, Fluoride Treatments, Cleanings, and X-rays, and an Office Visit and charges $30 for a combination of services during an office visit (Oral Exam, Fluoride Treatment, and Cleaning) with a separate $20 copayment for X-rays, then under the Copayment, the MA plan should select "Yes" to the question, "Is there a combination of services included in a single cost per office visit?". The MA plan should then select the services covered under the $30 office visit and separately define the X-rays for $20 per visit up to 4 visits per year. See an illustration of this example below.


PBP 2007 Data Entry System - Section B-16, Contract H7666, Plan 001, Segment 1
File Help
#16a Preventive Dental - Base 1
RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT
Do you offer any Mandatory or Optional Supplemental Benefits?
Yes
No
Select enhanced benefits:
Oral Exams
Prophylaxis (Cleaning)
Fluoride Treatment
Dental X-Rays
Select type of benefit for Oral Exams:
Mandatory
Optional
Is this benefit unlimited for Oral Exams?
Yes
No, indicate number
Indicate number of visits for Oral Exams:
Select the Oral Exams periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select type of benefit for Prophylaxis (Cleaning):
Mandatory
Optional
Is this benefit unlimited for Prophylaxis (Cleaning)?
Yes
No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):
Select the Prophylaxis (Cleaning) periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select type of benefit for Fluoride Treatment:
Mandatory
Optional
Is this benefit unlimited for Fluoride Treatment?
Yes
No, indicate number
Indicate number of visits for Fluoride Treatment:
Select the Fluoride Treatment periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe


PBP 2007 Data Entry System - Section B-16, Contract H7666, Plan 001, Segment 1
File Help
#16a Preventive Dental - Base 2
Select type of benefit for Dental X-Rays:
Mandatory
Optional
Is this benefit unlimited for Dental X-Rays?
Yes
No, indicate number
Indicate number of visits for Dental X-Rays:
4
Select the Dental X-Rays periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Is there a service-specific Maximum Plan Benefit Coverage amount?
Yes
No
Indicate Maximum Plan Benefit Coverage amount:
Select the Maximum Plan Benefit Coverage periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select the Coverage Basis for Maximum Plan Benefit Coverage:
Published Fee Schedule
MA Organization Developed Fee Schedule
MA Organization Developed Cost Structure
Medicare Fee-for-Service Charge Structure
Medicare Fee-for-Service Prospective Payment System
Other, describe



The SB includes bullets describing the benefits that are included in the Office Visit.

Data elements in the Preventive Dental and Comprehensive Dental categories allow for a maximum plan benefit coverage amount for either preventive dental, comprehensive dental, an individual maximum plan benefit coverage amount for each category, or a combined maximum plan benefit coverage amount for both categories.

HELPFUL HINT:
See Section "PBP B-17a: Eye Exams, SB 31: Vision Services" below for further detailed information.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-16b: Comprehensive Dental

SB 29: Dental Services

This category collects information on Medicare-covered and non-Medicare-covered dental benefits offered by the plan.

Data elements in the Preventive Dental and Comprehensive Dental categories allow for a maximum plan benefit coverage amount for either preventive dental, comprehensive dental, an individual maximum plan benefit coverage amount for each category, or a combined maximum plan benefit coverage amount for both categories.

HELPFUL HINT:
See Section "PBP B-17a: Eye Exams, SB 31: Vision Services" below for further detailed information.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

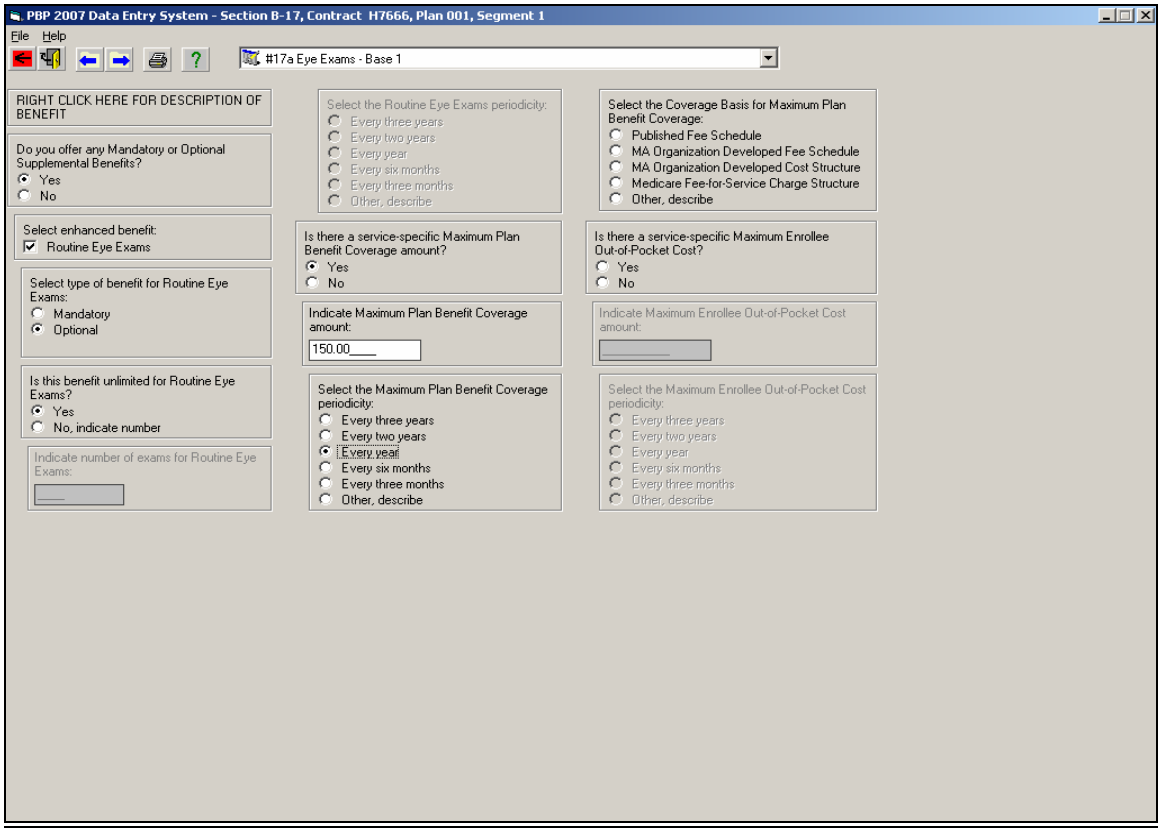
PBP B-17a: Eye Exams

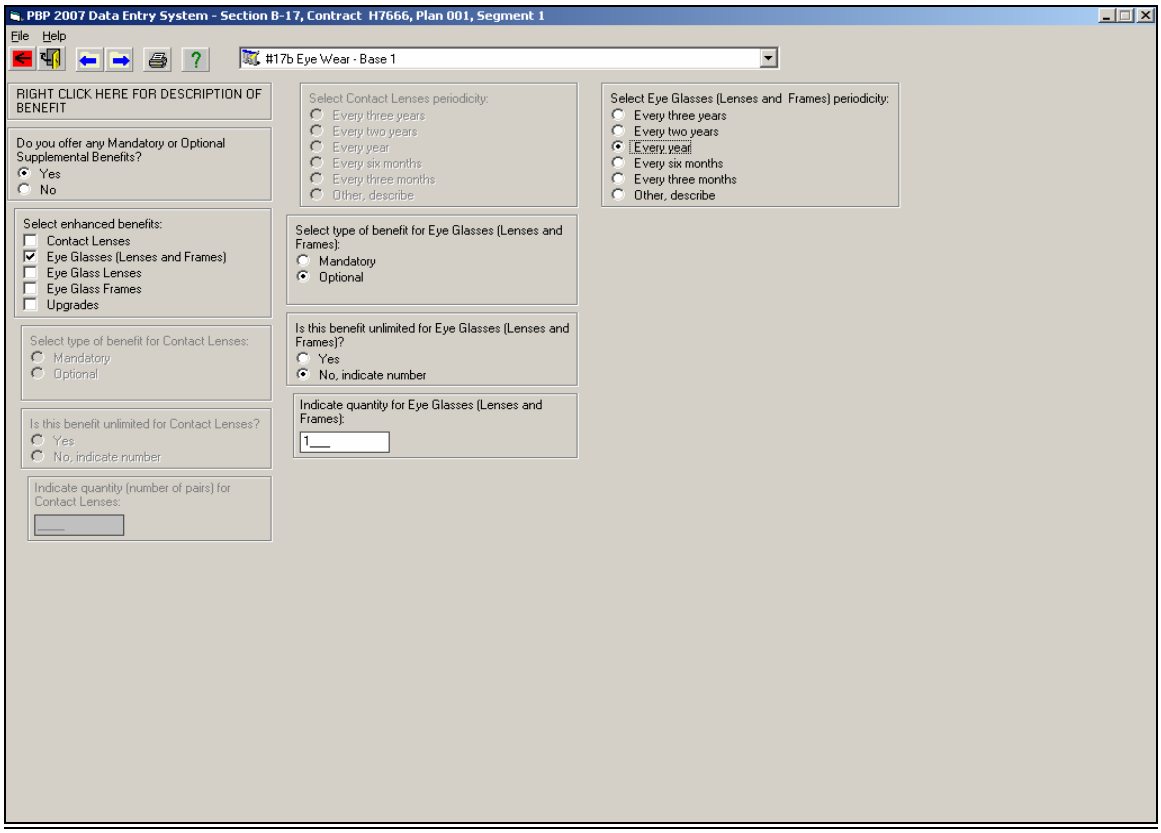
SB 31: Vision Services

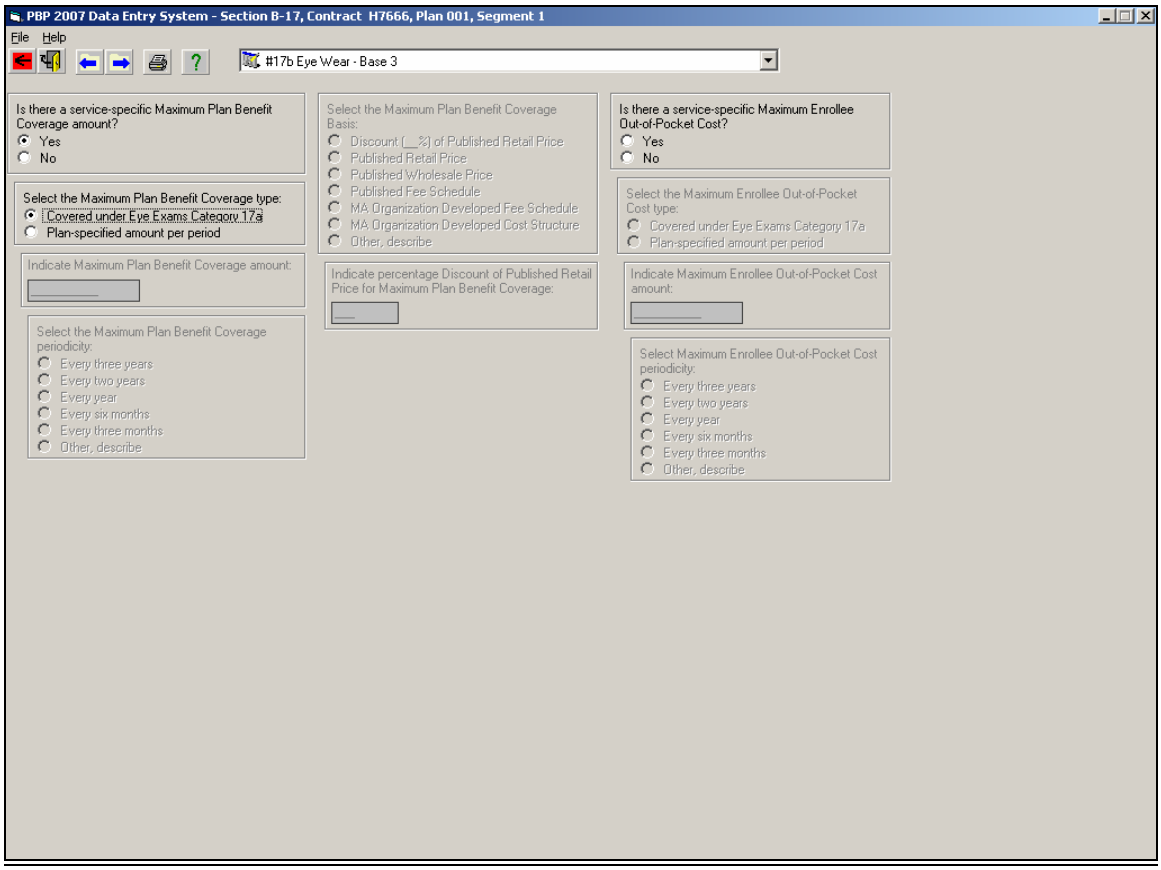
This category collects information on Medicare-covered and non-Medicare-covered vision services offered by the plan.

Data elements in the Eye Exam and Eye Wear categories allow for a maximum plan benefit coverage amount for either eye wear, eye exams, an individual maximum plan benefit coverage amount for each category, or a combined maximum plan benefit coverage amount for both categories.

HELPFUL HINT:
Example: A plan offers a $150 annual maximum plan benefit coverage amount for eye care. This includes both 17a-Eye Exams and 17b-Eye Wear. In 17a-Eye Exams Base 1, select "Yes" to "Is there a service-specific Maximum Plan Benefit Coverage amount?", enter $150 and select "Every year". In 17b-Eye Wear Base 3, select "Yes" to "Is there a service-specific Maximum Plan Benefit Coverage amount?", and for the next question, "Select the Maximum Plan Benefit Coverage type", select the option "Covered under Eye Exams Category 17a". See an illustration of this example below.


PBP 2007 Data Entry System - Section B-17, Contract H7666, Plan 001, Segment 1
File Help
#17a Eye Exams - Base 1
RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT
Do you offer any Mandatory or Optional Supplemental Benefits?
Yes
No
Select enhanced benefit:
Routine Eye Exams
Select type of benefit for Routine Eye Exams:
Mandatory
Optional
Is this benefit unlimited for Routine Eye Exams?
Yes
No, indicate number
Indicate number of exams for Routine Eye Exams:
Select the Routine Eye Exams periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Is there a service-specific Maximum Plan Benefit Coverage amount?
Yes
No
Indicate Maximum Plan Benefit Coverage amount:
150.00
Select the Maximum Plan Benefit Coverage periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select the Coverage Basis for Maximum Plan Benefit Coverage:
Published Fee Schedule
MA Organization Developed Fee Schedule
MA Organization Developed Cost Structure
Medicare Fee-for-Service Charge Structure
Other, describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Yes
No
Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe


PBP 2007 Data Entry System - Section B-17, Contract H7666, Plan 001, Segment 1
File Help
#17b Eye Wear - Base 1
RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT
Do you offer any Mandatory or Optional Supplemental Benefits?
Yes
No
Select enhanced benefits:
Contact Lenses
Eye Glasses (Lenses and Frames)
Eye Glass Lenses
Eye Glass Frames
Upgrades
Select type of benefit for Contact Lenses:
Mandatory
Optional
Is this benefit unlimited for Contact Lenses?
Yes
No, indicate number
Indicate quantity (number of pairs) for Contact Lenses:
Select Contact Lenses periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select type of benefit for Eye Glasses (Lenses and Frames):
Mandatory
Optional
Is this benefit unlimited for Eye Glasses (Lenses and Frames)?
Yes
No, indicate number
Indicate quantity for Eye Glasses (Lenses and Frames):
1
Select Eye Glasses (Lenses and Frames) periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe



SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-17b: Eye Wear

SB 31: Vision Services

This category collects information on Medicare-covered and non-Medicare-covered eyewear benefits offered by the plan.

There are data entry elements in the Eye Exam and Eye Wear categories to define a maximum plan benefit coverage amount for eye wear, eye exams, an individual maximum plan benefit coverage amount for each category, or a combined maximum plan benefit coverage amount for both categories.

HELPFUL HINT:
See Section "PBP B-17a: Eye Exams, SB 31: Vision Services" above for further detailed information.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-18a: Hearing Exams

SB 30: Hearing Services

This category collects information on Medicare-covered and non-Medicare-covered hearing services offered by the plan.

Data elements in the Hearing Exams and Hearing Aids categories allow for a maximum plan benefit coverage amount for either preventive dental, comprehensive dental, an individual maximum plan benefit coverage amount for each category, or a combined maximum plan benefit coverage amount for both categories.

HELPFUL HINT:
See Section "PBP B-17a: Eye Exams, SB 31: Vision Services" above for further detailed information.

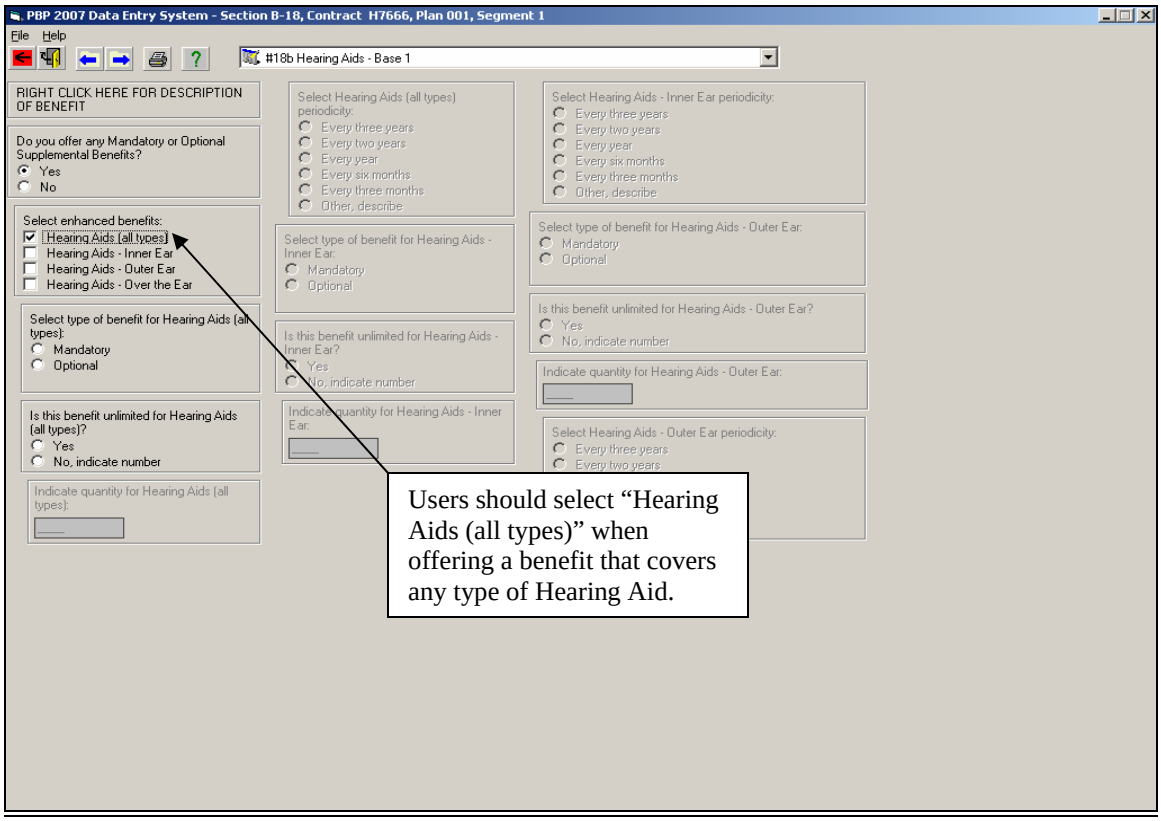
SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

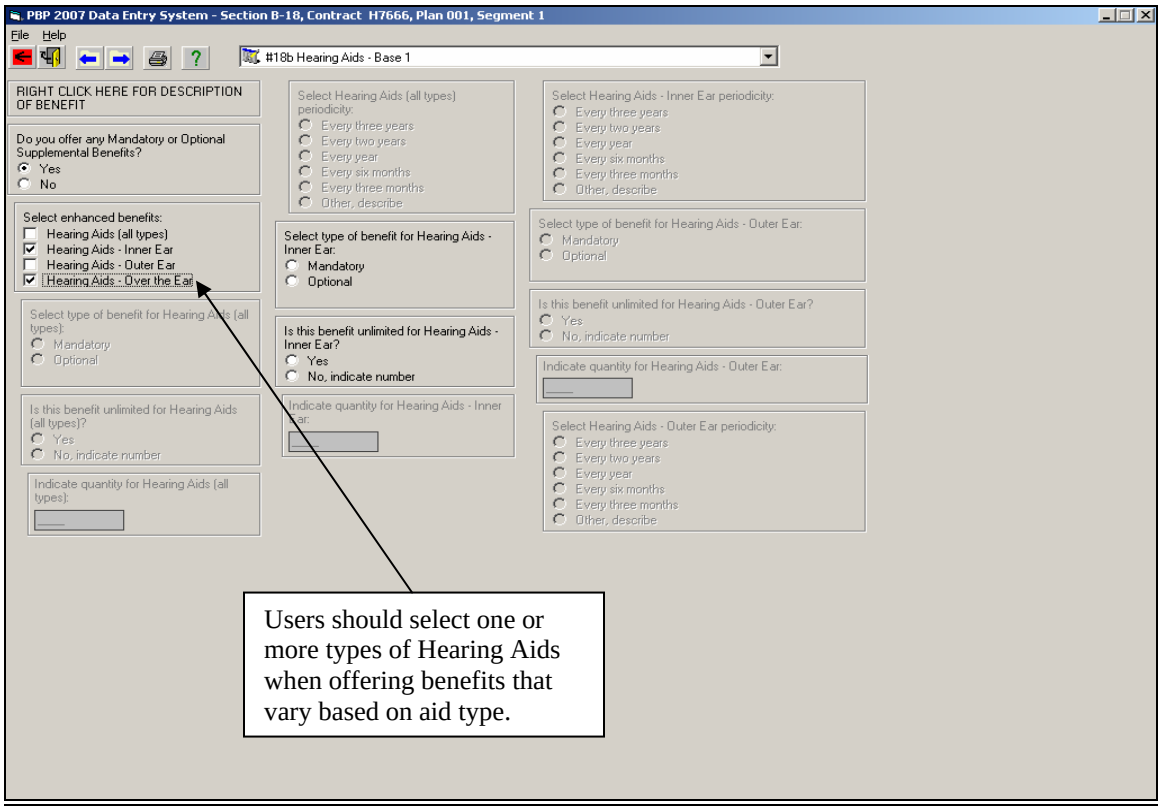
PBP B-18b: Hearing Aids

SB 30: Hearing Services

This category collects information on Medicare-covered and non-Medicare-covered hearing benefits offered by the plan.

HELPFUL HINT:
For enhanced benefits, the plan may select Hearing Aids (all types) **OR** one or more of the individual types of aids (Inner Ear, Outer Ear, and/or Over the Ear). If Hearing Aids (all types) is selected, then the MA plan may NOT select an individual type of aid. There is a min/max cost share available for the plan to price Hearing Aids (all types). See an illustration of this example below.


PBP 2007 Data Entry System - Section B-18, Contract H7666, Plan 001, Segment 1
File Help
#18b Hearing Aids - Base 1
RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT
Do you offer any Mandatory or Optional Supplemental Benefits?
Yes
No
Select enhanced benefits:
Hearing Aids (all types)
Hearing Aids - Inner Ear
Hearing Aids - Outer Ear
Hearing Aids - Over the Ear
Select type of benefit for Hearing Aids (all types):
Mandatory
Optional
Is this benefit unlimited for Hearing Aids (all types)?
Yes
No, indicate number
Indicate quantity for Hearing Aids (all types):
Select Hearing Aids (all types) periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select type of benefit for Hearing Aids - Inner Ear:
Mandatory
Optional
Is this benefit unlimited for Hearing Aids - Inner Ear?
Yes
No, indicate number
Indicate quantity for Hearing Aids - Inner Ear:
Select Hearing Aids - Inner Ear periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select type of benefit for Hearing Aids - Outer Ear:
Mandatory
Optional
Is this benefit unlimited for Hearing Aids - Outer Ear?
Yes
No, indicate number
Indicate quantity for Hearing Aids - Outer Ear:
Select Hearing Aids - Outer Ear periodicity:
Every three years
Every two years
Users should select “Hearing Aids (all types)” when offering a benefit that covers any type of Hearing Aid.


PBP 2007 Data Entry System - Section B-18, Contract H7666, Plan 001, Segment 1
File Help
#18b Hearing Aids - Base 1
RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT
Do you offer any Mandatory or Optional Supplemental Benefits?
Yes
No
Select enhanced benefits:
Hearing Aids (all types)
Hearing Aids - Inner Ear
Hearing Aids - Outer Ear
Hearing Aids - Over the Ear
Select type of benefit for Hearing Aids (all types):
Mandatory
Optional
Is this benefit unlimited for Hearing Aids (all types)?
Yes
No, indicate number
Indicate quantity for Hearing Aids (all types):
Select Hearing Aids (all types) periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select type of benefit for Hearing Aids - Inner Ear:
Mandatory
Optional
Is this benefit unlimited for Hearing Aids - Inner Ear?
Yes
No, indicate number
Indicate quantity for Hearing Aids - Inner Ear:
Select Hearing Aids - Inner Ear periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select type of benefit for Hearing Aids - Outer Ear:
Mandatory
Optional
Is this benefit unlimited for Hearing Aids - Outer Ear?
Yes
No, indicate number
Indicate quantity for Hearing Aids - Outer Ear:
Select Hearing Aids - Outer Ear periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Users should select one or more types of Hearing Aids when offering benefits that vary based on aid type.

HELPFUL HINT:
See Section "PBP B-17a: Eye Exams, SB 31: Vision Services" above for further detailed information.

SB Out-of-Network sentences may be generated based on data entered in Section C for out-of-network benefits.

PBP B-20: Outpatient Prescription Drugs (for Cost Plans only that are NOT offering Part D)

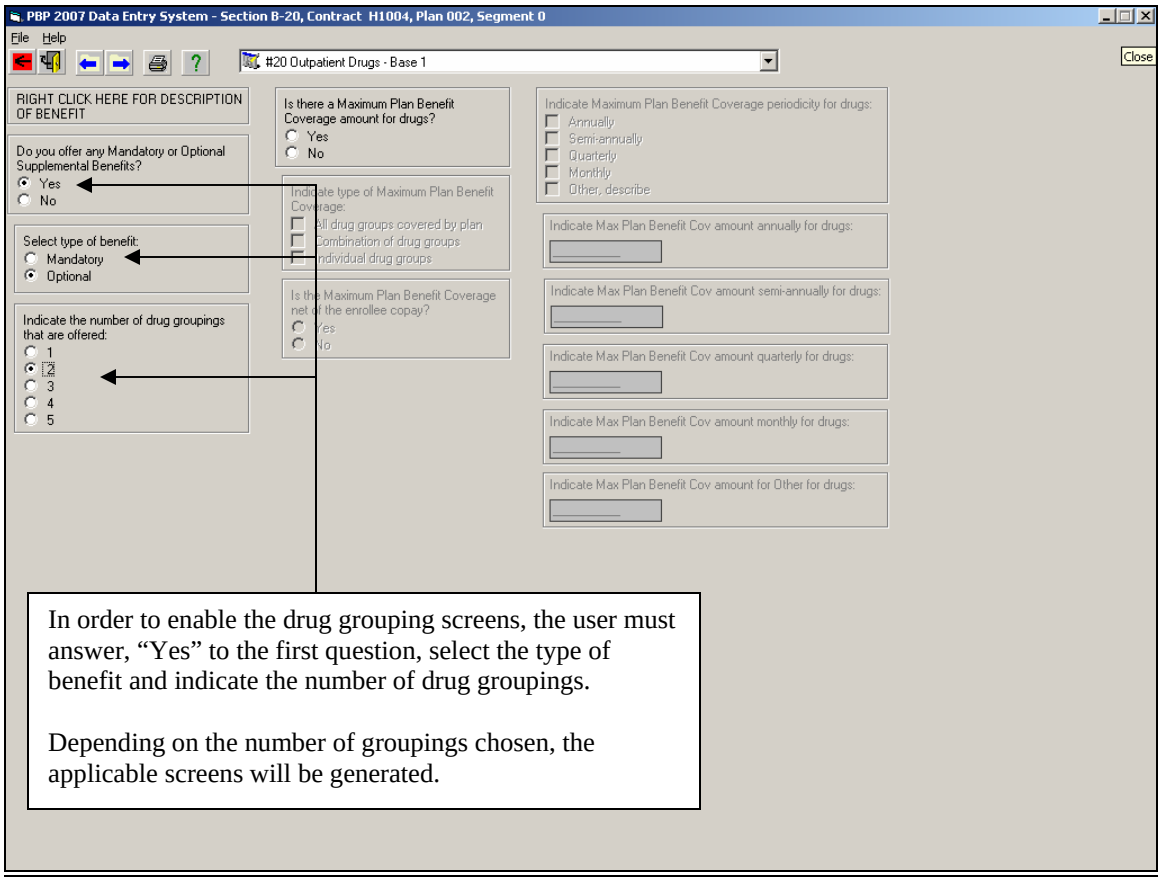
SB 28: Outpatient Prescription Drugs

This category collects information on Medicare-covered and non-Medicare covered prescription drugs benefits offered by Cost plans.

NOTE: This category is only enabled for Cost Plans not offering the Medicare Part D benefit.

HELPFUL HINT:
To provide more flexibility for describing a plan's drug benefit, a plan may describe its drug benefit in terms of 'tiers', rather than having to specifically refer to Formulary/Non-formulary and Generic/Brand/Preferred Brand drugs, as in previous years. However, these drug types are also available as drug groups. (For further clarification on the term 'tiers', please see the section titled "PBP Features & Policy Clarifications" or "Glossary of Terms".)

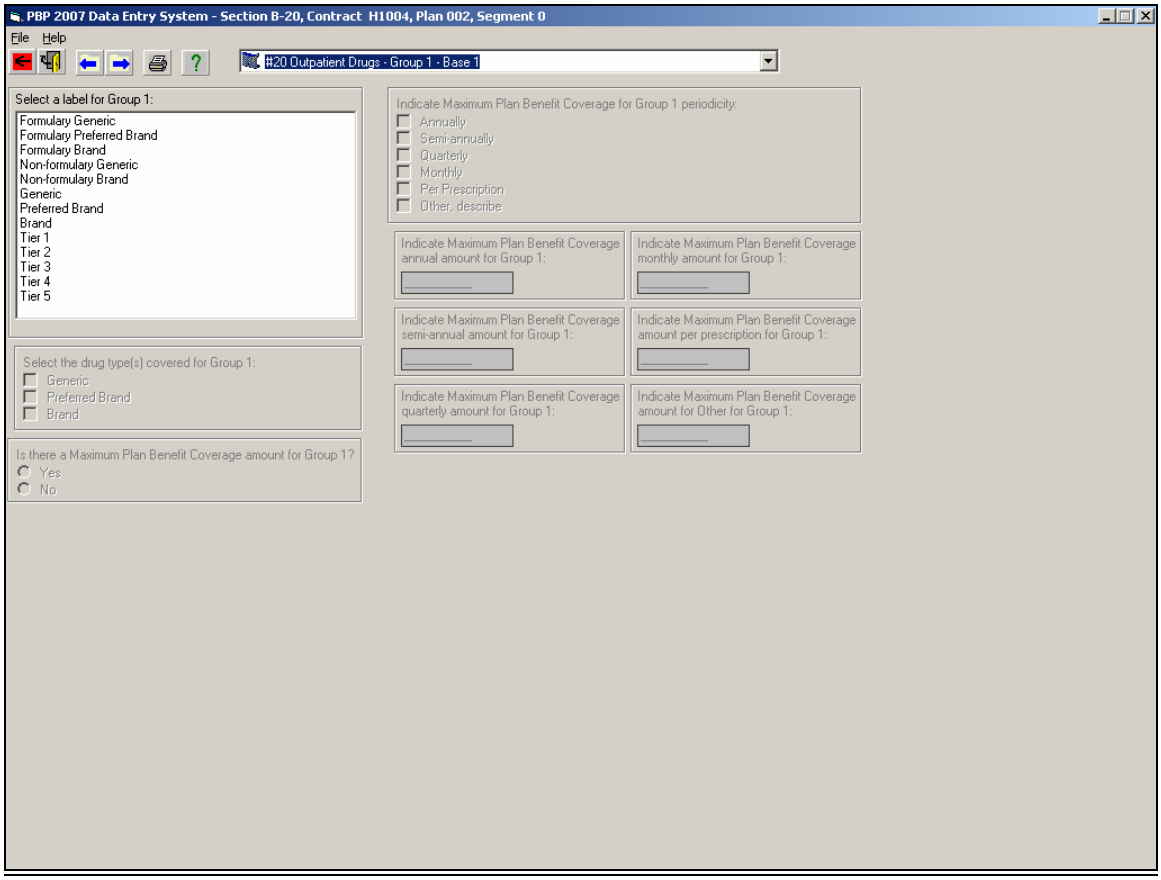
Base 1 screen: The set of five Base screens contains benefit level questions regarding the type of drug benefit offered by the plan (Mandatory or Optional Supplemental, or Medicare covered only), maximum plan drug benefit coverage, maximum enrollee out of pocket costs, deductibles, cost shares for Medicare covered drugs, and authorization. See an illustration of this example below.



In order to enable the drug grouping screens, the user must answer, "Yes" to the first question, select the type of benefit and indicate the number of drug groupings.

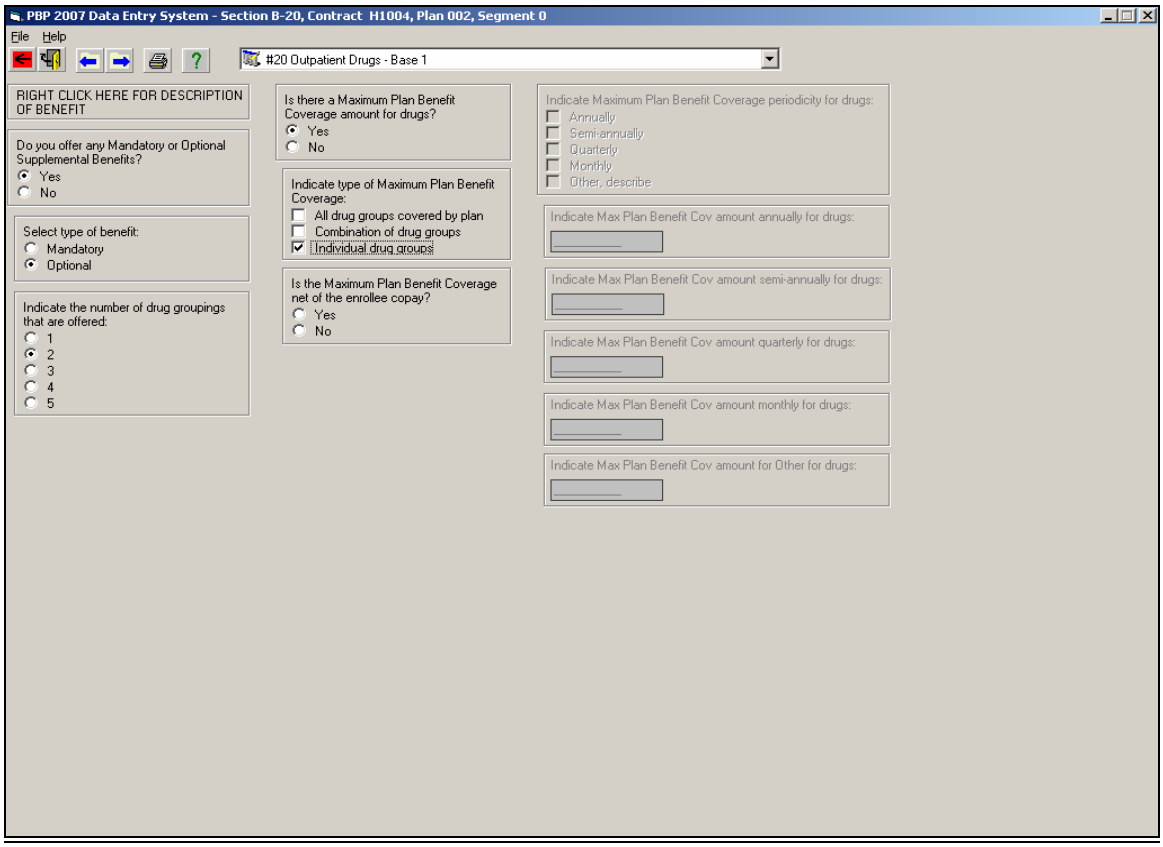
Depending on the number of groupings chosen, the applicable screens will be generated.

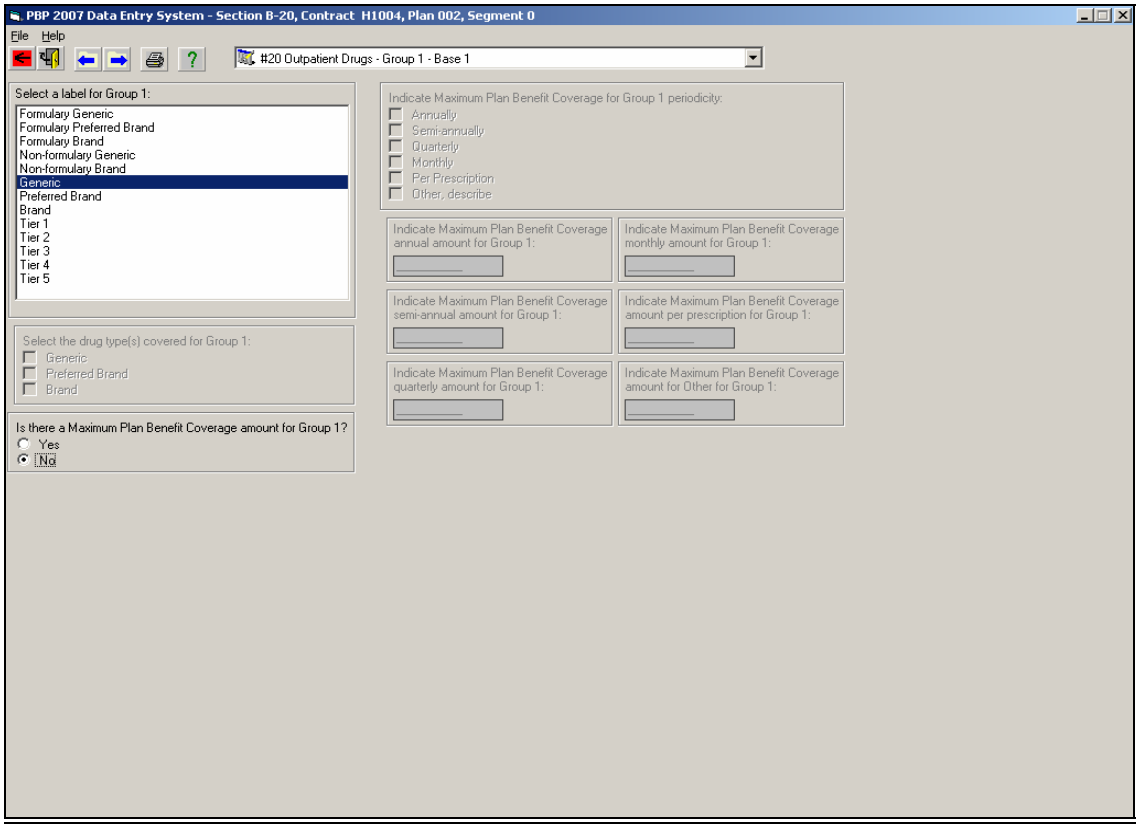
Drug Groups: There are a set of screens for each of five potential drug groups that the plan may designate to describe its drug benefit. For each drug group, the plan selects a label from a pick list that consists of: Tiers 1-5, Generic, Brand, Formulary-Generic, Formulary-Brand, Formulary-Preferred Brand, Non-formulary Generic, and Non-formulary Brand. No selection may be used more than once. If the group is designated as a tier, then the plan must indicate what drug types (Generic, Brand, Preferred Brand) are included in that tier. The plan then indicates individual coverage limits for that drug group, locations where those drugs can be acquired, cost shares, and the time limits associated with those costs. See an illustration of this example below.

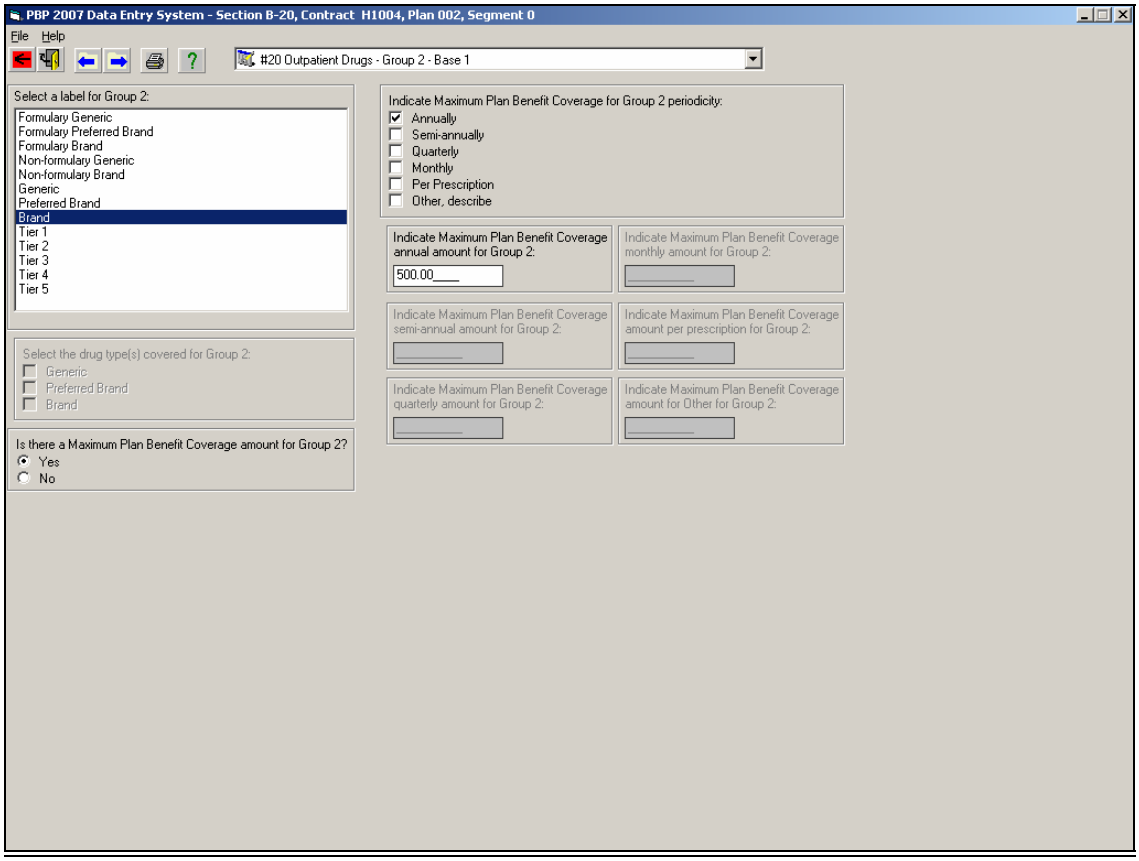


Drug Benefit Coverage Limits: A separate set of questions enables a plan to describe one or more limits on the drug benefit. If the plan indicates that it has a maximum plan benefit coverage amount, then the plan must designate if there is an overall limit, a limit on a combination of drug groups, and/or limit(s) on individual drug groups.

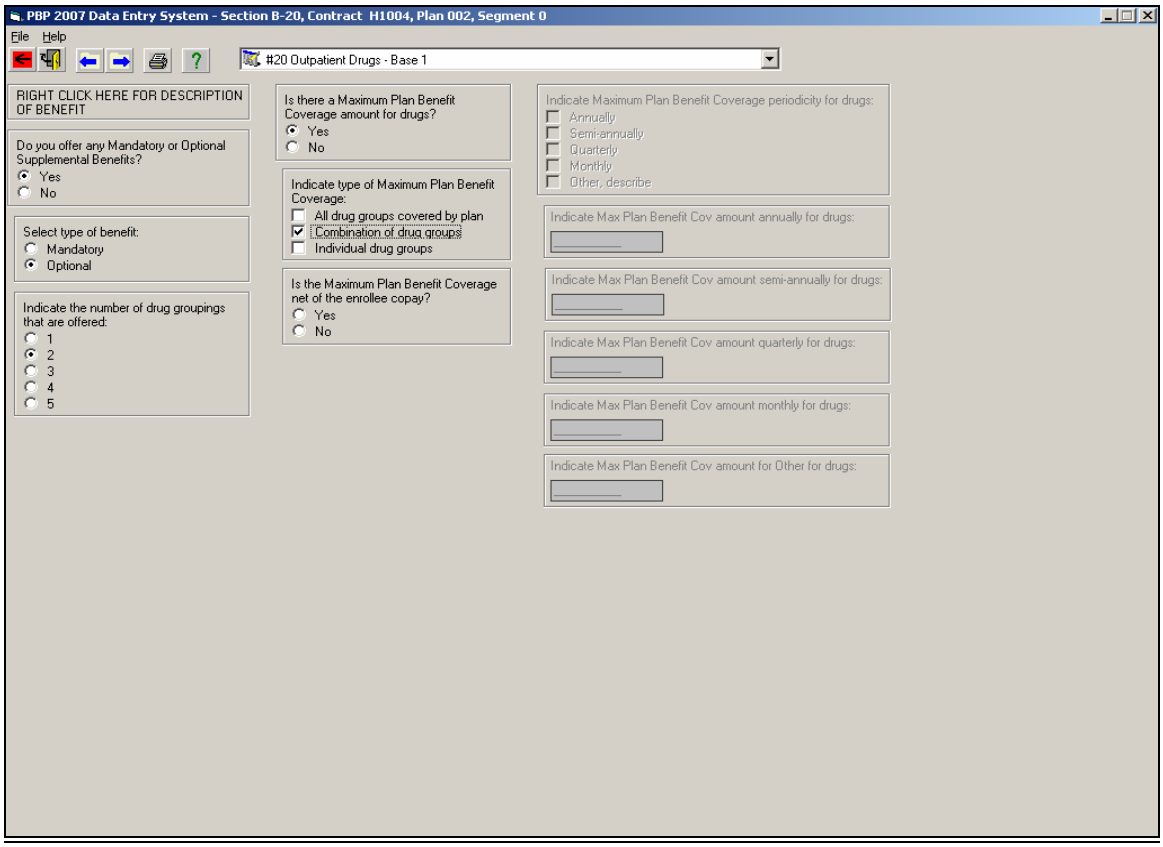
Example 1: The plan offers Generic and Brand drug groups and has unlimited Generic drugs and a $500 annual limit on Brand drugs. The plan would designate that it has a maximum plan benefit coverage amount, and that this includes Individual drug types. For the Generic group, the plan would indicate that there is NO maximum plan benefit coverage amount. For the Brand group, the plan would indicate that there is a maximum plan benefit coverage amount of $500 annually. See an illustration of this example below.

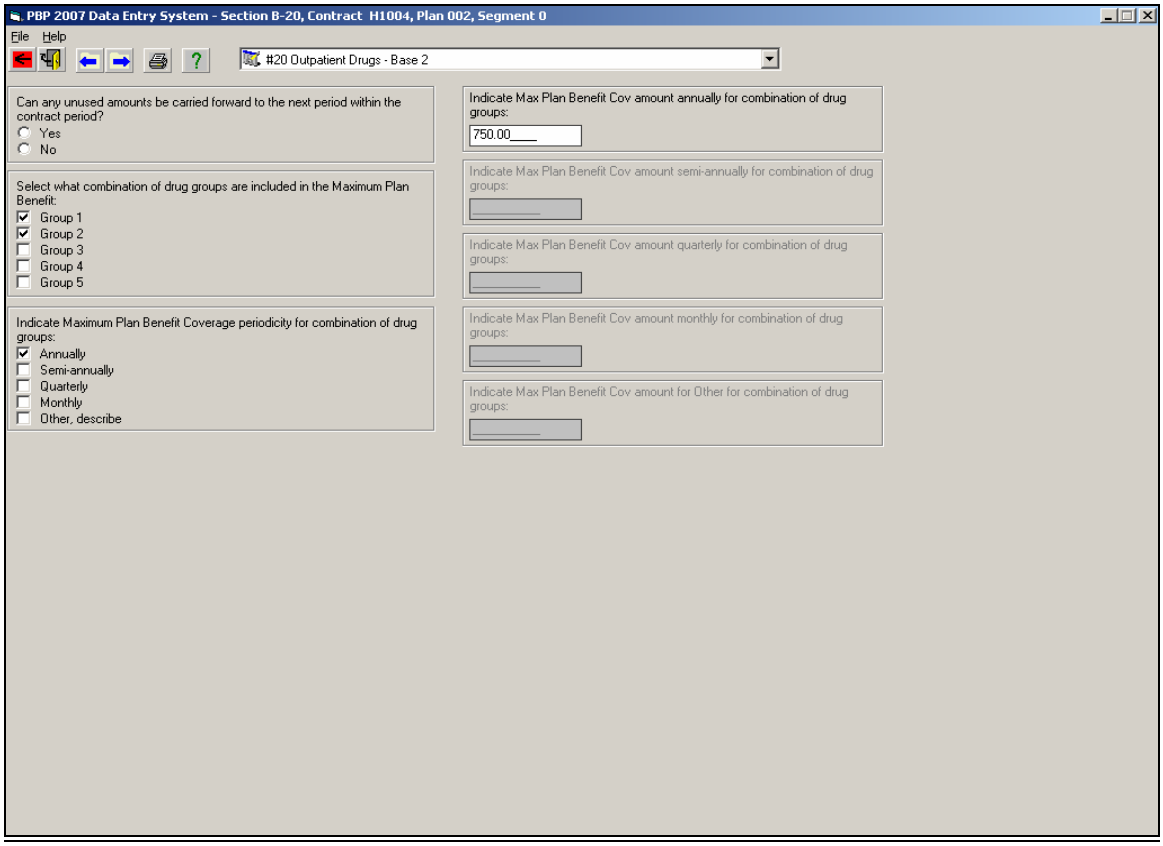


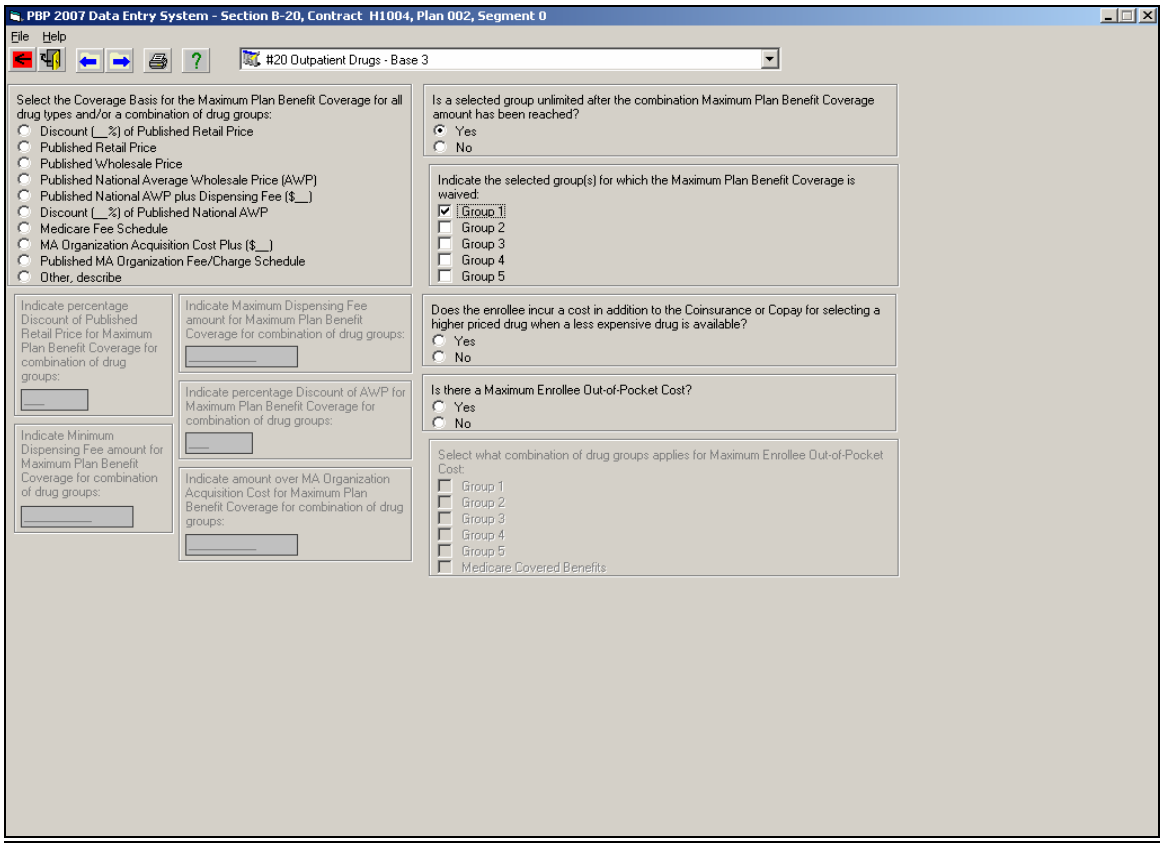

PBP 2007 Data Entry System - Section B-20, Contract H1004, Plan 002, Segment 0
File Help
#20 Outpatient Drugs - Group 1 - Base 1
Select a label for Group 1:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-formulary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 1:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 1?
Yes
No
Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Prescription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 1:
Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:

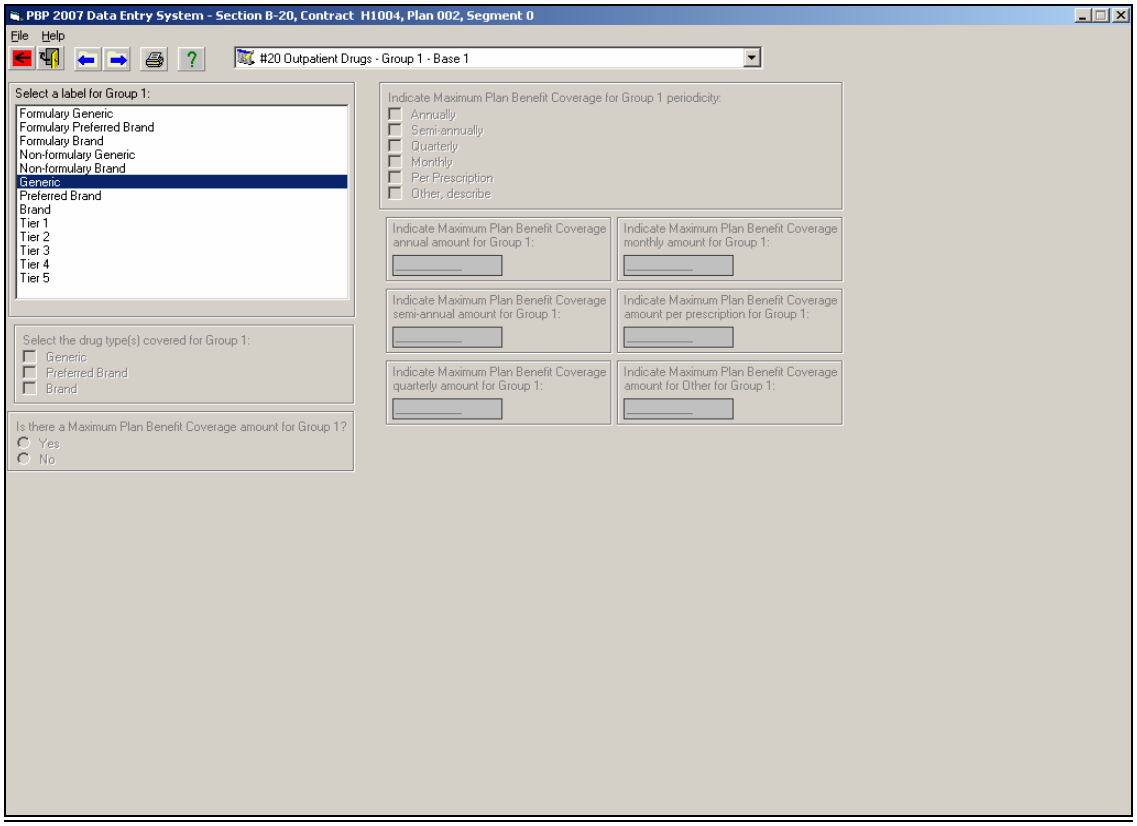

PBP 2007 Data Entry System - Section B-20, Contract H1004, Plan 002, Segment 0
File Help
#20 Outpatient Drugs - Group 2 - Base 1
Select a label for Group 2:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-formulary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 2:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 2?
Yes
No
Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Prescription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 2:
500.00
Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:

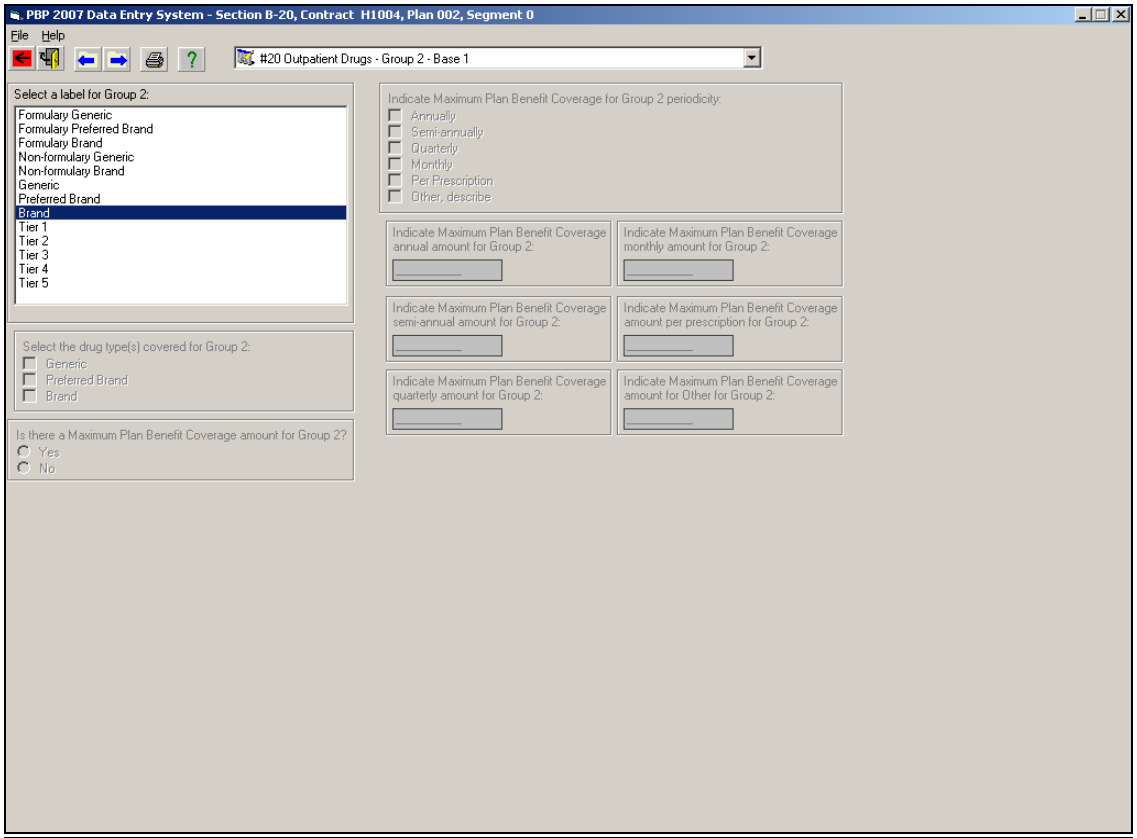
Example 2: The plan offers two drug groups - Brand and Generic, and has a $750 annual limit on the combination of drugs, but unlimited Generic after the limit is reached. The plan would designate that it has a maximum plan benefit coverage amount, and that this includes Combination of drug groups. The plan would select Group 1 and Group 2 as the combination of drug groups included in the maximum plan benefit coverage amount, and enter an overall limit of $750 annually. Following this, the plan would indicate that there is a selected group that is unlimited after the combination max limit has been reached, and select the group (1 or 2) that will be labeled as Generic. See an illustration of this example below.



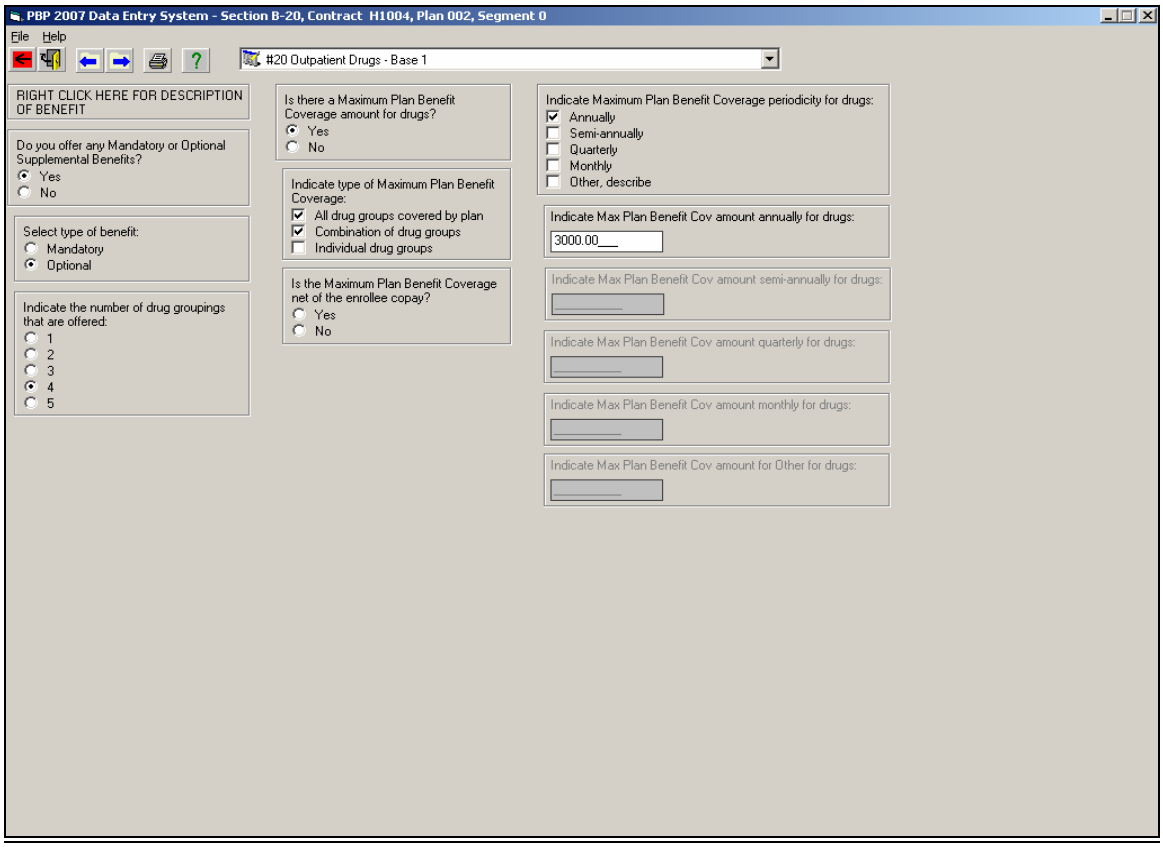

PBP 2007 Data Entry System - Section B-20, Contract H1004, Plan 002, Segment 0
File Help
#20 Outpatient Drugs - Base 2
Can any unused amounts be carried forward to the next period within the contract period?
Yes
No
Select what combination of drug groups are included in the Maximum Plan Benefit:
Group 1
Group 2
Group 3
Group 4
Group 5
Indicate Maximum Plan Benefit Coverage periodicity for combination of drug groups:
Annually
Semi-annually
Quarterly
Monthly
Other, describe
Indicate Max Plan Benefit Cov amount annually for combination of drug groups:
750.00
Indicate Max Plan Benefit Cov amount semi-annually for combination of drug groups:
Indicate Max Plan Benefit Cov amount quarterly for combination of drug groups:
Indicate Max Plan Benefit Cov amount monthly for combination of drug groups:
Indicate Max Plan Benefit Cov amount for Other for combination of drug groups:

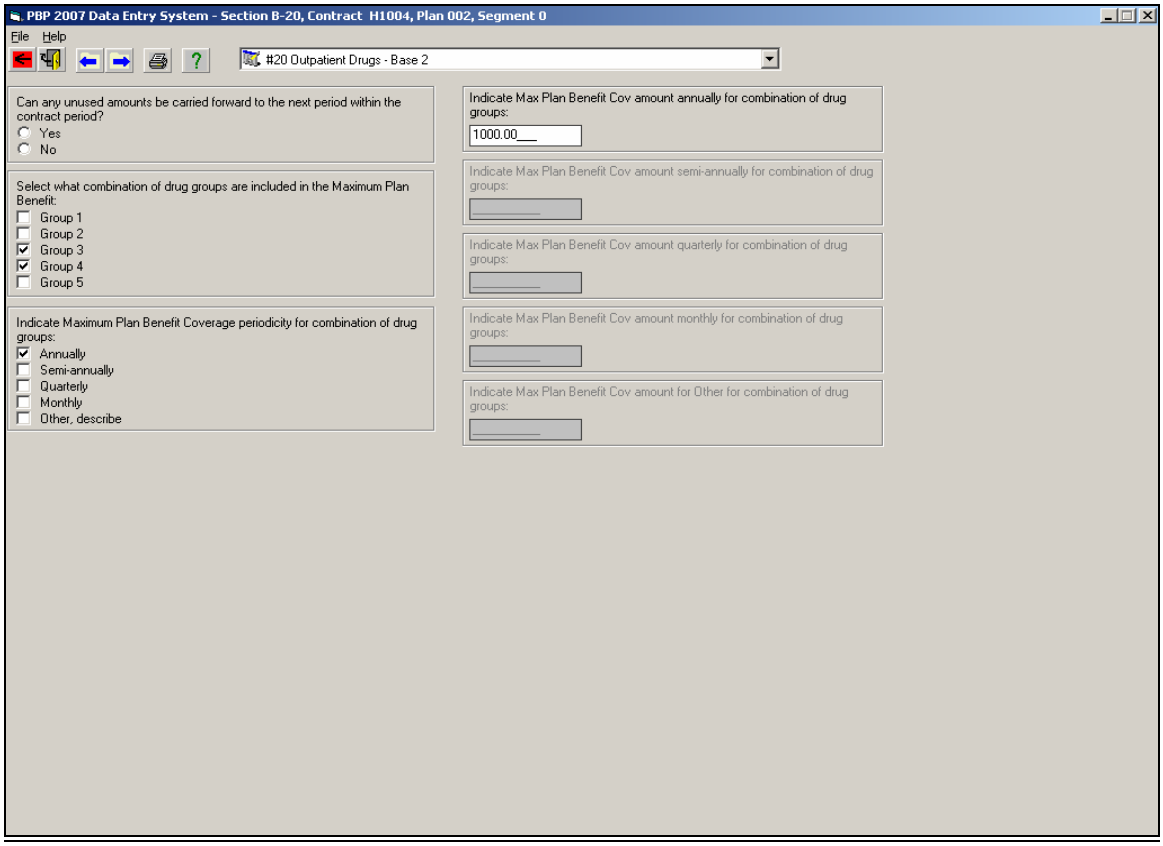

PBP 2007 Data Entry System - Section B-20, Contract H1004, Plan 002, Segment 0
File Help
#20 Outpatient Drugs - Base 3
Select the Coverage Basis for the Maximum Plan Benefit Coverage for all drug types and/or a combination of drug groups:
Discount (__%) of Published Retail Price
Published Retail Price
Published Wholesale Price
Published National Average Wholesale Price (AWP)
Published National AWP plus Dispensing Fee ($__)
Discount (__%) of Published National AWP
Medicare Fee Schedule
MA Organization Acquisition Cost Plus ($__)
Published MA Organization Fee/Charge Schedule
Other, describe
Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage for combination of drug groups:
Indicate Minimum Dispensing Fee amount for Maximum Plan Benefit Coverage for combination of drug groups:
Indicate Maximum Dispensing Fee amount for Maximum Plan Benefit Coverage for combination of drug groups:
Indicate percentage Discount of AWP for Maximum Plan Benefit Coverage for combination of drug groups:
Indicate amount over MA Organization Acquisition Cost for Maximum Plan Benefit Coverage for combination of drug groups:
Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached?
Yes
No
Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived:
Group 1
Group 2
Group 3
Group 4
Group 5
Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available?
Yes
No
Is there a Maximum Enrollee Out-of-Pocket Cost?
Yes
No
Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost:
Group 1
Group 2
Group 3
Group 4
Group 5
Medicare Covered Benefits


PBP 2007 Data Entry System - Section B-20, Contract H1004, Plan 002, Segment 0
File Help
#20 Outpatient Drugs - Group 1 - Base 1
Select a label for Group 1:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-formulary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 1:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 1?
Yes
No
Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Prescription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 1:
Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:


PBP 2007 Data Entry System - Section B-20, Contract H1004, Plan 002, Segment 0
File Help
#20 Outpatient Drugs - Group 2 - Base 1
Select a label for Group 2:
Formulary Generic
Formulary Preferred Brand
Formulary Brand
Non-formulary Generic
Non-formulary Brand
Generic
Preferred Brand
Brand
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Select the drug type(s) covered for Group 2:
Generic
Preferred Brand
Brand
Is there a Maximum Plan Benefit Coverage amount for Group 2?
Yes
No
Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:
Annually
Semi-annually
Quarterly
Monthly
Per Prescription
Other, describe
Indicate Maximum Plan Benefit Coverage annual amount for Group 2:
Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:
Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:
Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:

Example 3: The plan has a $3,000 annual limit on four drug groups, with a $1,000 annual limit on Groups 3 and 4 combined, and no individual limit on Groups1 and 2. In this scenario, the plan would designate that it has a maximum plan benefit coverage amount, and that this includes all drug groups covered by plan AND Combination of drug groups. The plan would enter the overall limit of $3,000 annually, and a combination limit of $1,000 annually that includes the Groups 3 and 4 in the combination.





Drug Maximum Enrollee Out-of-Pocket Costs: The plan should indicate if there is an overall drug benefit maximum enrollee out-of-pocket cost on the Base 3 screen. On this screen, the plan can also select the drug groups, including Medicare covered benefits, for which the out-of-pocket maximum applies. There are no other enrollee out-of-pocket cost questions for any of the individual drug groups.

Deductible: The plan should specify the drug benefit deductible amount on the Base 5 screen. On this screen, the plan can also select the drug groups, including Medicare covered benefits, for which the deductible applies. There are no other deductible questions for any of the individual drug groups.

Coinsurance/Copayment: The coinsurance and copayment amounts for Medicare covered drugs should be entered in the Base screens. The coinsurance and copayment amounts for each of the individual drug groups should be entered in the appropriate Group set of screens.

Authorization: There is one Authorization question in the Prescription Drug category on Base 5. Written prescriptions from a physician are not considered to be an authorization for this category.

SECTION C (OON BENEFITS; COST SHARE REDUCTIONS; POS OPTION; VISITOR/TRAVEL PROGRAM)

To begin data entry, click on the command button located beneath Section C. This command button will display three possible states of data entry. These include:

- **<New>** -- Section C has not been opened for data entry.
- **<Incomplete>** -- Data entry has begun and has not been completed.
- **<Completed>** -- Data entry has been completed and validated.

The status of Section C (e.g., New, Incomplete, and Completed) appears directly on the command button. Once data entry has been completed and validated for Section C, the Status on the command button will display Completed**.**

NOTE: Please refer to Table 4-1 for plans that have access to the various sub-sections in Section C.

Out-of-Network Benefits

Generally, an out-of-network benefit provides a beneficiary with the option to access plan services outside of the plan's contracted network of providers. In some cases, a beneficiary's out-of-pocket costs may be higher for an out-of-network benefit.

NEW FOR 2007:
Section C collects out-of-network benefit information for Local and Regional PPO plans, Network PFFS plans, and ESRD I Demo plans only. This information includes coinsurance, copayment, and deductible amounts. The Out-of-Network Maximum Plan Benefit Coverage and Maximum Enrollee Out-of-Pocket Cost questions have been removed from this section.

The OON section provides detailed questions for the plan to describe cost shares for out-of-network inpatient hospital benefits and up to ten groups for other Out-of-Network benefits. A pick list of PBP categories is provided for the plan to select services as part of the Out-of-Network benefit groups to describe cost sharing.

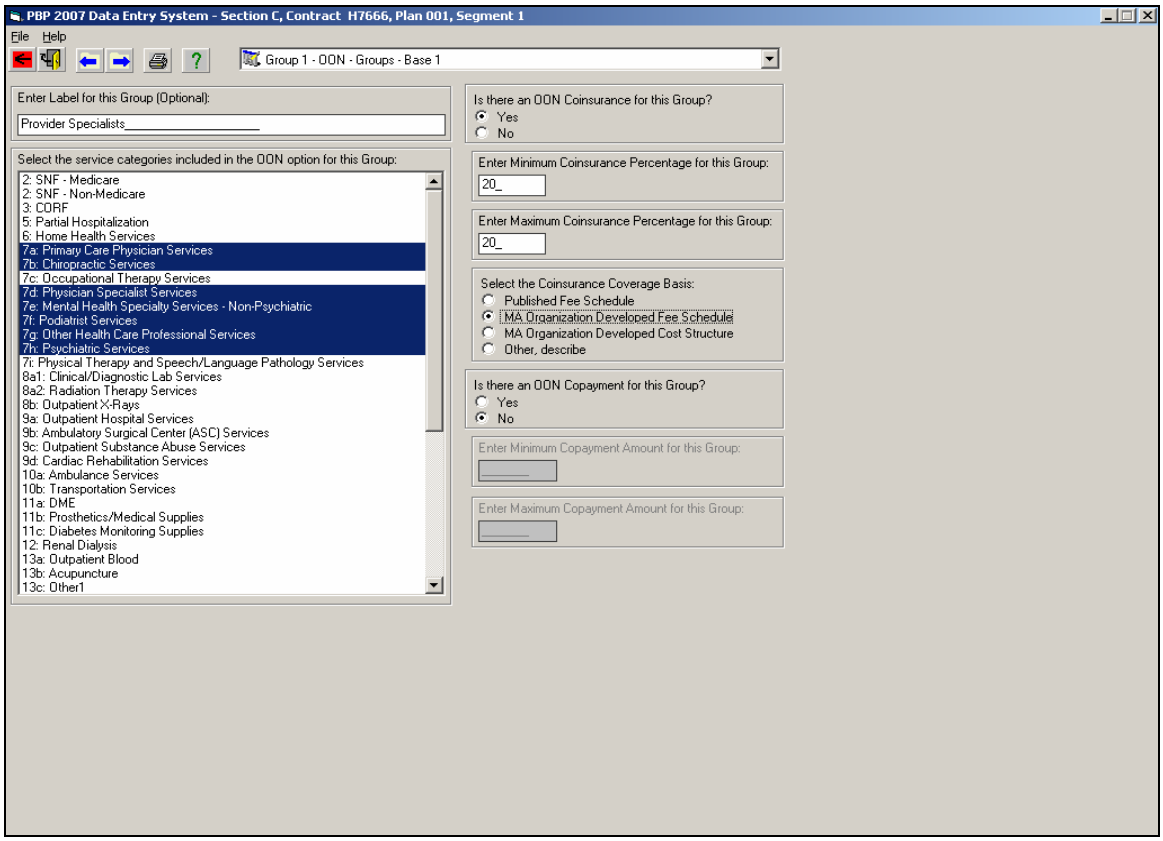
NEW FOR 2007:
A field has been added so the plan can enter a label for each SNF/Outpatient group. Also, a Deductible field has been added for each group.

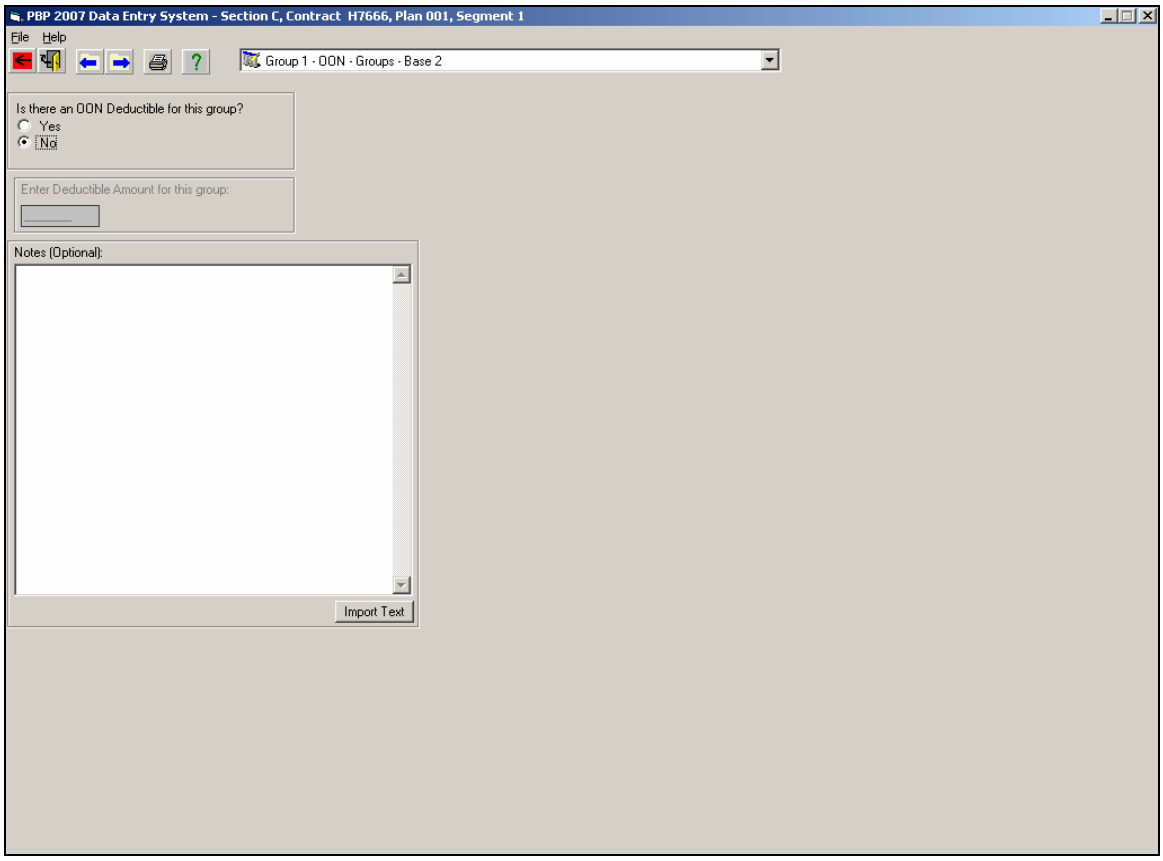
NOTE: Plan-level Out-of-Network and Combined (In-network and Out-of-network) Deductible amounts and Combined Maximum Enrollee Out-of-Pocket Cost amounts are now collected in Section D.

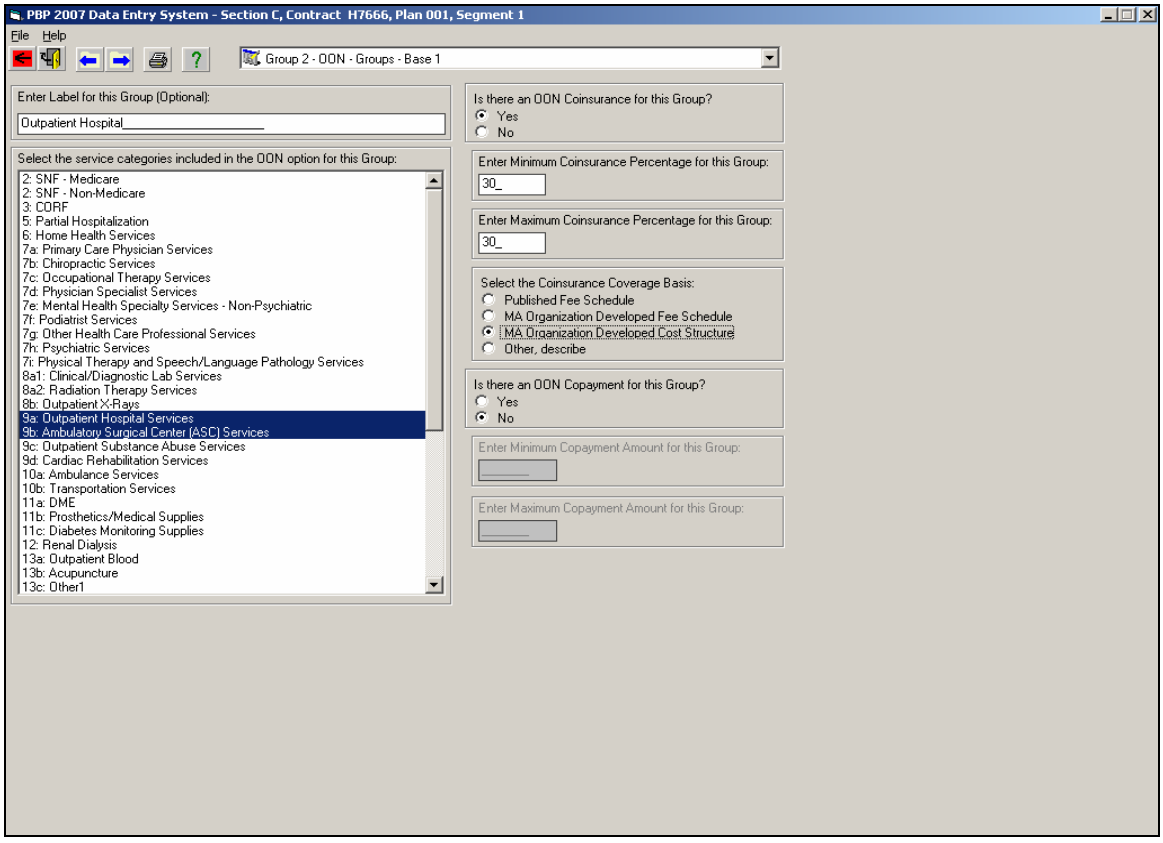
HELPFUL HINT:
- The plan can categorize one or more benefits into a "Group".
- Up to a maximum of 10 Groups, the plan can form groups based on various Copayment/Coinsurance structures.

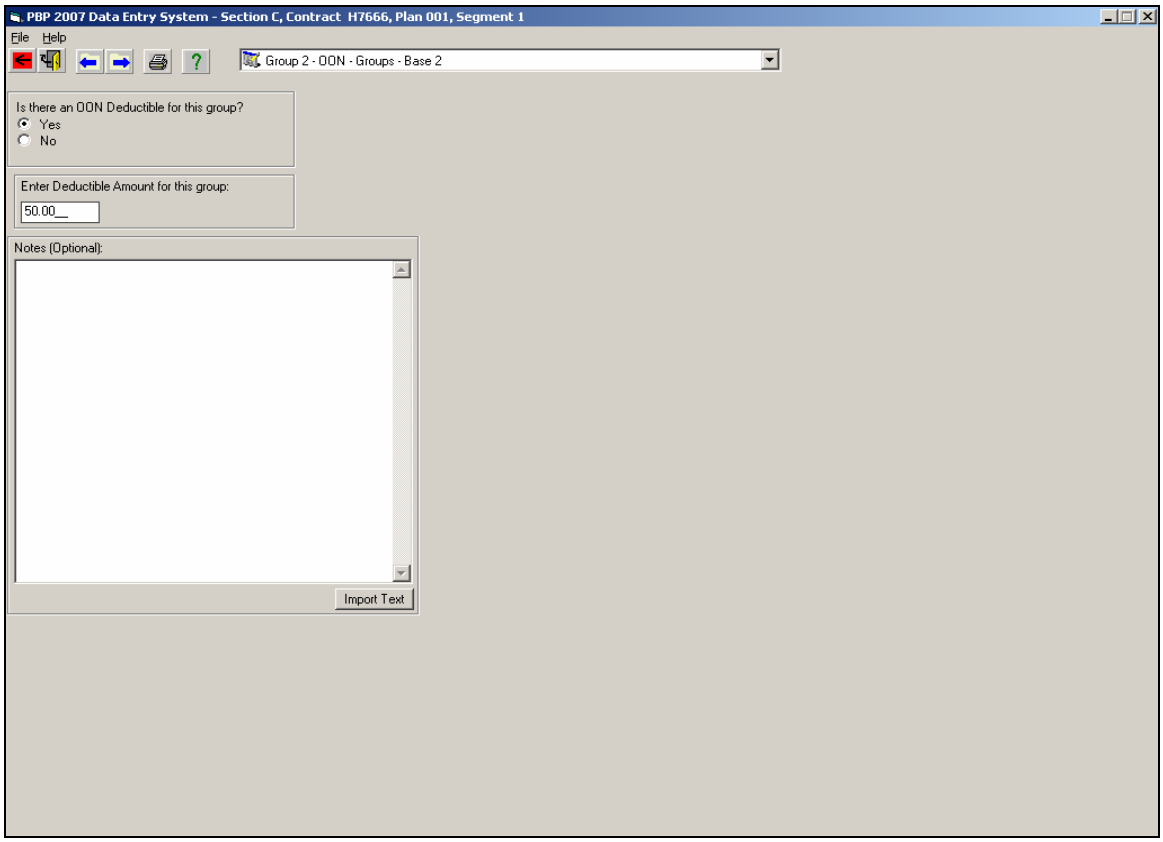
- CMS recommends developing the groups by attempting to arrange the benefits together having like benefit structures, for example:
  - Group 1: Provider Specialists - OON services for PCP, Specialist, Podiatry, Chiropractic, Psychiatry, Mental Health Specialists and Other Health Care Professionals
    - 20% Coinsurance
  - Group 2: Outpatient Hospital - OON services for Outpatient Hospital and ASC:
    - 30% Coinsurance
    - $50 Deductible

The data entry screens would be completed as follows for these two (2) "Groups":




PBP 2007 Data Entry System - Section C, Contract H7666, Plan 001, Segment 1
File Help
Group 1 - OON - Groups - Base 2
Is there an OON Deductible for this group?
Yes
No
Enter Deductible Amount for this group:
Notes (Optional):
Import Text


PBP 2007 Data Entry System - Section C, Contract H7666, Plan 001, Segment 1
File Help
Group 2 - OON - Groups - Base 1
Enter Label for this Group (Optional):
Outpatient Hospital
Select the service categories included in the OON option for this Group:
2: SNF - Medicare
2: SNF - Non-Medicare
3: CORF
5: Partial Hospitalization
6: Home Health Services
7a: Primary Care Physician Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7d: Physician Specialist Services
7e: Mental Health Specialty Services - Non-Psychiatric
7f: Podiatrist Services
7g: Other Health Care Professional Services
7h: Psychiatric Services
7i: Physical Therapy and Speech/Language Pathology Services
8a1: Clinical/Diagnostic Lab Services
8a2: Radiation Therapy Services
8b: Outpatient X-Rays
9a: Outpatient Hospital Services
9b: Ambulatory Surgical Center (ASC) Services
9c: Outpatient Substance Abuse Services
9d: Cardiac Rehabilitation Services
10a: Ambulance Services
10b: Transportation Services
11a: DME
11b: Prosthetics/Medical Supplies
11c: Diabetes Monitoring Supplies
12: Renal Dialysis
13a: Outpatient Blood
13b: Acupuncture
13c: Other1
Is there an OON Coinsurance for this Group?
Yes
No
Enter Minimum Coinsurance Percentage for this Group:
30
Enter Maximum Coinsurance Percentage for this Group:
30
Select the Coinsurance Coverage Basis:
Published Fee Schedule
MA Organization Developed Fee Schedule
MA Organization Developed Cost Structure
Other, describe
Is there an OON Copayment for this Group?
Yes
No
Enter Minimum Copayment Amount for this Group:
Enter Maximum Copayment Amount for this Group:



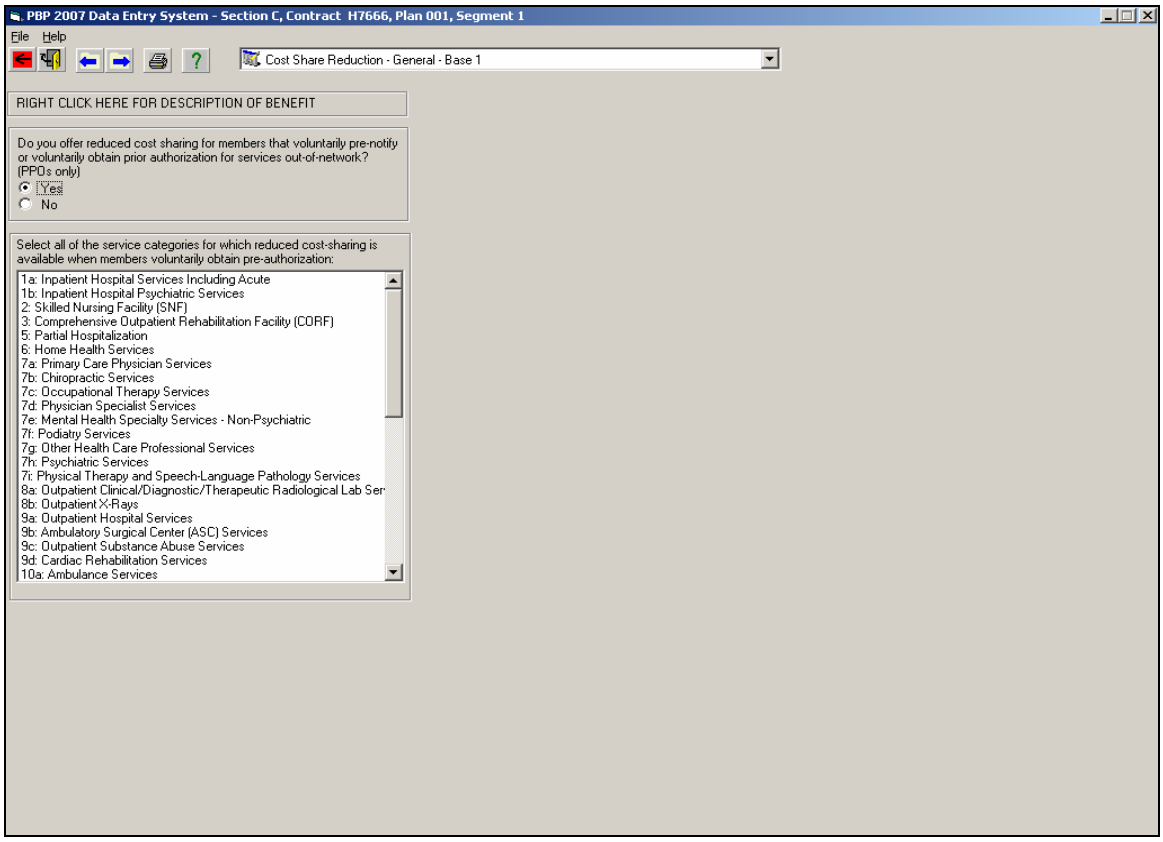
NOTE: Since the same benefits covered in network must be covered out of network (with a few exceptions) all service categories must be assigned to a group.

HELPFUL HINT:
Benefit category 4a: Emergency Care is purposely not included in the group pick list since beneficiaries cannot be charged differently out of network than in network for Emergency services.

NOTE: The benefit category 8a: Lab/Radiation Therapy has been split in the group pick list into two elements -- 8a1: Clinical/Diagnostic Lab Services; and 8a2: Radiation Therapy Services.

Cost Sharing Reduction

NEW FOR 2007:
PPO plans may now indicate that they offer Out-of-Network (OON) services with reduced cost sharing for members that voluntarily pre-notify or voluntarily obtain prior authorization. There is a service category pick-list to indicate which services have reduced cost sharing. Plans can enter reduced cost shares for Inpatient Hospital services and SNF/Outpatient services (up to 10 groups).



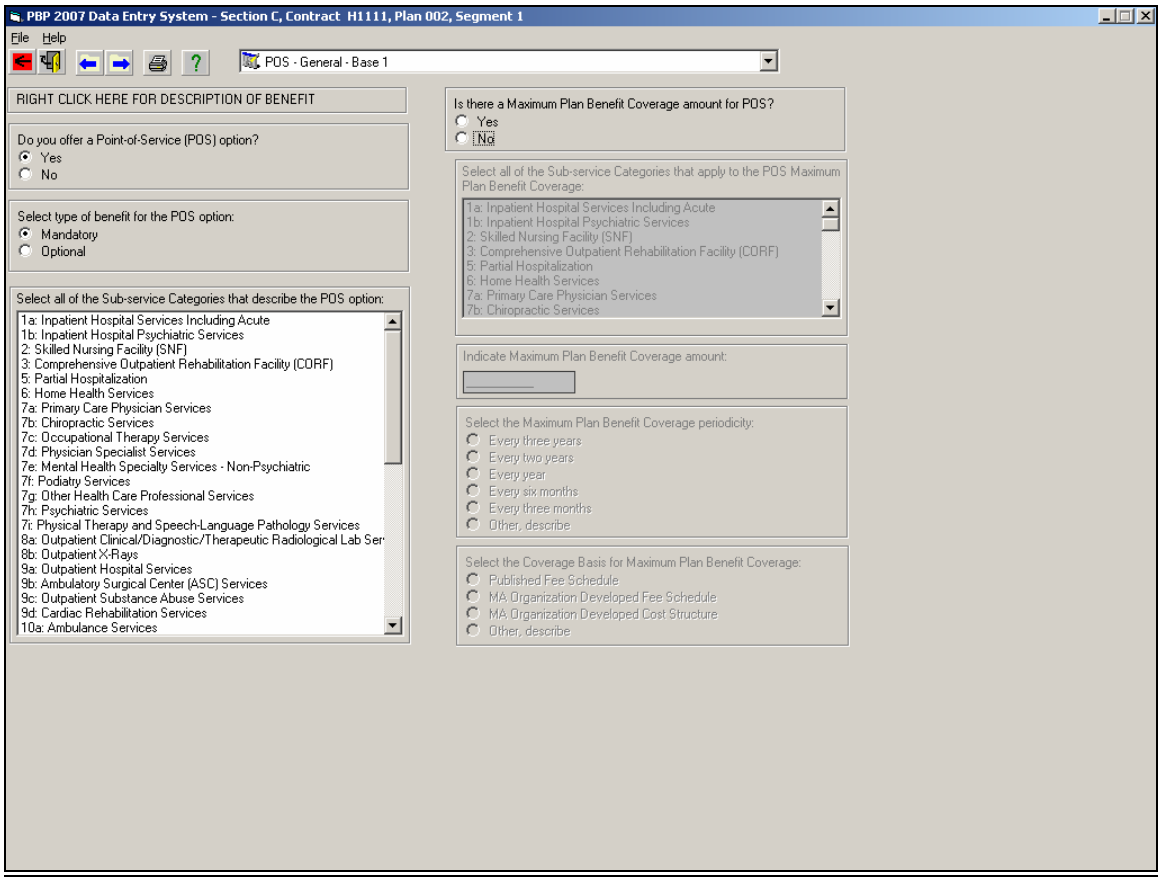
Point of Service (POS) Option

SB 36: Point of Service

NEW FOR 2007:
Section C now includes the Point of Service (POS) option (previously located in service category B-19 of Section B). This new POS section includes pick-lists to allow the MA plan to indicate which service categories describe the POS option and, in addition, which of those categories require a referral and which require authorization. This section collects information on non-Medicare-covered point-of-service options offered by the plan. In addition, the POS section includes detailed questions for the plan to describe cost shares for out-of-network inpatient hospital benefits and up to ten groups for other POS options. A pick list of PBP categories is provided for the plan to select services as part of the POS groups to describe cost sharing.

NOTE: Please refer to Table 4-1 for plans that have access to the POS section.

NOTE: See Section "PBP B-1a: Inpatient Hospital—Acute SB 3: Inpatient Hospital Services" for more detailed information regarding the warning message that also applies to this section.

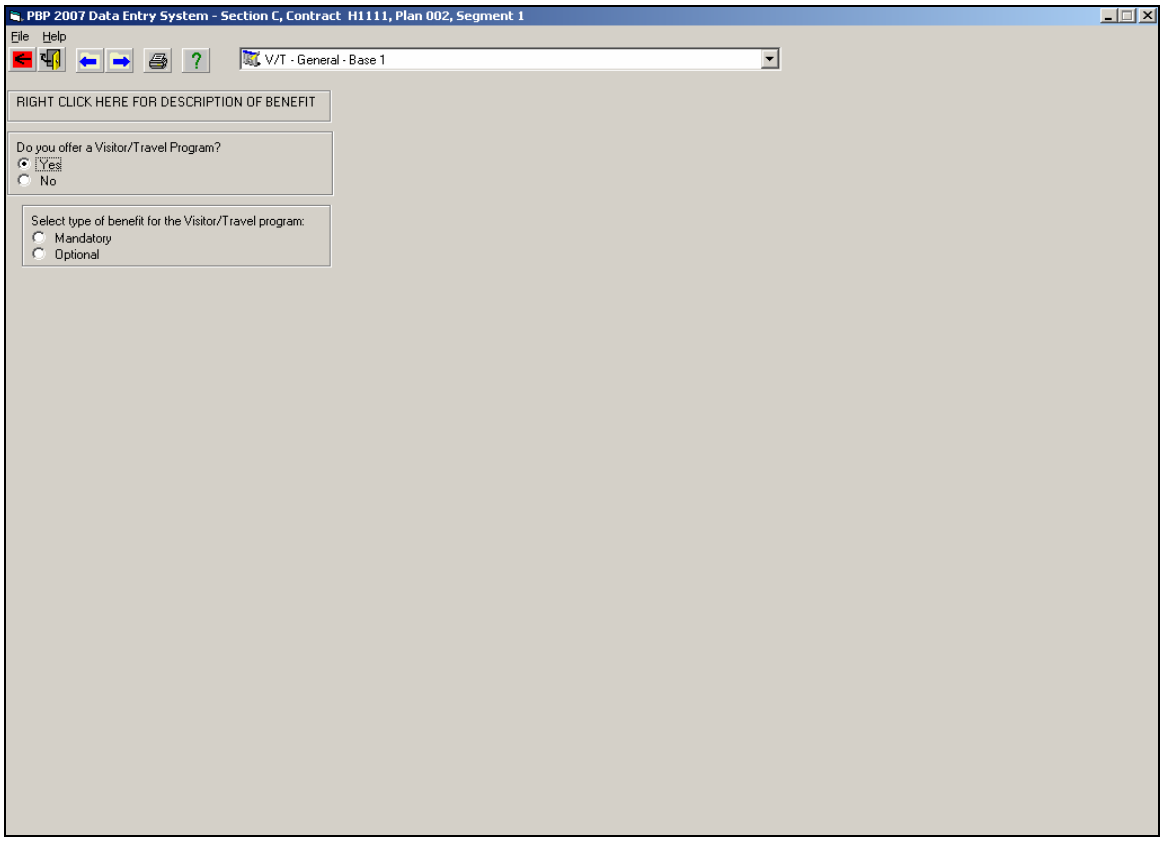


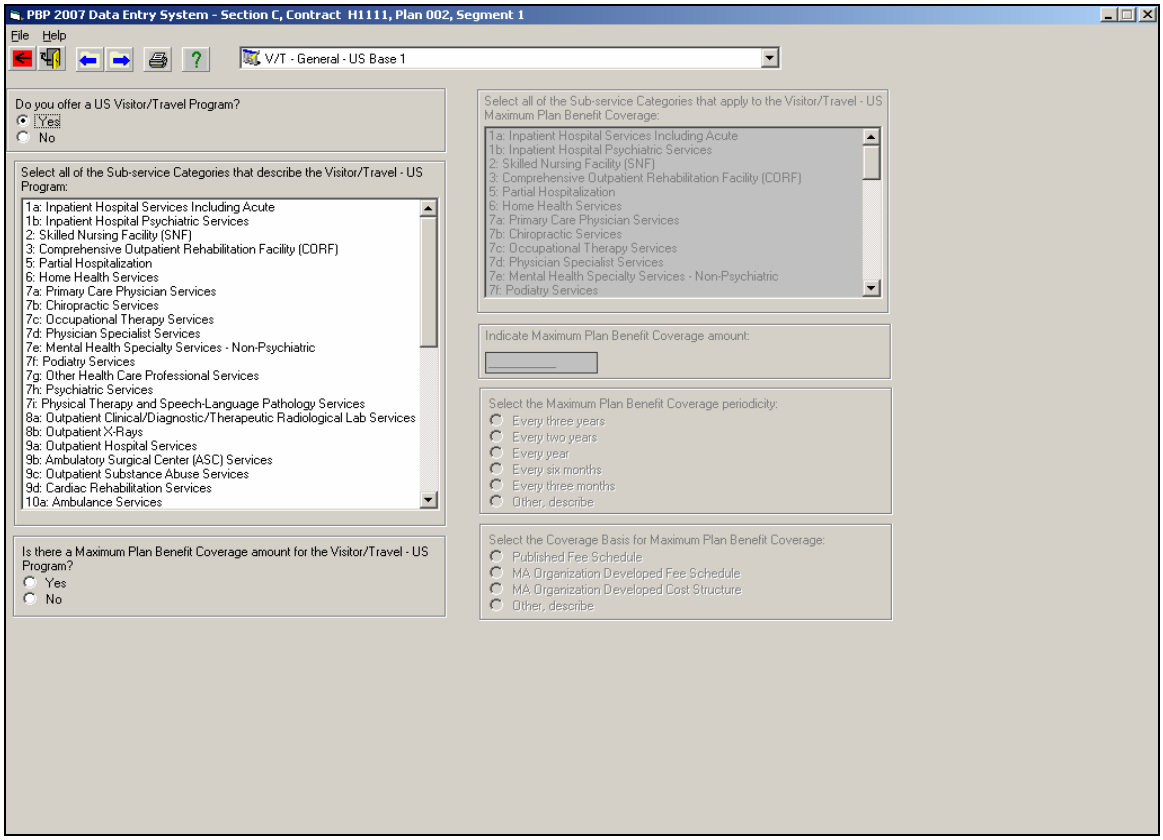
Visitor/Travel Program

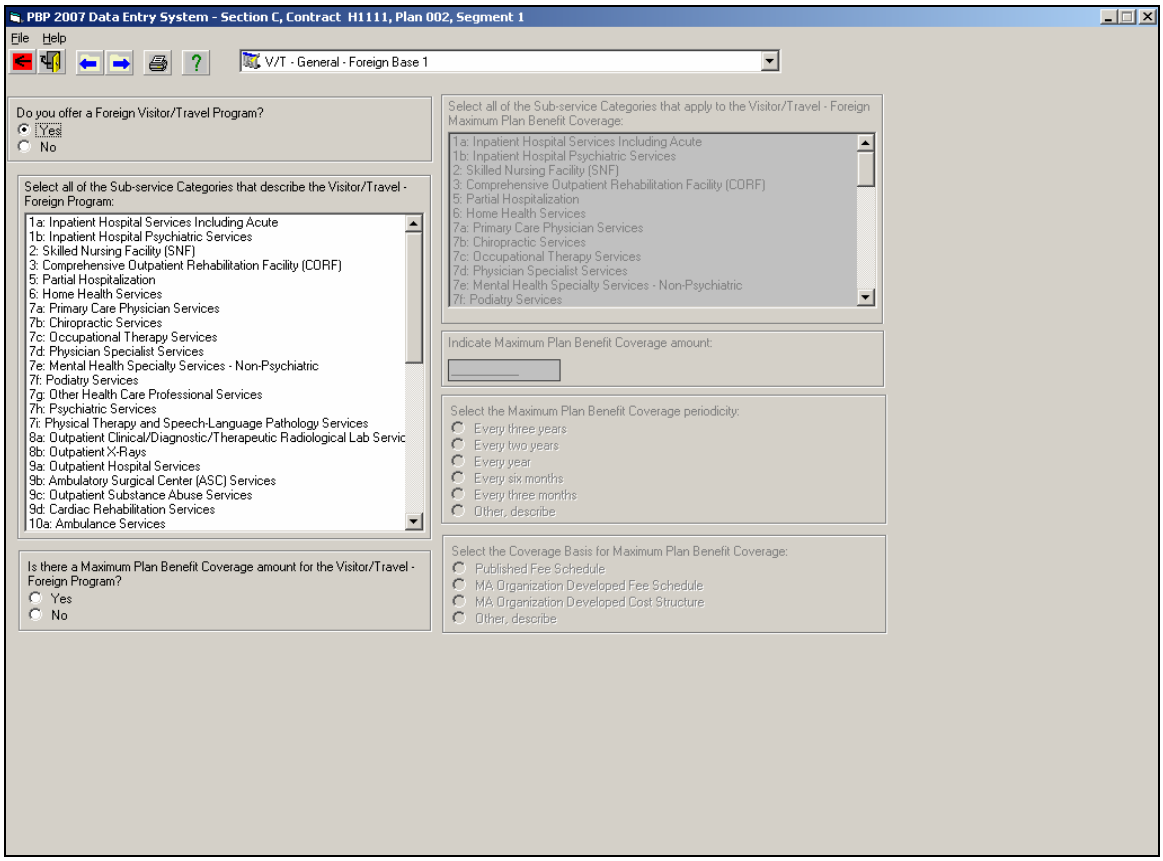
NEW FOR 2007:

Section C now contains detailed questions for the Visitor/Travel Program, including the type(s) of program(s): U.S.; Foreign; and, for each program: service categories that describe the program; Maximum Plan Benefit Coverage amount; Deductible (Foreign program only); Authorization; Referral; and Cost shares for Inpatient Hospital services and Outpatient services (up to 10 groups).

NOTE: Please refer to Table 4-1 for plans that have access to the V/T – U.S. and V/T - Foreign sections.


PBP 2007 Data Entry System - Section C, Contract H1111, Plan 002, Segment 1
File Help
V/T - General - Base 1
RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT
Do you offer a Visitor/Travel Program?
Yes
No
Select type of benefit for the Visitor/Travel program:
Mandatory
Optional


PBP 2007 Data Entry System - Section C, Contract H1111, Plan 002, Segment 1
File Help
V/T - General - US Base 1
Do you offer a US Visitor/Travel Program?
Yes
No
Select all of the Sub-service Categories that describe the Visitor/Travel - US Program:
1a: Inpatient Hospital Services Including Acute
1b: Inpatient Hospital Psychiatric Services
2: Skilled Nursing Facility (SNF)
3: Comprehensive Outpatient Rehabilitation Facility (CORF)
5: Partial Hospitalization
6: Home Health Services
7a: Primary Care Physician Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7d: Physician Specialist Services
7e: Mental Health Specialty Services - Non-Psychiatric
7f: Podiatry Services
7g: Other Health Care Professional Services
7h: Psychiatric Services
7i: Physical Therapy and Speech-Language Pathology Services
8a: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services
8b: Outpatient X-Rays
9a: Outpatient Hospital Services
9b: Ambulatory Surgical Center (ASC) Services
9c: Outpatient Substance Abuse Services
9d: Cardiac Rehabilitation Services
10a: Ambulance Services
Is there a Maximum Plan Benefit Coverage amount for the Visitor/Travel - US Program?
Yes
No
Select all of the Sub-service Categories that apply to the Visitor/Travel - US Maximum Plan Benefit Coverage:
1a: Inpatient Hospital Services Including Acute
1b: Inpatient Hospital Psychiatric Services
2: Skilled Nursing Facility (SNF)
3: Comprehensive Outpatient Rehabilitation Facility (CORF)
5: Partial Hospitalization
6: Home Health Services
7a: Primary Care Physician Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7d: Physician Specialist Services
7e: Mental Health Specialty Services - Non-Psychiatric
7f: Podiatry Services
Indicate Maximum Plan Benefit Coverage amount:
Select the Maximum Plan Benefit Coverage periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select the Coverage Basis for Maximum Plan Benefit Coverage:
Published Fee Schedule
MA Organization Developed Fee Schedule
MA Organization Developed Cost Structure
Other, describe


PBP 2007 Data Entry System - Section C, Contract H1111, Plan 002, Segment 1
File Help
V/T - General - Foreign Base 1
Do you offer a Foreign Visitor/Travel Program?
Yes
No
Select all of the Sub-service Categories that describe the Visitor/Travel - Foreign Program:
1a: Inpatient Hospital Services Including Acute
1b: Inpatient Hospital Psychiatric Services
2: Skilled Nursing Facility (SNF)
3: Comprehensive Outpatient Rehabilitation Facility (CORF)
5: Partial Hospitalization
6: Home Health Services
7a: Primary Care Physician Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7d: Physician Specialist Services
7e: Mental Health Specialty Services - Non-Psychiatric
7f: Podiatry Services
7g: Other Health Care Professional Services
7h: Psychiatric Services
7i: Physical Therapy and Speech-Language Pathology Services
8a: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Servic
8b: Outpatient X-Rays
9a: Outpatient Hospital Services
9b: Ambulatory Surgical Center (ASC) Services
9c: Outpatient Substance Abuse Services
9d: Cardiac Rehabilitation Services
10a: Ambulance Services
Is there a Maximum Plan Benefit Coverage amount for the Visitor/Travel - Foreign Program?
Yes
No
Select all of the Sub-service Categories that apply to the Visitor/Travel - Foreign Maximum Plan Benefit Coverage:
1a: Inpatient Hospital Services Including Acute
1b: Inpatient Hospital Psychiatric Services
2: Skilled Nursing Facility (SNF)
3: Comprehensive Outpatient Rehabilitation Facility (CORF)
5: Partial Hospitalization
6: Home Health Services
7a: Primary Care Physician Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7d: Physician Specialist Services
7e: Mental Health Specialty Services - Non-Psychiatric
7f: Podiatry Services
Indicate Maximum Plan Benefit Coverage amount:
Select the Maximum Plan Benefit Coverage periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select the Coverage Basis for Maximum Plan Benefit Coverage:
Published Fee Schedule
MA Organization Developed Fee Schedule
MA Organization Developed Cost Structure
Other, describe

SECTION D

Section D collects plan-level cost sharing and limits designated for each of the individual plans. Cost sharing and limits include each plan's premium, deductible, maximum plan benefit coverage (i.e., plan expenditure limits), and maximum enrollee out-of-pocket costs. It is important to distinguish that Section D identifies plan-level cost sharing amounts, while Section B requests service-specific cost sharing amounts for each service category. It is recommended that Section B be completed prior to entering Section D. As certain items are entered in Section B, additional items are triggered in Section D for data entry. (i.e. – Optional Supplemental Benefits)

All supplemental benefits that were designated Optional in Section B must be associated with an Optional Premium in Section D before completing a plan's PBP. In addition, Section D requests that the user define the services and premiums for both individual and grouped optional supplemental benefits. A special set of screens is provided in each Optional Supplemental Benefit package for data entry of step-up benefits for nine selected subcategories:

- 7b-Chiropractic Services,
- 7f-Podiatry Services,
- 10b-Transportation,
- 16a-Preventive Dental,
- 16b-Comprehensive Dental,
- 17a-Eye Exams,
- 17b-Eye Wear,
- 18a-Hearing Exams, and
- 18b-Hearing Aids.

If a plan's optional benefits package includes a step-up benefit for which there are no special step-up screens in Section D (not one of the nine selected subcategories), these step-up benefits must be described in the corresponding Notes field of the service category in Section B.

To begin data entry, click on the command button located beneath Section D. This command button will display three possible states of data entry. These include:

- **<New>** -- Section D has not been opened for data entry.
- **<Incomplete>** -- Data entry has begun and has not been completed.
- **<Completed>** -- Data entry has been completed and validated.

Once data entry has been completed and validated for Section D, the Status on the command button will display Completed.

NOTE: Refer to the Perform Data Entry section of this manual for further details about Step-Ups (Optional Supplemental Benefits).

NEW FOR 2007:
For Plans that submit a BPT as part of their Bid Submission, the Plan Premium and Part B Premium Reduction have been removed from the PBP. This information will **only** be collected in the BPT. After the Bid submission is complete, *plans should refer to the HPMS CY 2007 Summary of Benefits Report for the exact wording of the premium sentences to* ***manually insert*** *into their hard copy SB.*

The plan premium information will still be collected in the PBP for 1876 Cost plans. Cost plans should enter the monthly plan premium amount, which will then be used to populate the corresponding SB sentences.

Section D enables the plan to designate whether the plan-level Deductible and Maximum Enrollee Out-of-Pocket Cost apply to All benefits (both Medicare and Enhanced), Medicare benefits only, or Enhanced benefits only.

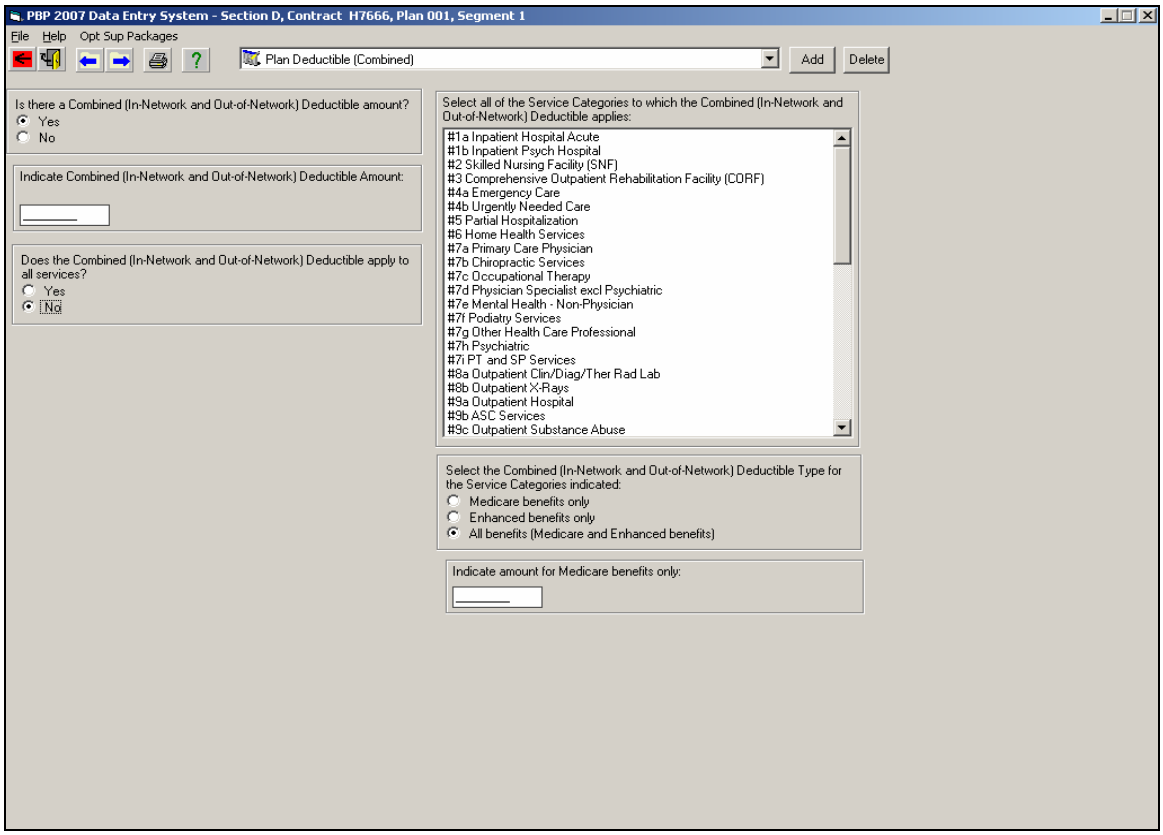
NOTE: Except for PPO, Network PFFS, and ESRD I plan types, all plans may enter only plan-level In-Network Deductible and In-Network Maximum Enrollee Out-of-Pocket cost amounts.

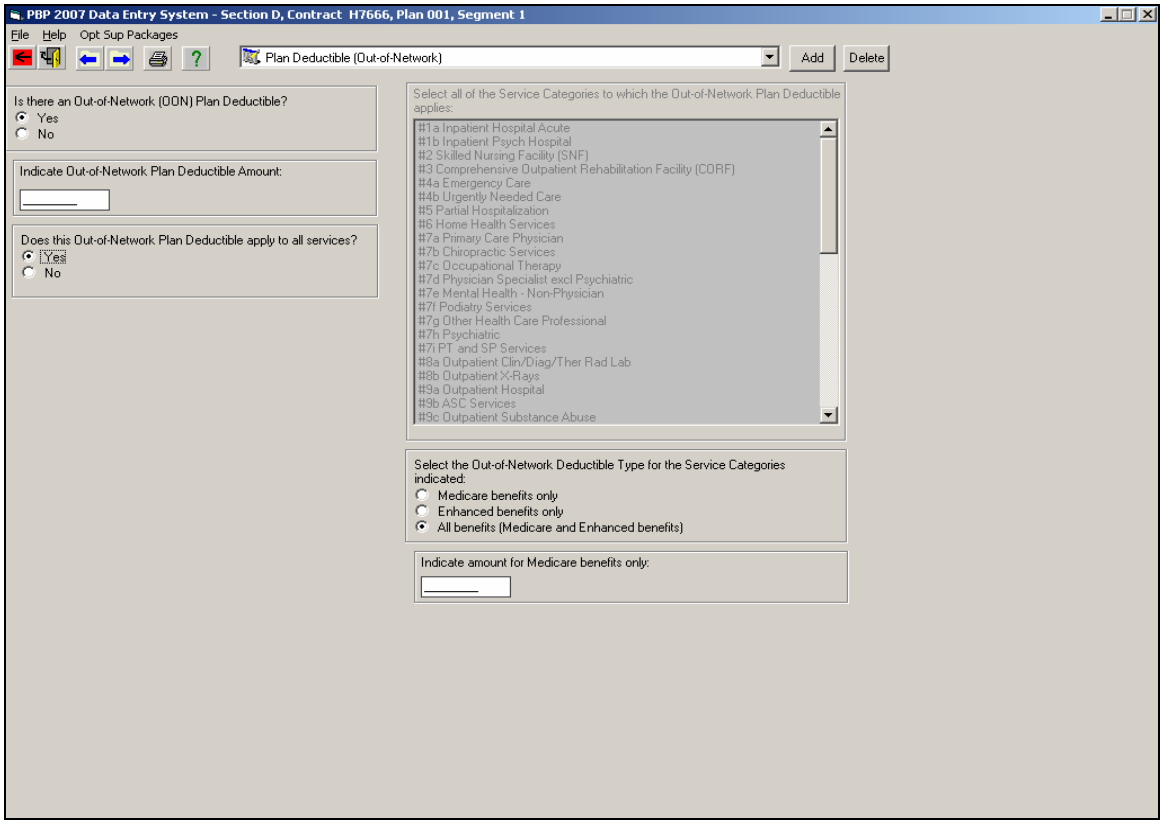
NEW FOR 2007:
For plans that offer Out-of-Network benefits, Section D now collects plan-level Out-of-Network and Combined (In-Network and Out-of-Network) Deductible amounts and Combined Maximum Enrollee Out-of-Pocket Cost amounts.

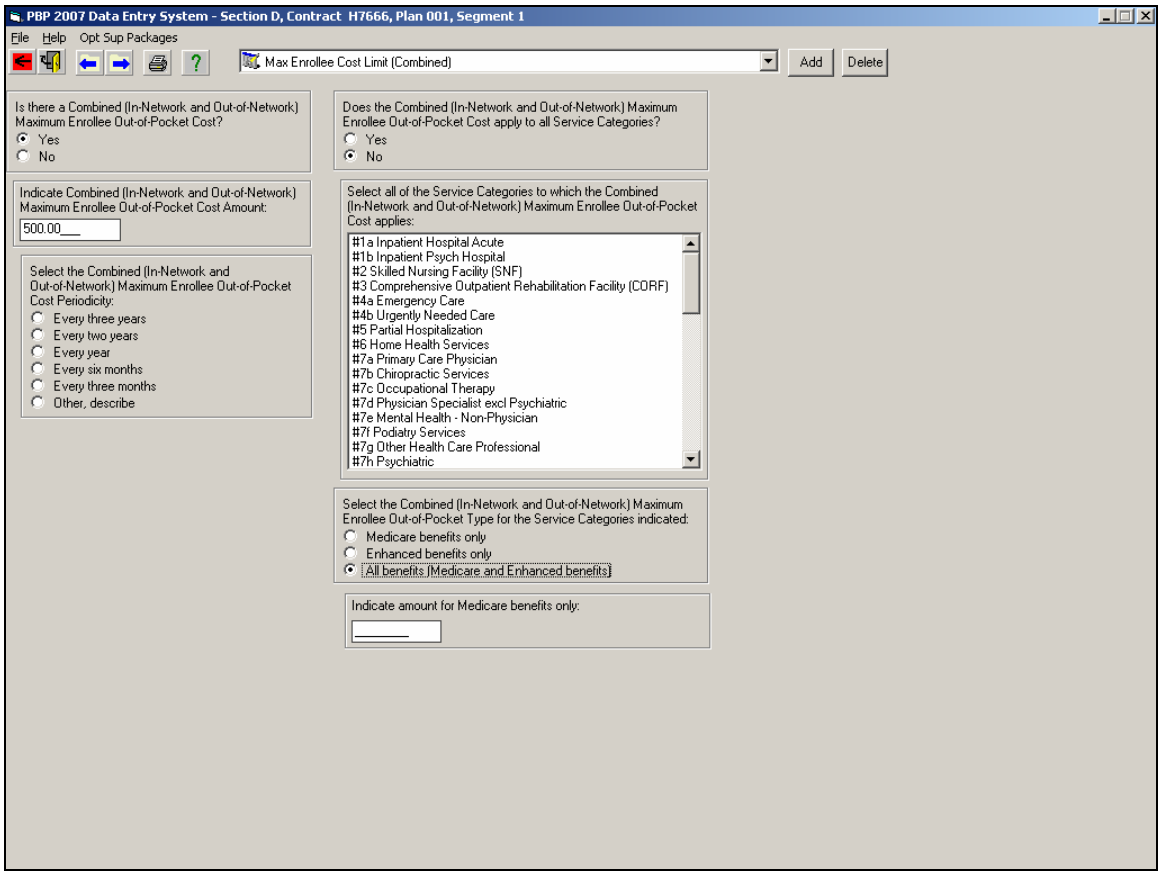
Regional PPO plans must enter a combined deductible amount for Medicare benefits only or for all Medicare and enhanced benefits. If a combined deductible amount is provided for all Medicare and enhanced benefits, the Regional PPO plan must provide a breakdown for the amount for Medicare benefits only.

Local PPO plans may enter an OON deductible amount. If an amount is provided for all Medicare and enhanced benefits, the plan must provide a breakdown for the amount for Medicare benefits only.

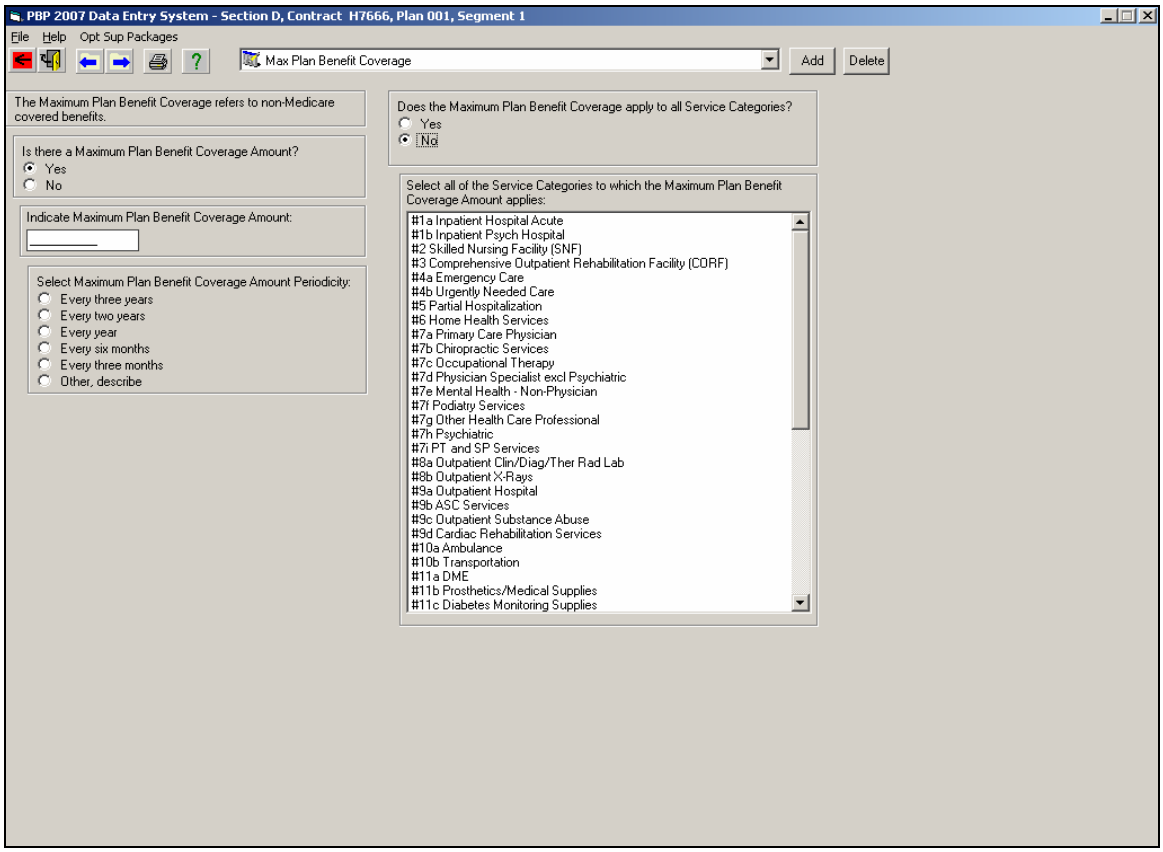
PPO plans may enter a Combined Maximum Enrollee Out-of-Pocket Cost amount. If an amount is provided for all Medicare and enhanced benefits, the plan must provide a breakdown for the amount for Medicare benefits only.


PBP 2007 Data Entry System - Section D, Contract H7666, Plan 001, Segment 1
File Help Opt Sup Packages
Plan Deductible (Combined)
Add
Delete
Is there a Combined (In-Network and Out-of-Network) Deductible amount?
Yes
No
Indicate Combined (In-Network and Out-of-Network) Deductible Amount:
Does the Combined (In-Network and Out-of-Network) Deductible apply to all services?
Yes
No
Select all of the Service Categories to which the Combined (In-Network and Out-of-Network) Deductible applies:
#1a Inpatient Hospital Acute
#1b Inpatient Psych Hospital
#2 Skilled Nursing Facility (SNF)
#3 Comprehensive Outpatient Rehabilitation Facility (CORF)
#4a Emergency Care
#4b Urgently Needed Care
#5 Partial Hospitalization
#6 Home Health Services
#7a Primary Care Physician
#7b Chiropractic Services
#7c Occupational Therapy
#7d Physician Specialist excl Psychiatric
#7e Mental Health - Non-Physician
#7f Podiatry Services
#7g Other Health Care Professional
#7h Psychiatric
#7i PT and SP Services
#8a Outpatient Clin/Diag/Ther Rad Lab
#8b Outpatient X-Rays
#9a Outpatient Hospital
#9b ASC Services
#9c Outpatient Substance Abuse
Select the Combined (In-Network and Out-of-Network) Deductible Type for the Service Categories indicated:
Medicare benefits only
Enhanced benefits only
All benefits (Medicare and Enhanced benefits)
Indicate amount for Medicare benefits only:


PBP 2007 Data Entry System - Section D, Contract H7666, Plan 001, Segment 1
File Help Opt Sup Packages
Plan Deductible (Out-of-Network)
Add
Delete
Is there an Out-of-Network (OON) Plan Deductible?
Yes
No
Indicate Out-of-Network Plan Deductible Amount:
Does this Out-of-Network Plan Deductible apply to all services?
Yes
No
Select all of the Service Categories to which the Out-of-Network Plan Deductible applies:
#1a Inpatient Hospital Acute
#1b Inpatient Psych Hospital
#2 Skilled Nursing Facility (SNF)
#3 Comprehensive Outpatient Rehabilitation Facility (CORF)
#4a Emergency Care
#4b Urgently Needed Care
#5 Partial Hospitalization
#6 Home Health Services
#7a Primary Care Physician
#7b Chiropractic Services
#7c Occupational Therapy
#7d Physician Specialist excl Psychiatric
#7e Mental Health - Non-Physician
#7f Podiatry Services
#7g Other Health Care Professional
#7h Psychiatric
#7i PT and SP Services
#8a Outpatient Clin/Diag/Ther Rad Lab
#8b Outpatient X-Rays
#9a Outpatient Hospital
#9b ASC Services
#9c Outpatient Substance Abuse
Select the Out-of-Network Deductible Type for the Service Categories indicated:
Medicare benefits only
Enhanced benefits only
All benefits (Medicare and Enhanced benefits)
Indicate amount for Medicare benefits only:


PBP 2007 Data Entry System - Section D, Contract H7666, Plan 001, Segment 1
File
Help
Opt Sup Packages
Max Enrollee Cost Limit (Combined)
Add
Delete
Is there a Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost?
Yes
No
Does the Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost apply to all Service Categories?
Yes
No
Indicate Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost Amount:
500.00
Select the Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost Periodicity:
Every three years
Every two years
Every year
Every six months
Every three months
Other, describe
Select all of the Service Categories to which the Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost applies:
#1a Inpatient Hospital Acute
#1b Inpatient Psych Hospital
#2 Skilled Nursing Facility (SNF)
#3 Comprehensive Outpatient Rehabilitation Facility (CORF)
#4a Emergency Care
#4b Urgently Needed Care
#5 Partial Hospitalization
#6 Home Health Services
#7a Primary Care Physician
#7b Chiropractic Services
#7c Occupational Therapy
#7d Physician Specialist excl Psychiatric
#7e Mental Health - Non-Physician
#7f Podiatry Services
#7g Other Health Care Professional
#7h Psychiatric
Select the Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Type for the Service Categories indicated:
Medicare benefits only
Enhanced benefits only
All benefits (Medicare and Enhanced benefits)
Indicate amount for Medicare benefits only:

Section D also collects detailed information on the plan-level Maximum Plan Benefit Coverage amount. This applies to non-Medicare covered benefits only. In addition to indicating the amount and periodicity, then plan may select the service categories that are included in this coverage amount.

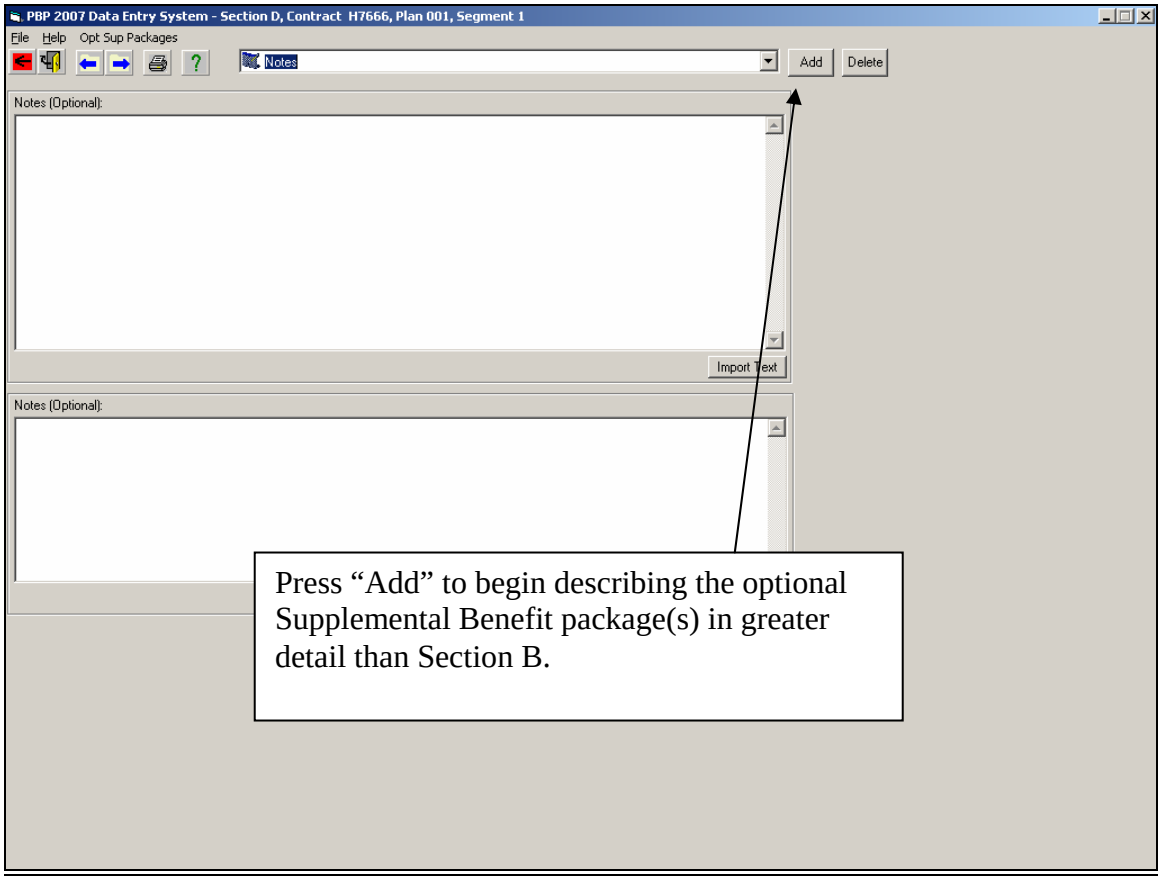


NEW FOR 2007:

MSA and MSA Demo plans may enter an Annual MSA Deductible amount and also indicate the Annual amount CMS will deposit into the enrollee MSA.

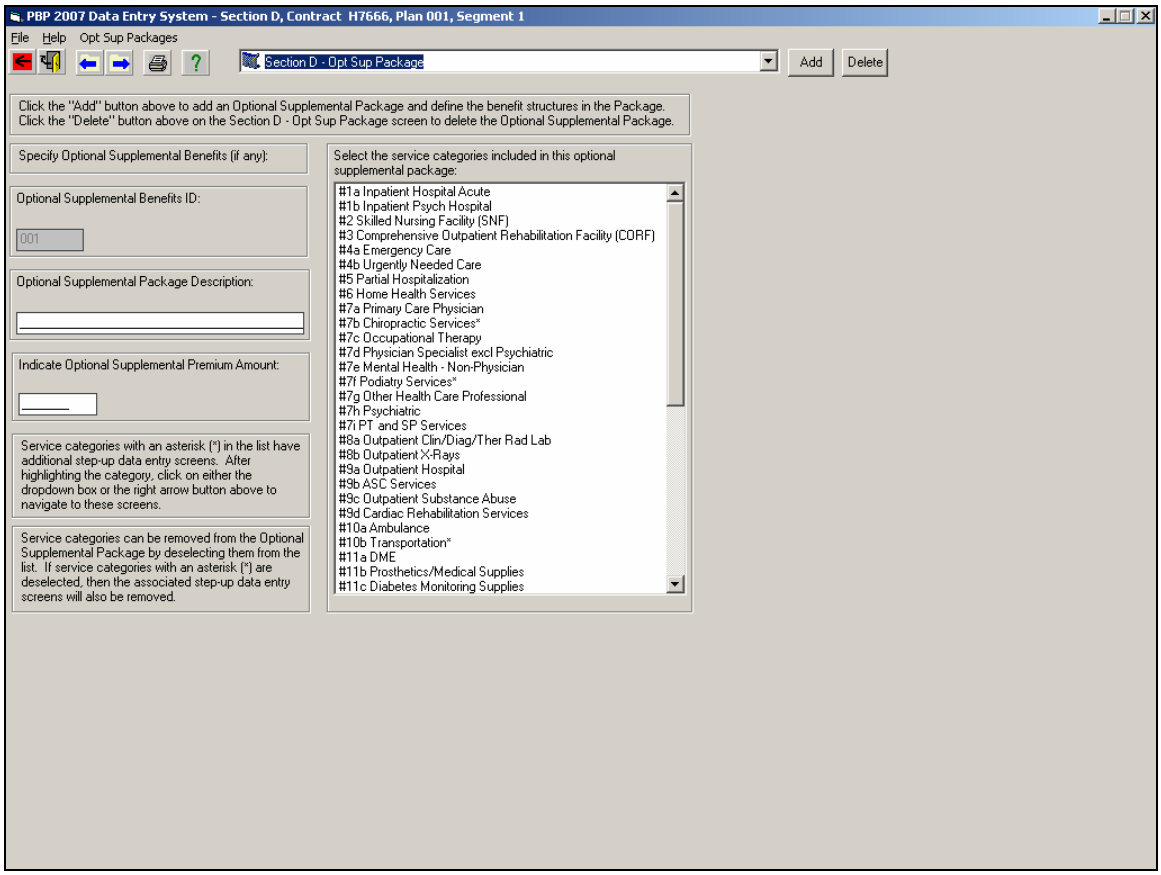
Designation of Optional Supplemental Benefits Package

Section D is also used to describe Optional Supplemental Benefits packages offered by the plan. Section D enables the user to create one or more Optional Supplemental Benefit packages with an associated premium.



The user must enter the Package Label and Premium amount for the Optional Supplemental Benefits package, and select from the pick list the set of service categories that describe the optional supplemental benefits included in that package.

NOTE: The system will automatically number each Optional Supplemental Benefit Package.



If one or more of the Optional supplemental benefit(s) denoted with an asterisk (*) are selected, the user must then describe these benefit on the third screen. The data entry screens for these nine step-up benefits are similar to the screens in Section B. **If the package includes a step-up benefit that is not one of these nine, then the plan must describe the step-up benefit in the category Notes in Section B.**

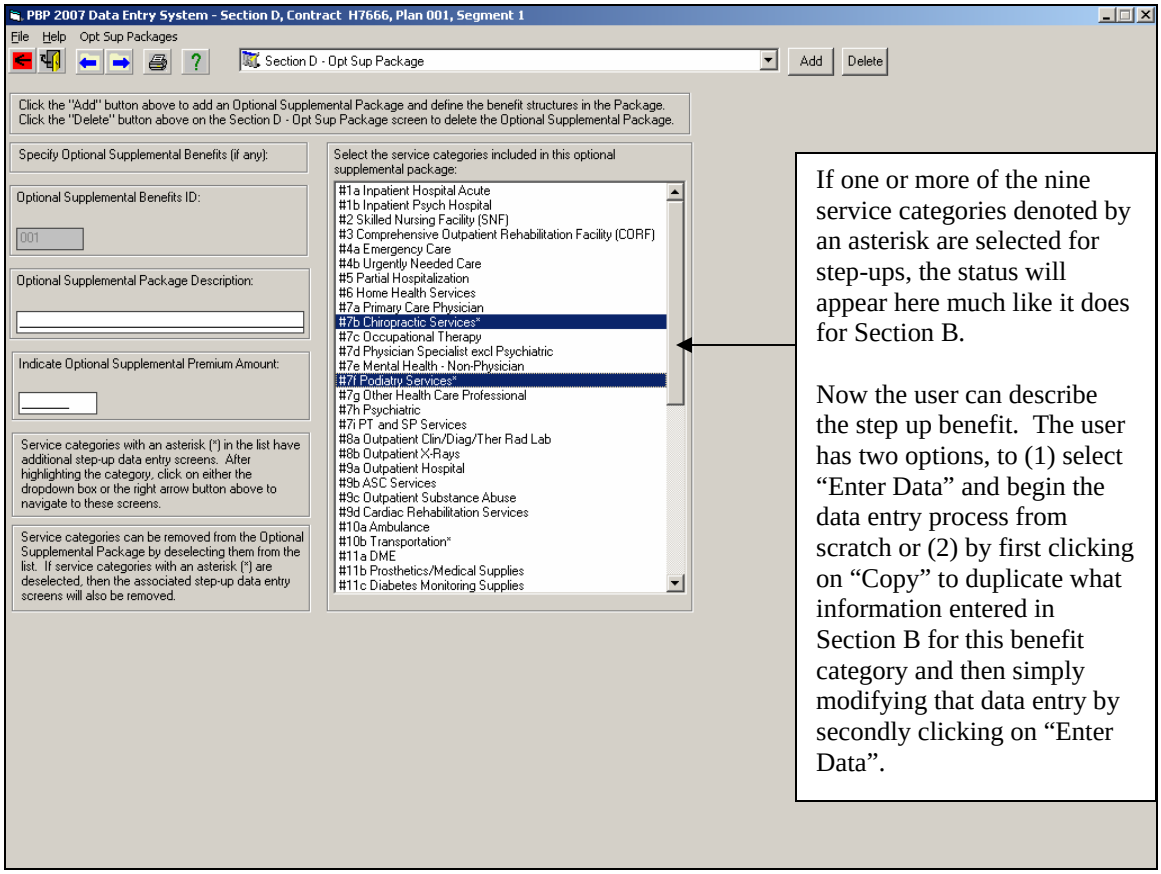
The nine Optional step-up benefit categories are:

- Chiropractic Services (7b)
- Podiatrist Services (7f)
- Transportation Services (10b)
- Dental - Preventive Services (16a)
- Dental - Comprehensive Services (16b)
- Vision - Eye Exams (17a)
- Vision - Eye Wear (17b)
- Hearing - Hearing Exams (18a)
- Hearing - Hearing Aids (18b)

Specify the step-up benefit by highlighting one subcategory at a time from the Category column and then select either the <Enter Data> or <Copy> buttons. If the <Enter Data> button is selected, the appropriate subcategory's screens will automatically appear for

data entry. The step-up data entry screens are similar to and should be completed in the same manner as the Section B screens.

As an alternative, if the <Copy> button is selected, data previously entered in Section B for the subcategory will be copied to the step-up benefit subcategory screens. However, the step-up data entry will have an "Incomplete" status until the step-up modifications are entered in the step-up benefit subcategory screens.



If one or more of the nine service categories denoted by an asterisk are selected for step-ups, the status will appear here much like it does for Section B.

Now the user can describe the step up benefit. The user has two options, to (1) select "Enter Data" and begin the data entry process from scratch or (2) by first clicking on "Copy" to duplicate what information entered in Section B for this benefit category and then simply modifying that data entry by secondly clicking on "Enter Data".

MEDICARE PART D RX SECTION

The Rx section contains data entry questions that a plan would use to describe its Medicare Part D benefit coverage. The Medicare Prescription Drug Section is enabled if a plan indicates in the Plan Creation portion of HPMS that a Part D benefit is offered. A plan may offer only one Part D coverage benefit type. The indication that a Formulary is offered is also downloaded from HPMS.

NEW FOR 2007:
This section has been enhanced for CY 2007 to allow plans to describe their gap coverage.

NEW FOR 2007:
The actual dollar amounts for the Medicare-defined deductible, ICL, OOP cost threshold and cost share amounts are no longer displayed on the PBP screens or in the SB sentences. Once these data are released by CMS, a patch will be released to all plans to update the SB sentences as necessary. The PBP will continue to not display the actual dollar amounts.

The Medicare Prescription Drug Section begins by asking the plan to indicate the type of Part D coverage offered – Defined Standard, Actuarially Equivalent Standard, Basic Alternative, or Enhanced Alternative benefit.

NOTE: Fallback plans may only choose either the Defined Standard or Actuarially Equivalent Standard coverage benefit types for their plans.

The Part D premium will not be entered by the plan into the PBP software. As part of the bidding process, the Part D premium for each plan will be calculated by the CMS Office of the Actuary (OACT). Plans will be able to access their calculated Part D premium via HPMS. Further guidance will be provided on this matter separately from CMS.

The Medicare Rx General screen displays the fields that the plan offers a Part D benefit and offers a drug Formulary. These fields are pre-populated using data downloaded from HPMS. In addition, the plan must also enter the following information on this screen:

- The type of drug benefit
- The number of tiers in the Part D benefit
- If there are maximum quantity amounts for certain drugs
- If prior authorization is required for certain prescription drugs
- If any drugs in the formulary require a step therapy plan
- If the plan offers a free first fill for any drugs (enabled based on drug benefit type)
- If the plan is a Part D payment Demo; if so, what type (enabled based on organization type and drug benefit type)
- Describe the components of the plan's pharmacy network

It is important that the locations where drugs can be obtained, and corresponding supply amounts, be entered for the Part D benefit coverage. Therefore, a general location/supply screen will appear as the second to last screen for each Part D benefit type, if the plan has not previously indicated the locations and supply amounts. For example, the location/supply screen will always appear for the Defined Standard benefit. For the other three benefit types, if the plan indicates that it has Cost Share Tiers, then the locations and supply amounts will be entered for the tiers, so the general location/supply screen will NOT be enabled. That is, as long as the plan indicates at some point in the Rx screens the locations and supply amounts for tiers, then the general location/supply screen will not be enabled.

NEW FOR 2007:
In CY 2006, certain organizations were able to designate Part D Payment demonstration plans under their contract in HPMS during Bid upload. In CY 2007, this data will be collected in the PBP.

An organization offering an Enhanced Alternative Part D drug benefit and is approved to participate in the Part D Payment Demo may select one of three options, based on organization type:

- Flexible Capitated option - Can be selected by any non-employer plan offering Part D under the following org types: Local CCP, PFFS, Demo, 1876 Cost, PDP, and Regional CCP.
- Fixed Capitated option - Can be selected by any non-employer plan offering Part D under the following org types: Local CCP, PFFS, Demo, 1876 Cost, PDP, and Regional CCP.
- Flexible MA rebate option - Can be selected by any non-employer plan offering Part D under the following org types: Local CCP, PFFS, 1876 Cost, Demo, and Regional CCP.

NOTE: The plan must indicate that an Out-of-Network Pharmacy location is offered. Also, if the plan enters Cost Share Tiers, every tier must include an Out-of-Network Pharmacy location.

NOTE: If a plan offers greater than a 30 day supply through mail order, the plan must also offer that same days supply at a retail location. The PBP will validate upon exit of the Rx section that this policy is followed.

If cost share tiers are used to describe cost sharing for the Part D benefit, the PBP software will enumerate those tiers in sequential order. Plans should enter the tier data in ascending order by cost share (e.g. Tier 1 should be lowest cost drugs, Tier 2 next lowest cost, …and last Tier should be highest cost drugs).

Tier labels may be copied from one tier type to another tier type. Tier label copying is designed as a tier-by-tier copy function (i.e., Tier 1 Pre-ICL copies to Tier 1 Gap and/or Tier 1 Post-OOP; Tier 2 Pre-ICL copies to Tier 2 Gap and/or Tier 2 Post-OOP, etc.) and can only be done one tier at a time. Besides copying the tier label, the copy function also

copies the three subsequent fields: 1) Select drug type(s) in this Tier; 2) Tier Includes (Enhanced Alternative only); and 3) Specialty Tier. The "Tier Labels/Copy from" function is available on the menu bar.

Defined Standard Benefit

For the Defined Standard benefit, the Medicare-defined Part D coverage is specified for the deductible and cost share amounts, the Initial Coverage Limit (ICL), and the out-of-pocket cost threshold; no data entry is required for these fields. The plan must indicate on the General Location/Supply screen the locations where drugs can be obtained and the quantities (number of days) available for each location selected. These include:

- In-Network Pharmacy
- In-Network Preferred Pharmacy
- In-Network Non-Preferred Pharmacy
- Out-of-Network Pharmacy
- Mail Order Pharmacy
- Mail Order Preferred Pharmacy
- Mail Order Non-Preferred Pharmacy

NOTE: The locations selected on the General Location/Supply Screen must agree with the locations selected for the components of the pharmacy network on the Medicare Rx General Screen.

Actuarially Equivalent Standard Benefit

For the Actuarially Equivalent Standard, the Medicare-defined Part D deductible amount applies. The plan must also indicate if it charges the lesser of the copayment or the cost of the drug. The plan must also indicate its Out-of-Network cost sharing structure.

The plan may choose to apply different cost sharing for drugs until the ICL is reached. The plan may select the Medicare-defined Part D coinsurance amount or the plan may indicate cost sharing for drug tiers. If the plan selects cost sharing, for each drug tier, the plan must enter the following:

- The Tier number (1-10) will be generated by the system, in sequential order
- Tier label must be entered
- Select the drug type(s) covered in this tier (Generic, Preferred Generic, Non-Preferred Generic, Brand, Preferred Brand, and/ or Non-Preferred Brand
- Specialty tier
- Select all the retail location/supply amount(s) that apply for this tier
- Enter number of days for each location/supply selected
- Do you have reference-based pricing for any drugs in this tier

- Indicate the type of cost sharing structure for this tier
- Select which location/supply amount(s) have a Coinsurance
- Select which location/supply amount(s) have a Copayment
- Indicate Coinsurance for the selected location/supply amount(s)
- Indicate Copayment for the selected location/supply amount(s)

The Actuarially Equivalent ICL and Annual Out-of-pocket Cost Threshold are Medicare-defined Part D amounts and may not be changed. However, a plan may choose to apply different cost sharing for drugs beyond the threshold. The plan may select the Medicare-defined Part D cost shares beyond the threshold, or the plan may indicate cost sharing for tiers of drugs and enter the required fields for each tier.

NOTE: If the plan defines their Part D benefit with cost share tiers, then the basic attributes for each tier must be the same across the benefit (i.e. pre-ICL, in the Gap, and post-out of pocket). These tier attributes include: Tier Label, Tier drug types, and Specialty tier.
NOTE: The locations selected on the Tier Locations Screen or the General Location/Supply Screen must agree with the locations selected for the components of the pharmacy network on the Medicare Rx General Screen.

Basic Alternative Benefit

For the Basic Alternative benefit, a plan may charge the Part D deductible or specify another amount. If the plan has a deductible, then the plan must indicate if the deductible applies to all drug types or excludes Generic drugs. If the deductible does not apply to Generic drugs, then the plan must indicate the type of cost sharing structure it has for Generic drugs until the deductible is reached. The plan must also indicate if it charges the lesser of the copayment or the cost of the drug. The plan must also indicate its Out-of-Network cost sharing structure.

A plan may choose to apply different cost sharing for drugs up until the ICL is reached. The plan may select the Medicare-defined Part D coinsurance amount or the plan may indicate cost sharing for drug tiers. If the plan selects cost sharing, for each drug tier, the plan must enter the following:

- The Tier number (1-10) will be generated by the system, in sequential order
- Tier label must be entered
- Select the drug type(s) covered in this tier (Generic, Preferred Generic, Non-Preferred Generic, Brand, Preferred Brand, and/ or Non-Preferred Brand
- Specialty tier
- Select all the retail location/supply amount(s) that apply for this tier
- Enter number of days for each location/supply selected
- Do you have reference-based pricing for any drugs in this tier
- Indicate the type of cost sharing structure for this tier
- Select which location/supply amount(s) have a Coinsurance
- Select which location/supply amount(s) have a Copayment

- Indicate Coinsurance for the selected location/supply amount(s)
- Indicate Copayment for the selected location/supply amount(s)

Under the Basic Alternative, a plan may use the pre-defined ICL or specify a plan-designated ICL amount. The annual out-of-pocket cost threshold amount is a Medicare-defined Part D amount, so no data entry is required.

A plan may choose to apply different cost sharing for drugs beyond the threshold. The plan may select the Medicare-defined Post Threshold cost shares, no cost sharing, or the plan may indicate cost sharing for tiers and enter the required fields for each tier.

NOTE: Fixed Capitated Demo plans should indicate the cost sharing that applies after the Medicare-defined total drug spending amount.

NOTE: If the plan defines their Part D benefit with cost share tiers, then the basic attributes for each tier must be the same across the benefit (i.e. pre-ICL, in the Gap, and post-out of pocket). These tier attributes include: Tier Label, Tier drug types, and Specialty tier.

NOTE: The locations selected on the Tier Locations Screen or the General Location/Supply Screen must agree with the locations selected for the components of the pharmacy network on the Medicare Rx General Screen.

Enhanced Alternative Benefit

For the Enhanced Alternative benefit, a plan may charge the Medicare-defined Part D deductible, no deductible, or specify a plan-designated deductible amount that is less than the Medicare-defined Part D deductible. If the plan has a deductible, then the plan must indicate if the deductible applies to all drug types or excludes Generic drugs. If the deductible does not apply to Generic drugs, then the plan must indicate the type of cost sharing structure it has for Generic drugs until the deductible is reached. The plan must also indicate if it charges the lesser of the copayment or the cost of the drug. The plan must also indicate its Out-of-Network cost sharing structure.

For the Enhanced Alternative benefit, the plan must indicate if any excluded drugs are part of the supplemental coverage. If the plan covers excluded drugs, it must indicate if it has a maximum plan benefit coverage amount for these drugs, and enter the amount.

The Plan must also indicate if it offers reduced cost sharing as part of the supplemental coverage, and indicate the types of cost sharing reductions provided.

A plan may choose to apply different cost sharing for drugs up until the ICL is reached. The plan may select the Medicare-defined Part D coinsurance amount, no cost sharing, or the plan may indicate cost sharing for tiers. If the plan selects cost sharing, for each drug tier, the plan must enter the following:

- The Tier number (1-10) will be generated by the system, in sequential order
- Tier label must be entered
- Select the drug type(s) covered in this tier (Generic, Preferred Generic, Non-Preferred Generic, Brand, Preferred Brand, and/ or Non-Preferred Brand
- Specialty tier
- Select all the retail location/supply amount(s) that apply for this tier
- Enter number of days for each location/supply selected
- Do you have reference-based pricing for any drugs in this tier
- Indicate the type of cost sharing structure for this tier
- Select which location/supply amount(s) have a Coinsurance
- Select which location/supply amount(s) have a Copayment
- Indicate Coinsurance for the selected location/supply amount(s)
- Indicate Copayment for the selected location/supply amount(s)

If the plan selects cost sharing, then for each drug tier, the plan must select from a list or enter text for a label to describe the tier, specify what type of drugs (Generic, Preferred Brand, and/ or Brand) are included in the tier, the location(s) were these drugs can be obtained, and the different supply amounts that may be obtained at each location. For each location and supply amount indicated, the plan must then enter the cost share amount (coinsurance and/or copayment).

NOTE: If the plan defines their Part D benefit with cost share tiers, then the basic attributes for each tier must be the same across the benefit (i.e. pre-ICL, in the Gap, and post-out of pocket). These tier attributes include: Tier Label, Tier drug types, and Specialty tier. For the Enhanced benefit coverage type, the tier attributes also include the drugs included in the tier (Part D drugs, Excluded drugs, Combination).

NOTE: The locations selected on the Tier Locations Screen or the General Location/Supply Screen must agree with the locations selected for the components of the pharmacy network on the Medicare Rx General Screen.

Example of PBP data entry for an Enhanced Alternative benefit

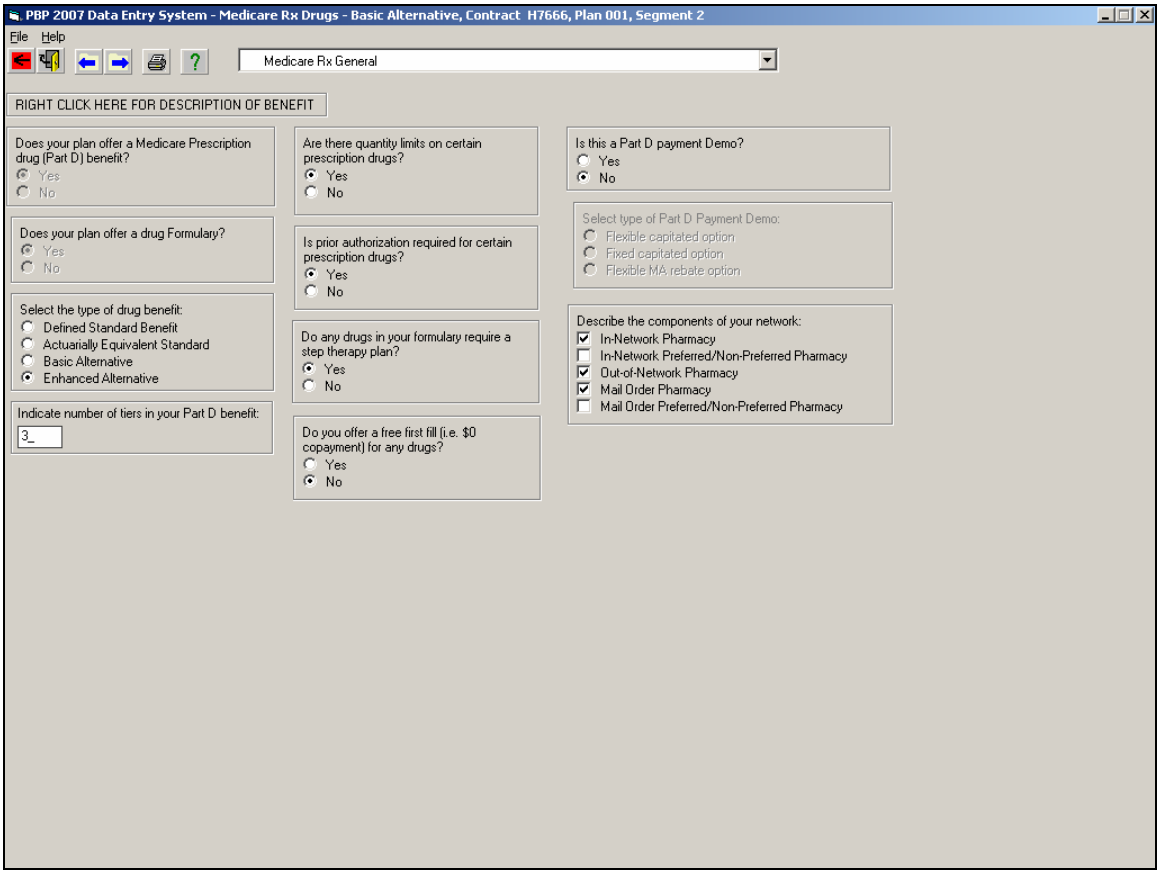
NOTE: This example was created for demonstration purposes ONLY; this example is NOT intended to suggest a CMS approved benefit package.

- Plan's drug benefit has 3 tiers
- There are quantity limits on certain prescription drugs
- Prior Authorization is required for certain prescription drugs
- There is a Step Therapy plan
- Drugs are available at In-Network, Out-of-Network, and Mail Order Pharmacies (this plan does not distinguish between Preferred and Non-Preferred Pharmacies)
- Deductible = $100 (does not apply to Generic drugs; Generics have a $3 copay)
- The plan charges the lesser of the cost or the copay for the drug

- As part of the plan's supplemental coverage, it offers excluded drugs, up to $500 of coverage
- 3 Tiers of cost sharing before ICL is reached:
    - Generic is available at In-Network, Out-of-Network, and Mail Order Pharmacies
        - In-Network Pharmacy has 34 day supply for $5 copay, and a 90 day supply for $15 copay
        - Out-of-Network Pharmacy has 34 day supply for $7.50 copay
        - Mail Order has 90 day supply for $10 copay
    - Brand is available at In-Network, Out-of-Network, and Mail Order Pharmacies
        - In-Network Pharmacy has 34 day supply for $10 copay, a 90 day supply for $20 copay, and a 60 day supply for $15 copay
        - Out-of-Network Pharmacy has 34 day supply for $20 copay
        - Mail Order has 90 day supply for $12.50 copay
    - Specialty Generic & Brand drugs (this tier includes excluded drugs only) are available at In-Network and Out-of-Network Pharmacies
        - In-Network Pharmacy has a 10 day supply at a cost of the greater of 20% coinsurance or $30 copay
        - Out-of-Network Pharmacy has a 10 day supply at a cost of the greater of 35% coinsurance or $50 copay
- The plan uses the Medicare-defined ICL
- The plan also covers some drugs in the gap
    - Generic drugs are covered in the gap at In-Network and Out-of-Network Pharmacies
        - In-Network Pharmacy has 34 day supply for $5 copay
        - Out-of-Network Pharmacy has 34 day supply for $7.50 copay
    - No other coverage in the gap
- Above the OOP Threshold, the plan charges the Medicare-defined cost share amounts

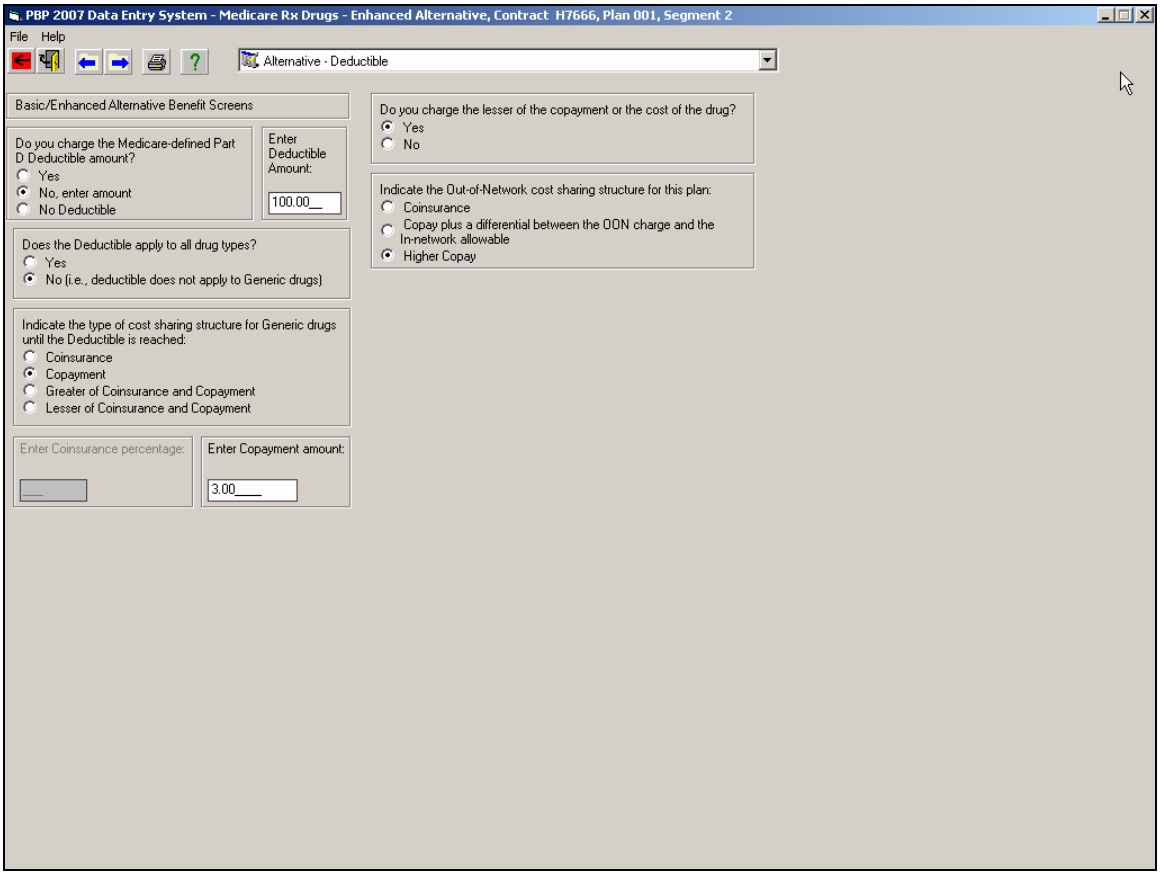
MEDICARE Rx GENERAL SCREEN

1. The Part D benefit offered and Formulary Yes/No questions are downloaded from HPMS
2. For type of drug benefit, select 'Enhanced Alternative'
3. Enter '3' for number of tiers in your Part D benefit
4. Select "Yes' for quantity limits on prescription drugs
5. Select 'Yes' for prior authorization
6. Select 'Yes' for Step Therapy plan
7. Select 'No' for free first fill
8. Select 'No' for Part D Payment Demo
9. Select network components 'In-Network Pharmacy', 'Out-of-Network Pharmacy' and 'Mail Order Pharmacy'



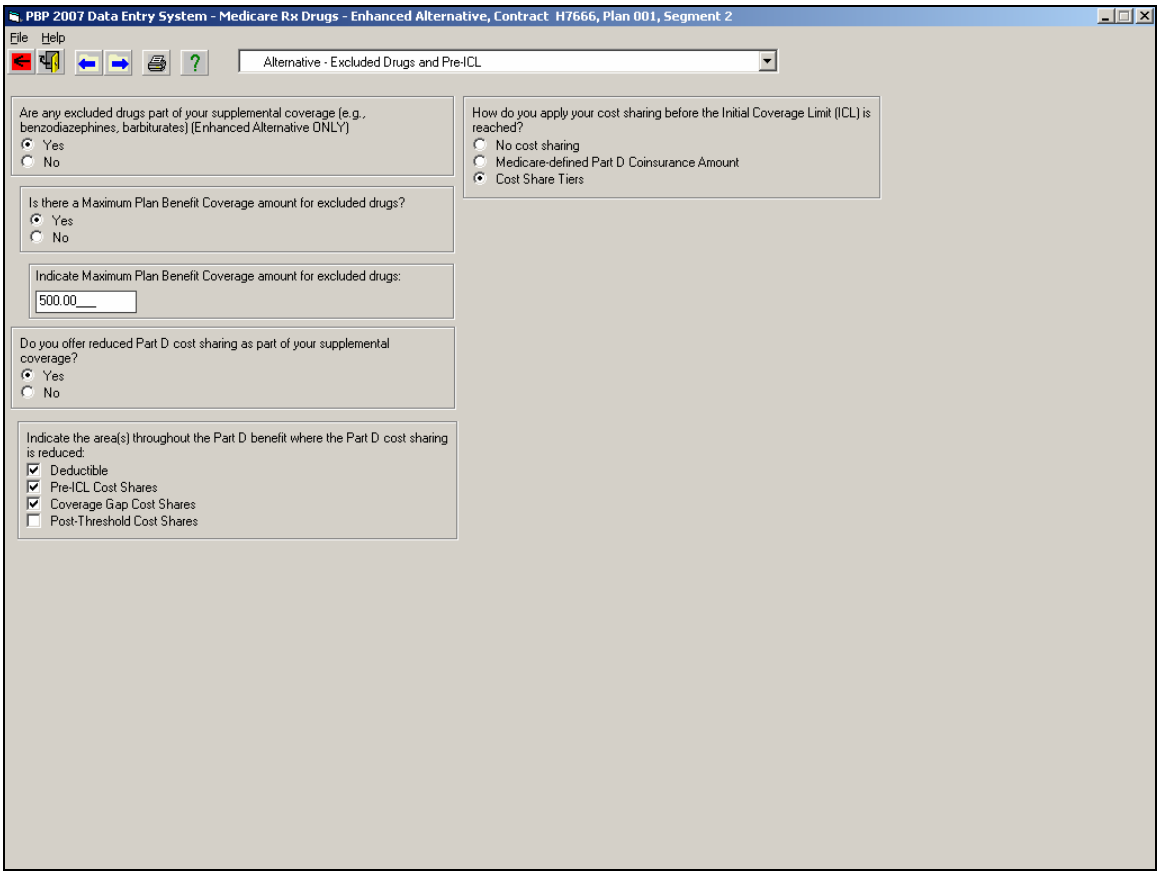
ENHANCED ALTERNATIVE – DEDUCTIBLE SCREEN

1. Since the plan does not use the Medicare-defined Deductible amount, select 'No, enter amount' for Deductible, and enter 100 to indicate your plan charges a $100 deductible.
2. Select 'No, deductible does not apply to Generic drugs'.
3. Select 'Copayment' cost share and enter '3' (there is a $3 copayment on Generic drugs until the deductible is reached).
4. Select 'Yes' to the plan charges the lesser of the copayment or the cost of the drug.
5. The Out-of-Network cost share structure for this plan is a higher copay amount.



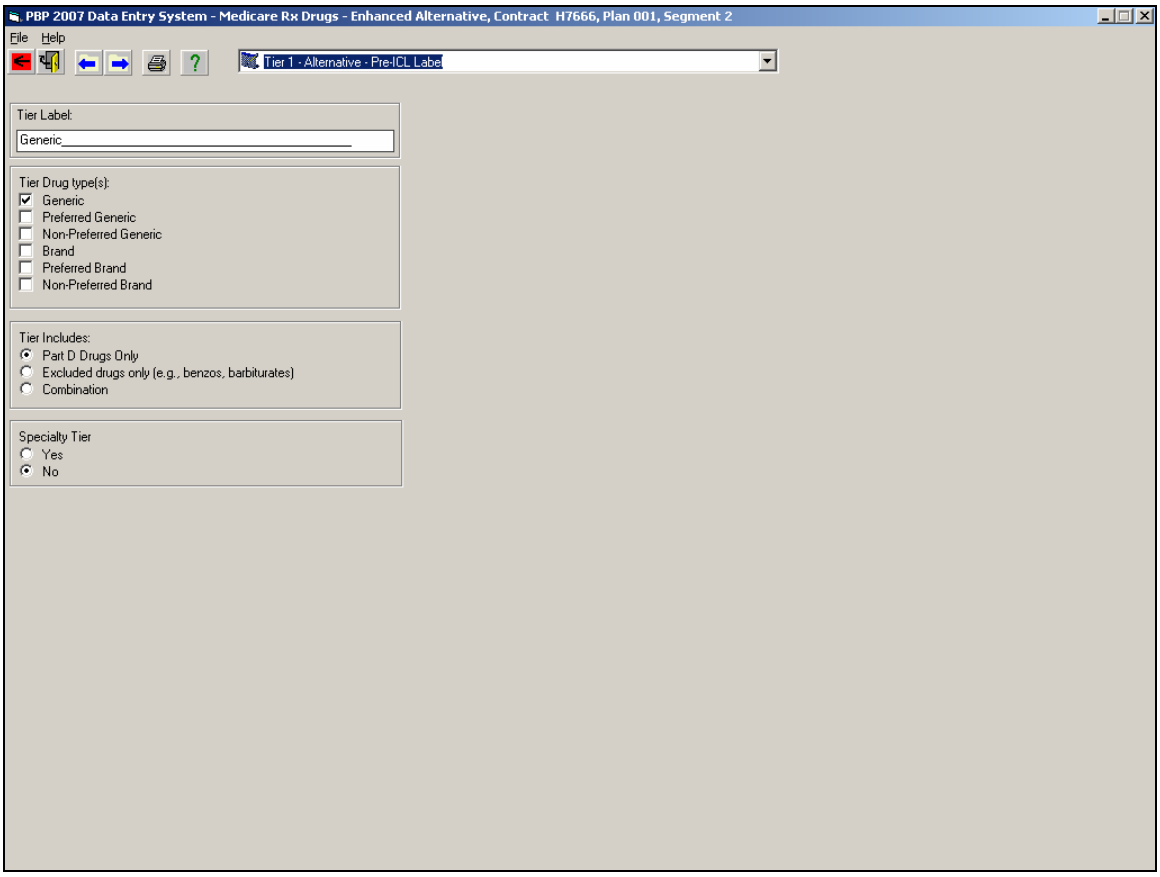
ENHANCED ALTERNATIVE – EXCLUDED DRUGS AND PRE-ICL SCREEN

1. Select 'Yes' this plan has excluded drugs as part of the supplemental coverage.
2. There is a $500 limit on the excluded drug coverage.
3. As part of the plan's supplemental coverage, it is reducing the deductible and the pre-ICL cost shares (from the Medicare-defined amount), and providing some drug coverage in the gap.
4. Select Cost Share Tiers are applied before the ICL.



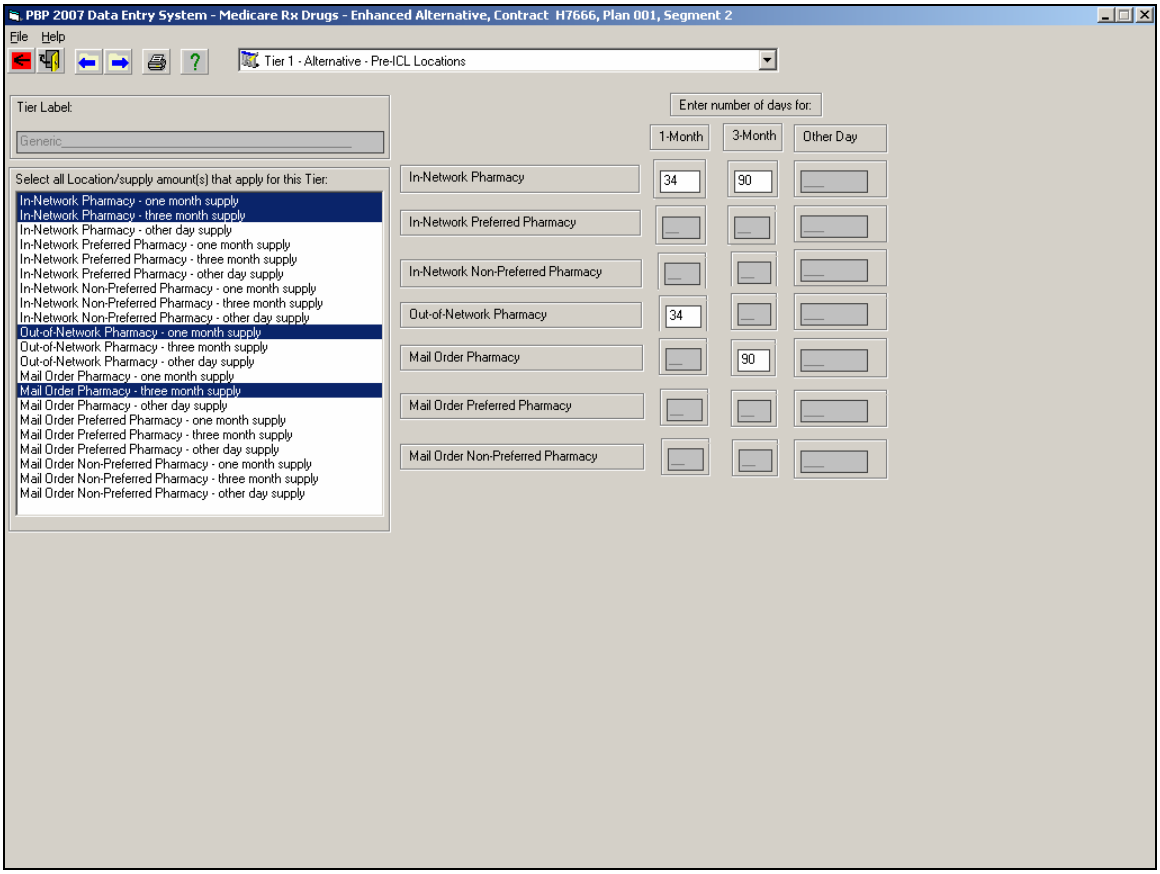
ENHANCED ALTERNATIVE – TIER 1 - ALTERNATIVE PRE-ICL LABEL SCREEN

1. Tier 1 includes Generic (Part D covered) drugs only, so enter ‘Generic’ as the Tier label. Note: The Tier label will appear in the SB sentences.
2. Select Generic as the drug type(s) covered.
3. Select ‘No’ for specialty tier.



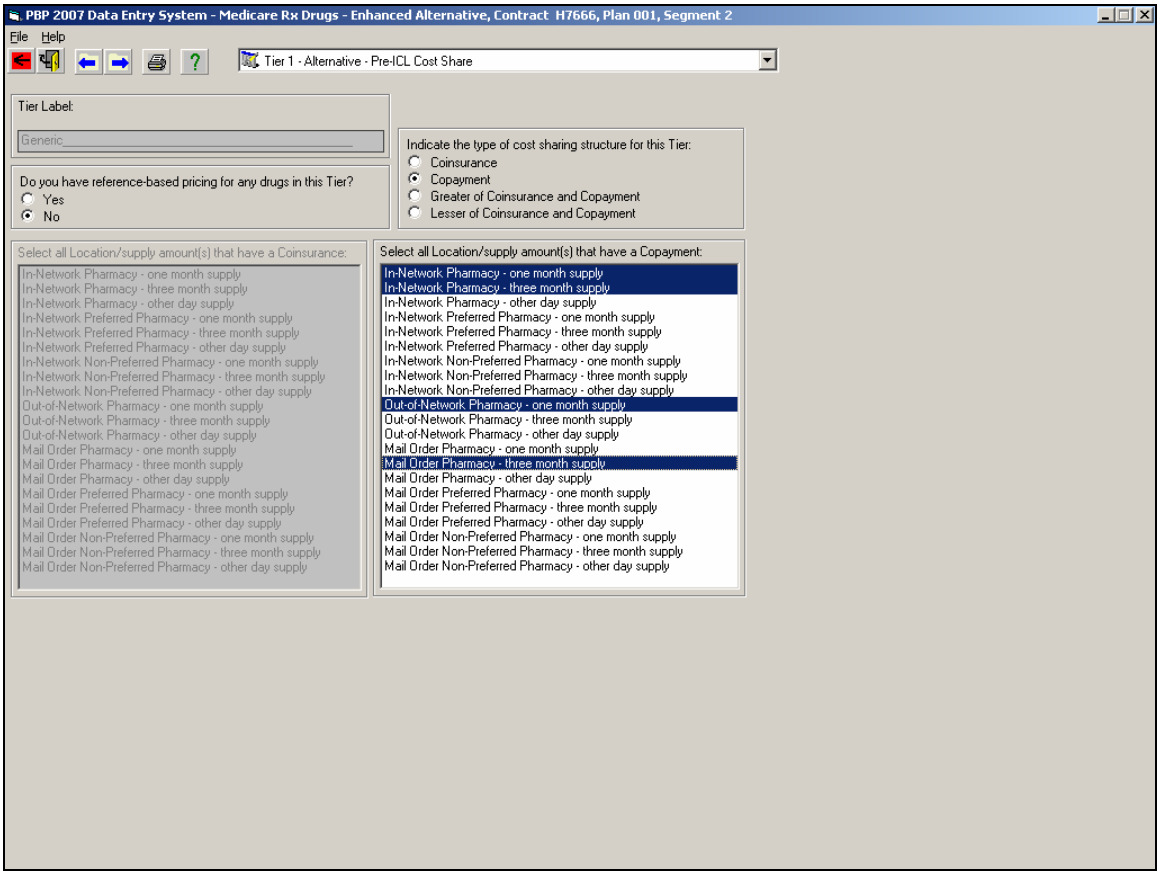
ENHANCED ALTERNATIVE – TIER 1 – ALTERNATIVE PRE-ICL LOCATIONS SCREEN

1. For Locations/supply amounts that apply for this tier, select 'In-Network Pharmacy – one month supply', 'In-Network Pharmacy – three month supply', 'Out-of-Network Pharmacy – one month supply', and 'Mail Order Pharmacy – three month supply'.
2. The relevant location/supply fields will be enabled; enter the number of days in the appropriate fields.



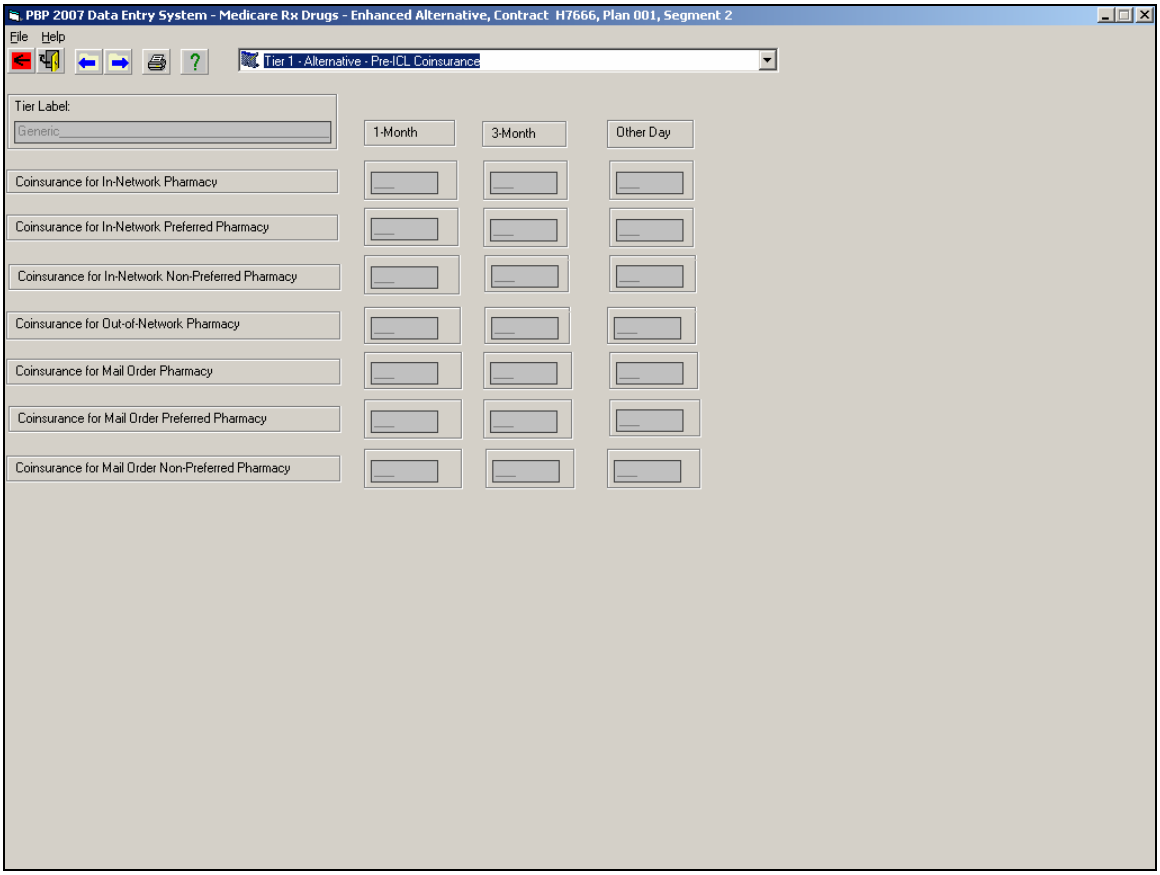
ENHANCED ALTERNATIVE – TIER 1 – ALTERNATIVE PRE-ICL COST SHARE SCREEN

1. Select 'No' for referenced –based pricing for this tier.
2. Select 'Copayment' for the type of cost sharing for this tier.
3. Select all the location/supply amounts that have a Copayment.



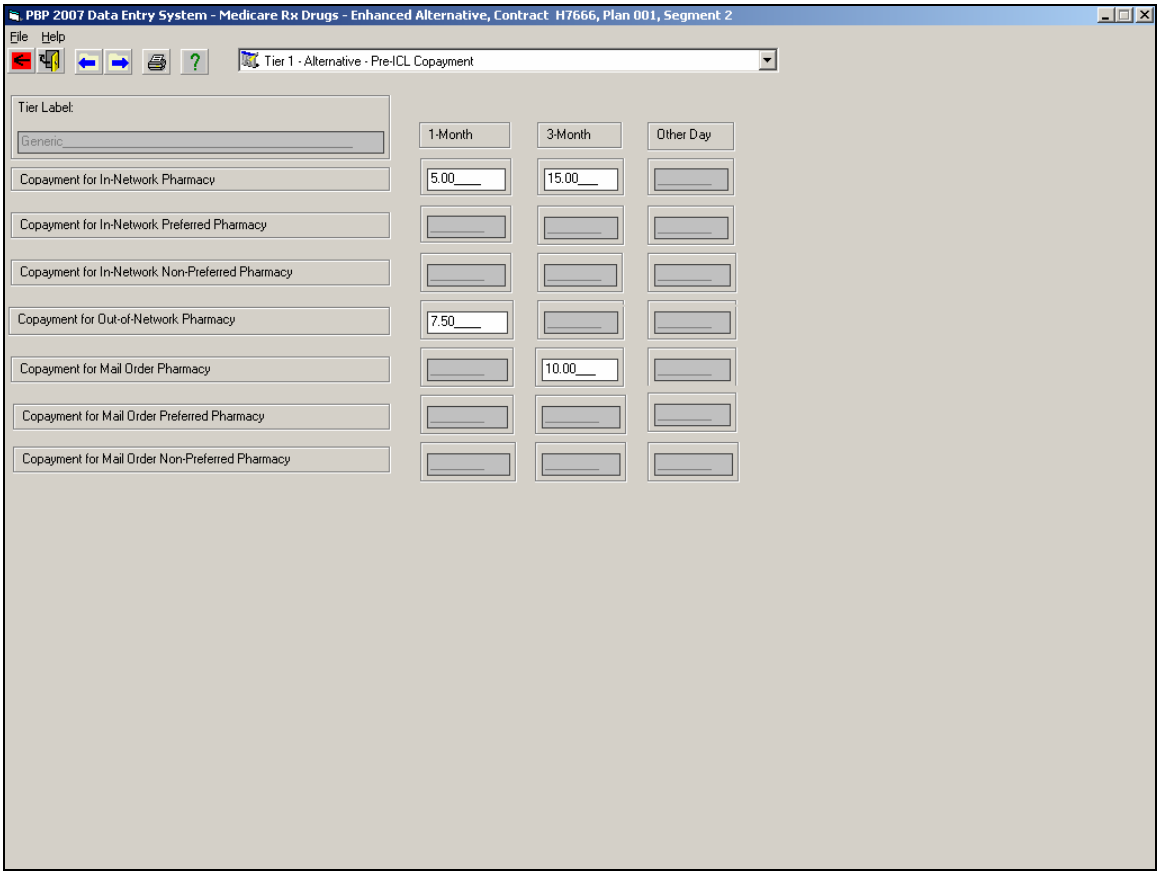
ENHANCED ALTERNATIVE – TIER 1 – ALTERNATIVE PRE-ICL COINSURANCE SCREEN

1. Since this tier does not have any coinsurance cost shares, this screen will not have any fields enabled.



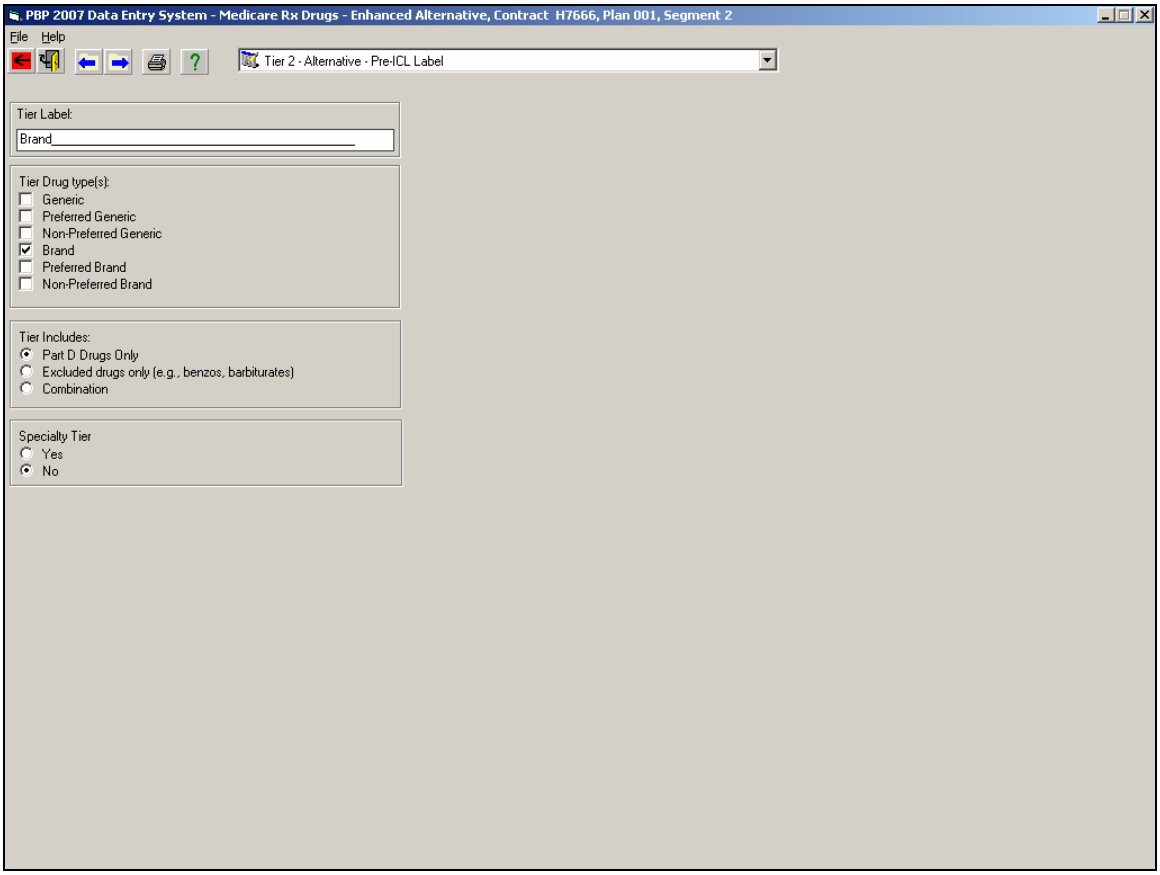
ENHANCED ALTERNATIVE – TIER 1 – ALTERNATIVE PRE-ICL COPAYMENT SCREEN

1. The copayment fields for the selected location/supply amounts will be enabled.
2. Enter the appropriate copayment amount into these fields.



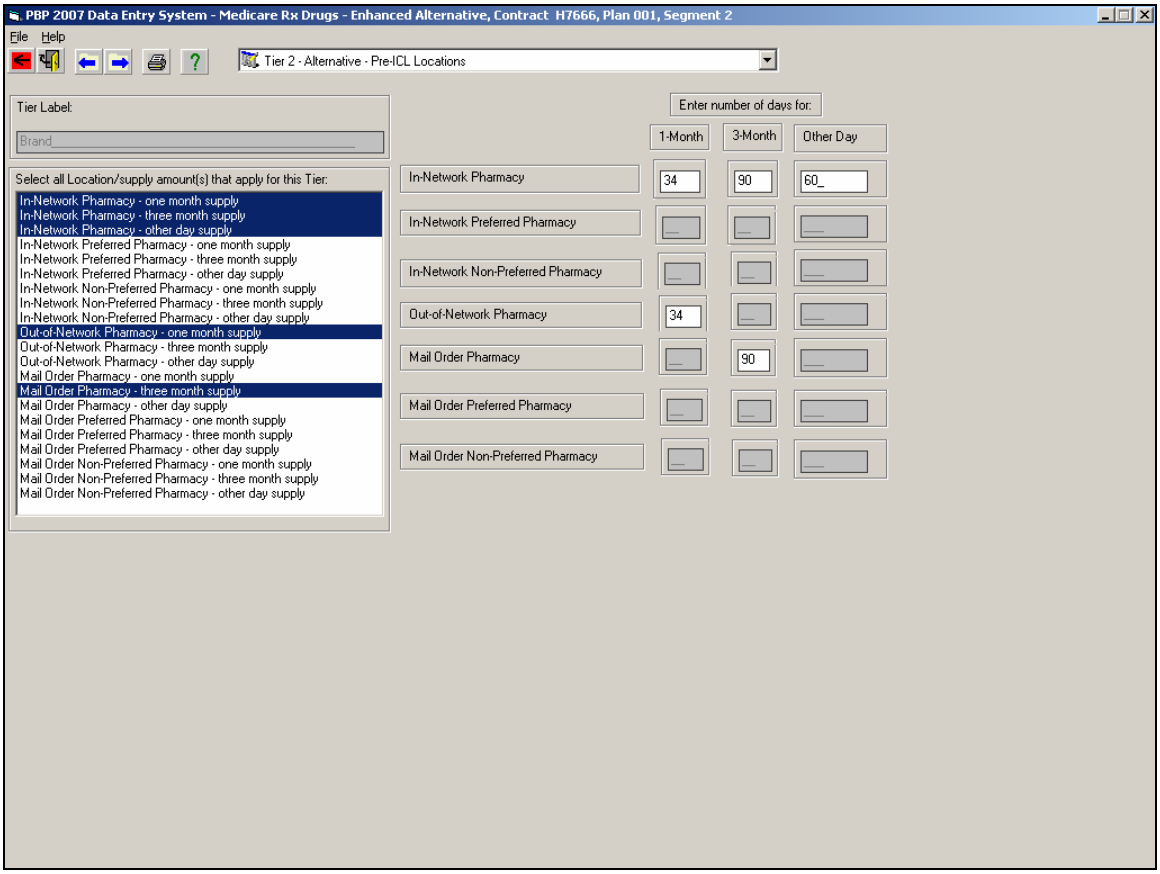
ENHANCED ALTERNATIVE – TIER 2 – ALTERNATIVE PRE-ICL LABEL SCREEN

1. Enter ‘Brand’ for the Tier Label.
2. Select Brand as the drug type.
3. Select ‘No’ for specialty tier.



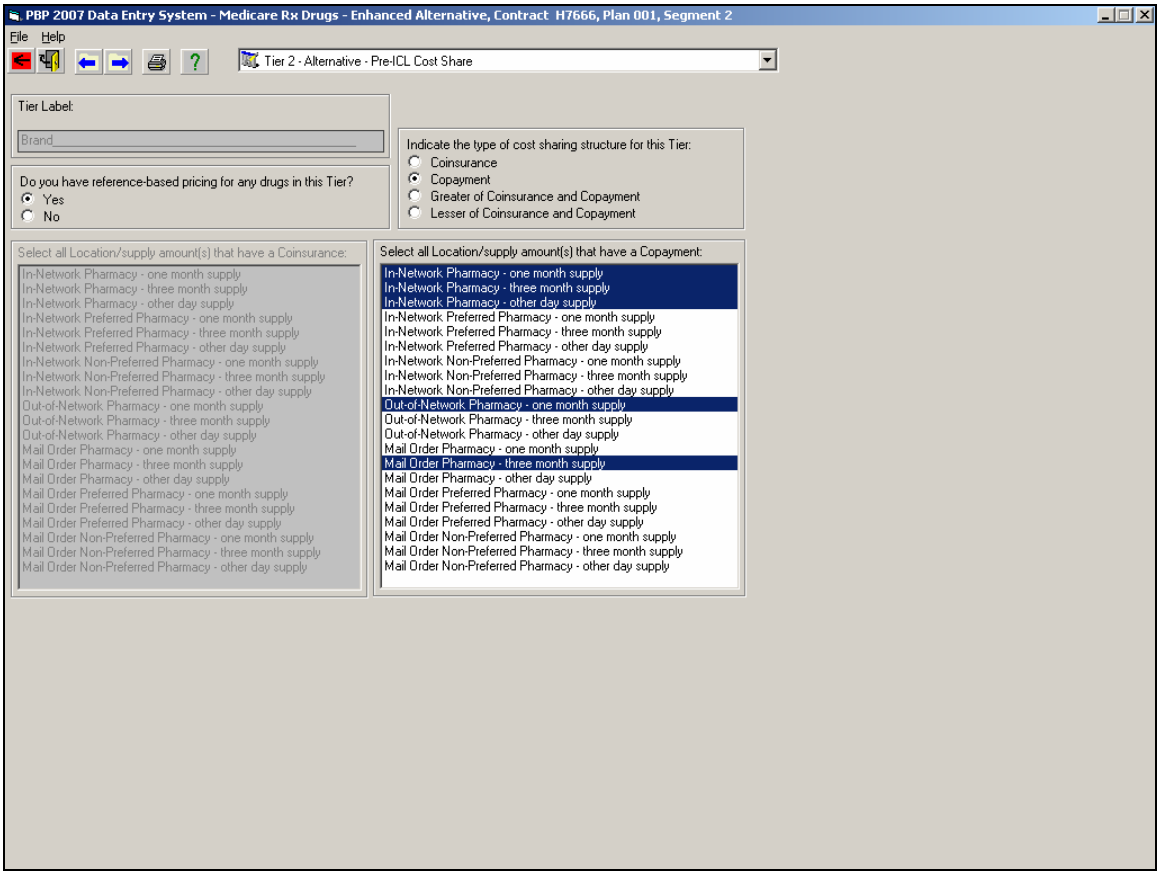
ENHANCED ALTERNATIVE – TIER 2 – ALTERNATIVE PRE-ICL LOCATIONS SCREEN

1. For Locations/supply amounts that apply for this tier, select ‘In-Network Pharmacy – one month supply’, ‘In-Network Pharmacy – three month supply’, ‘In-Network Pharmacy – other day supply’, ‘Out-of-Network Pharmacy – one month supply’, and ‘Mail Order Pharmacy – three month supply’.
2. The relevant location/supply fields will be enabled; enter the number of days in the appropriate fields.



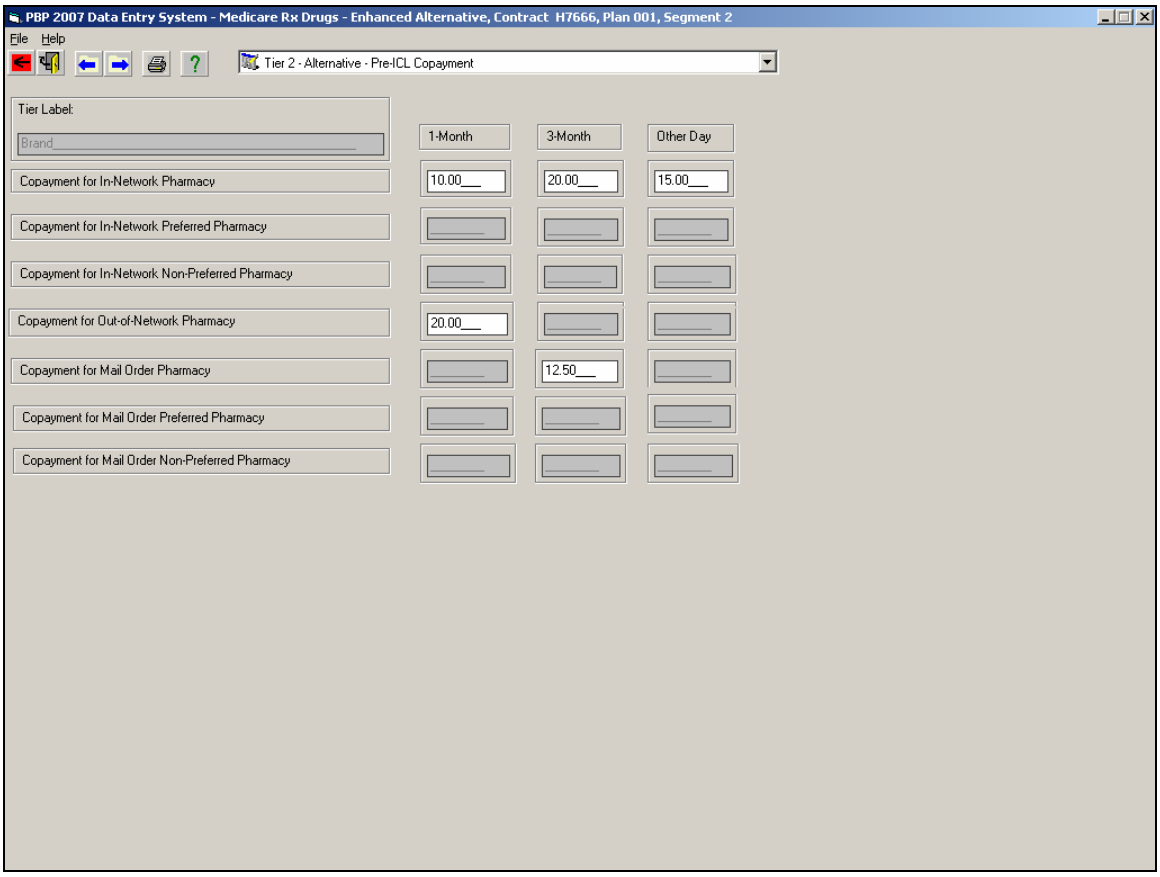
ENHANCED ALTERNATIVE – TIER 2 – ALTERNATIVE PRE-ICL COST SHARE SCREEN

1. Select 'Yes' for referenced –based pricing for this tier.
2. Select 'Copayment' for the type of cost sharing for this tier.
3. Select all the location/supply amounts that have a Copayment.



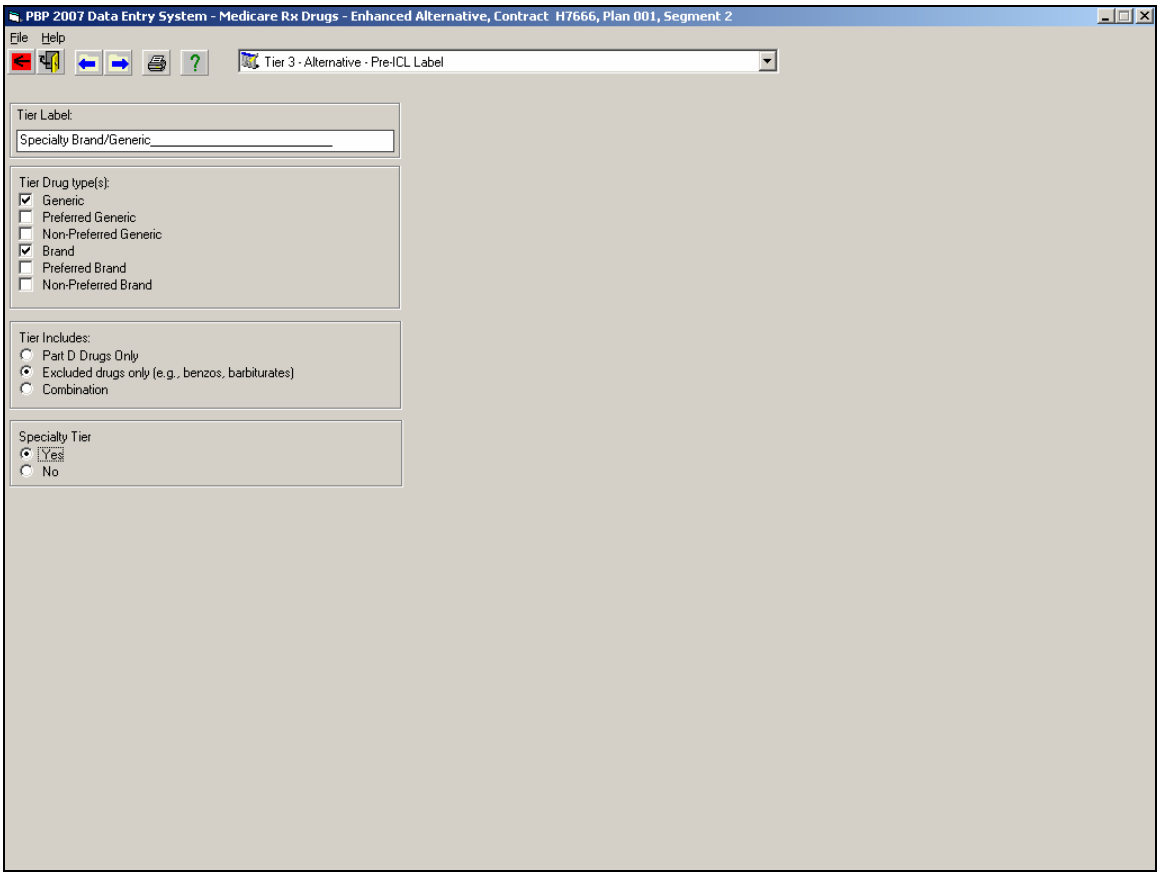
ENHANCED ALTERNATIVE – TIER 2 – ALTERNATIVE PRE-ICL COPAYMENT SCREEN

1. The copayment fields for the selected location/supply amounts will be enabled.
2. Enter the appropriate copayment amount into these fields.



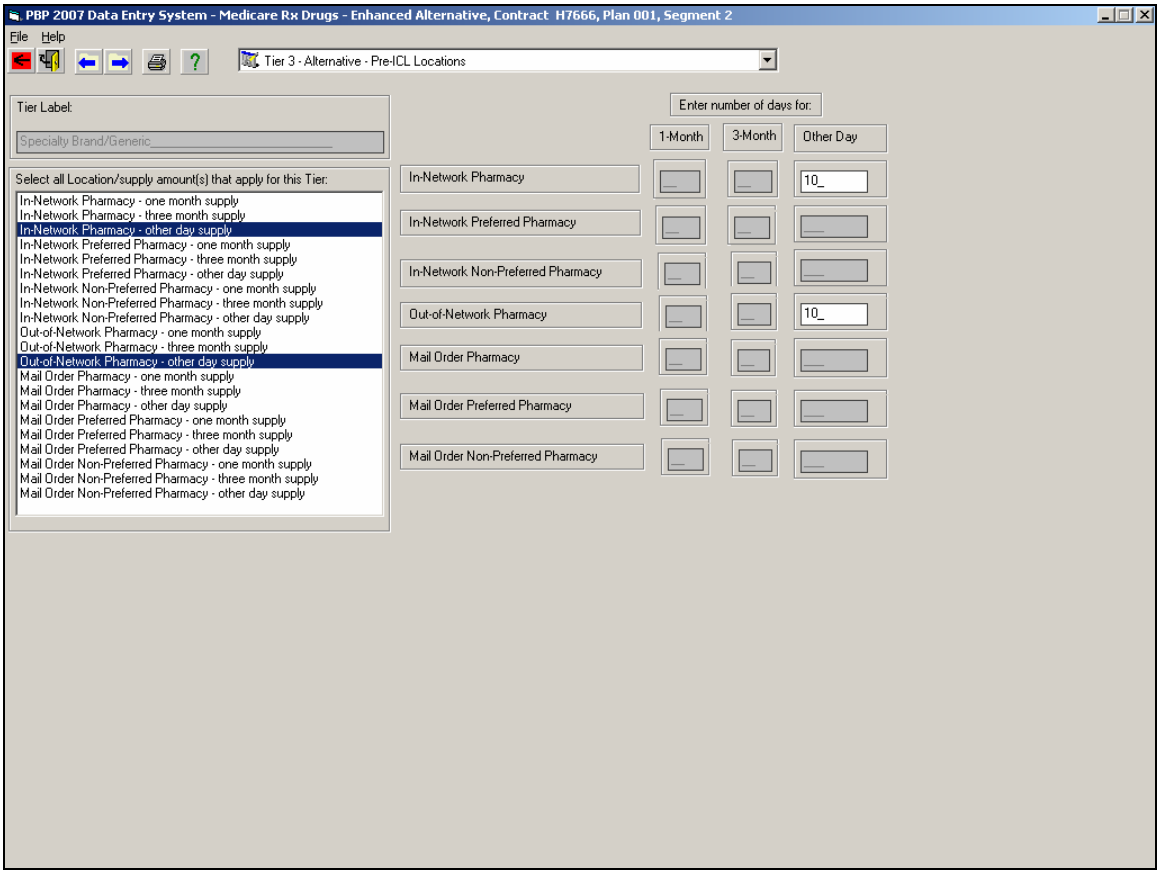
ENHANCED ALTERNATIVE – TIER 3 – ALTERNATIVE PRE-ICL LABEL SCREEN

1. Enter ‘Specialty Brand/Generic’ for the Tier Label.
2. Select Generic and Brand as the drug types (this tier includes excluded drugs only).
3. Select ‘Yes’ for specialty tier.



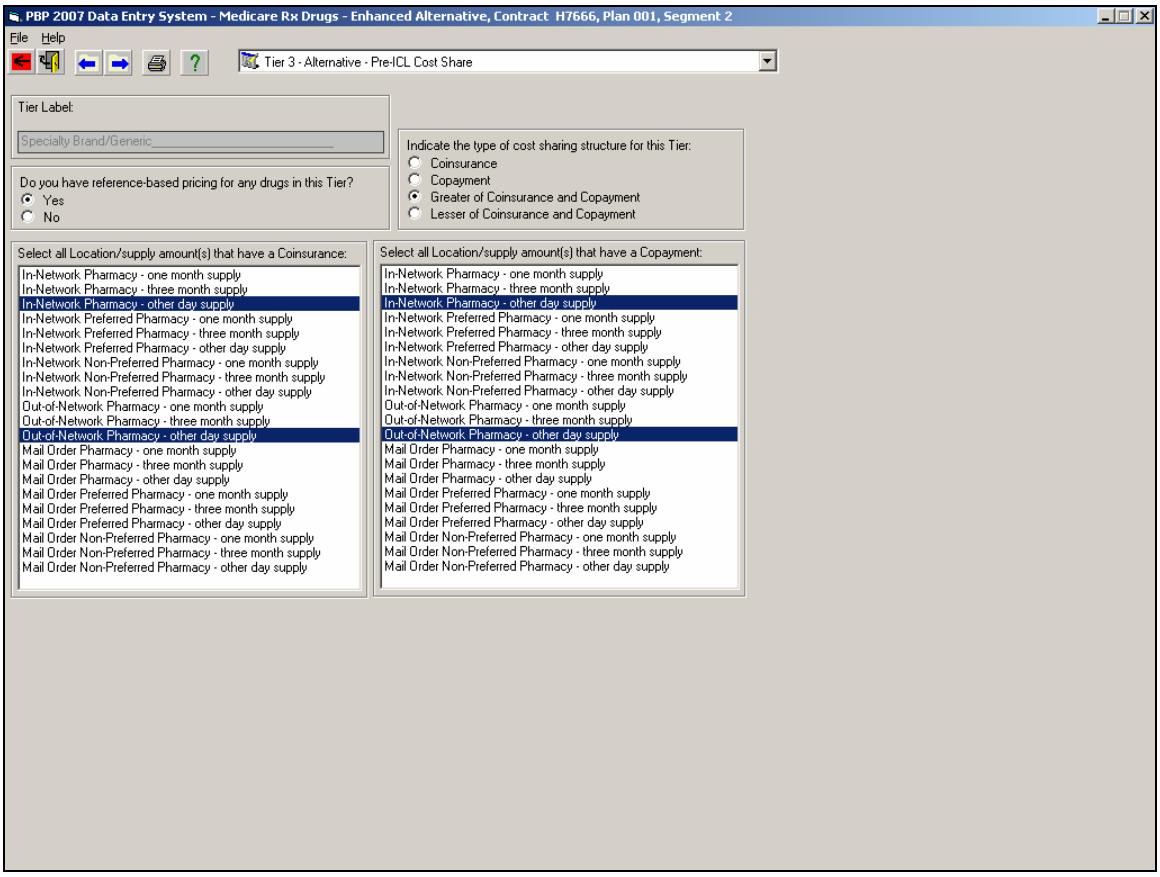
ENHANCED ALTERNATIVE – TIER 3 – ALTERNATIVE PRE-ICL LOCATIONS SCREEN

1. For Locations/supply amounts that apply for this tier, select 'In-Network Pharmacy – other day supply' and 'Out-of-Network Pharmacy – other day supply'.
2. The relevant location/supply fields will be enabled; enter the number of days in the appropriate fields.



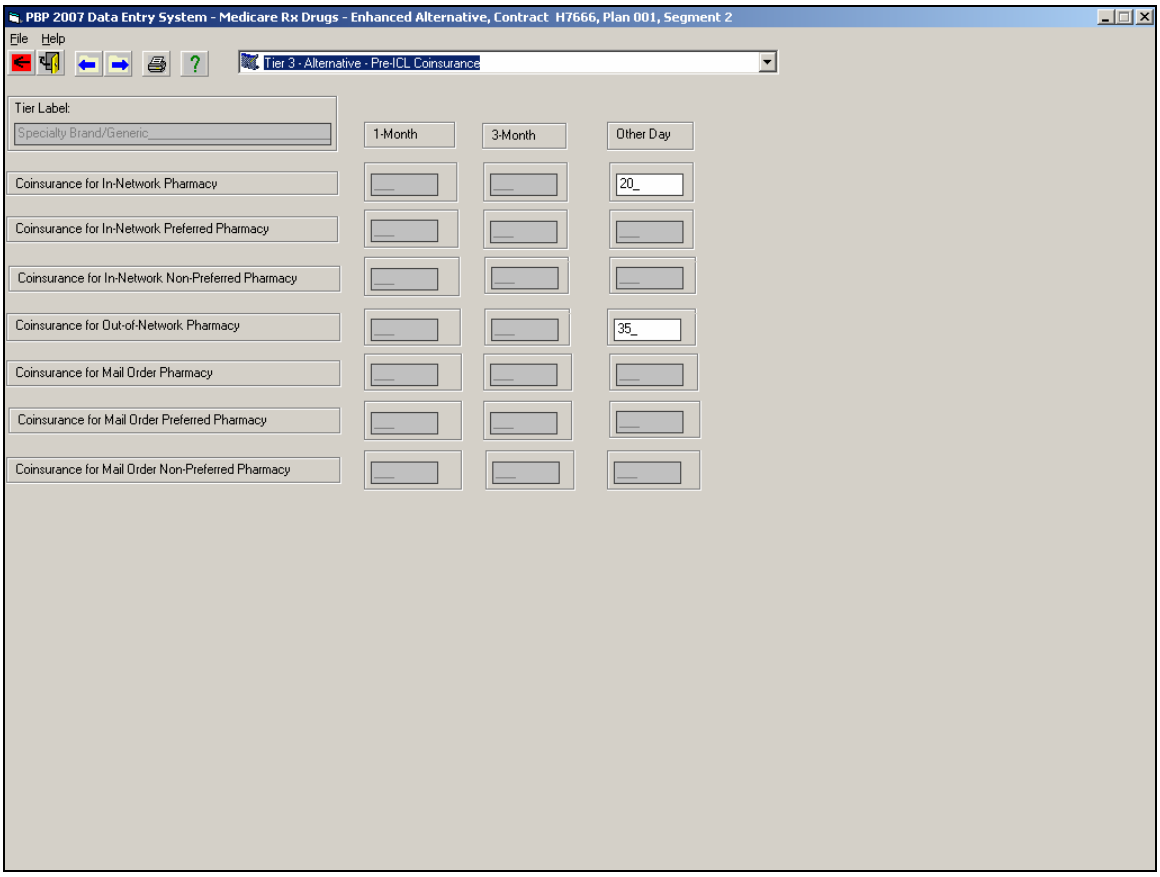
ENHANCED ALTERNATIVE – TIER 3 – ALTERNATIVE PRE-ICL COST SHARE SCREEN

1. Select 'Yes' for referenced –based pricing for this tier.
2. Select 'Greater of Coinsurance and Copayment' for the type of cost sharing for this tier.
3. Select all the location/supply amounts that have a Coinsurance and a Copayment.



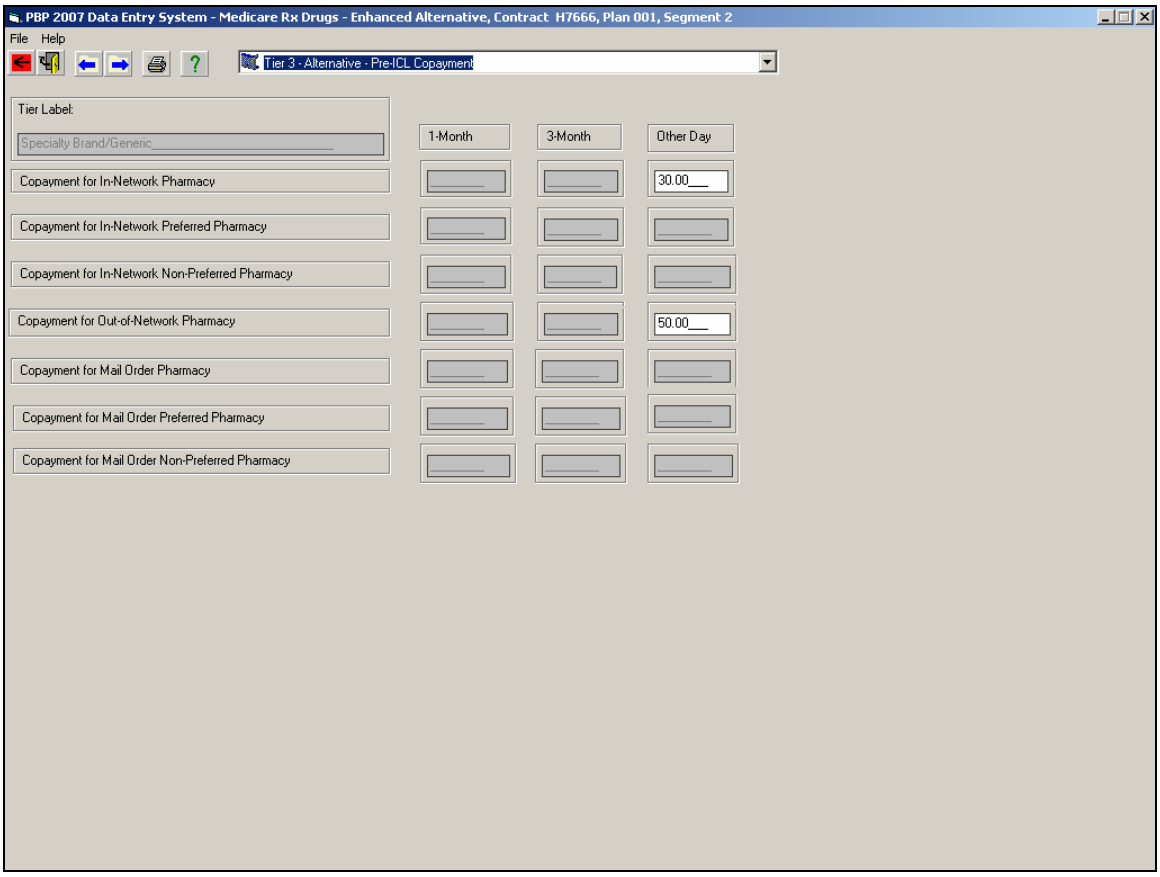
ENHANCED ALTERNATIVE – TIER 3 – ALTERNATIVE PRE-ICL COINSURANCE SCREEN

1. The coinsurance fields for the selected location/supply amounts will be enabled. Enter the appropriate coinsurance amount into these fields.



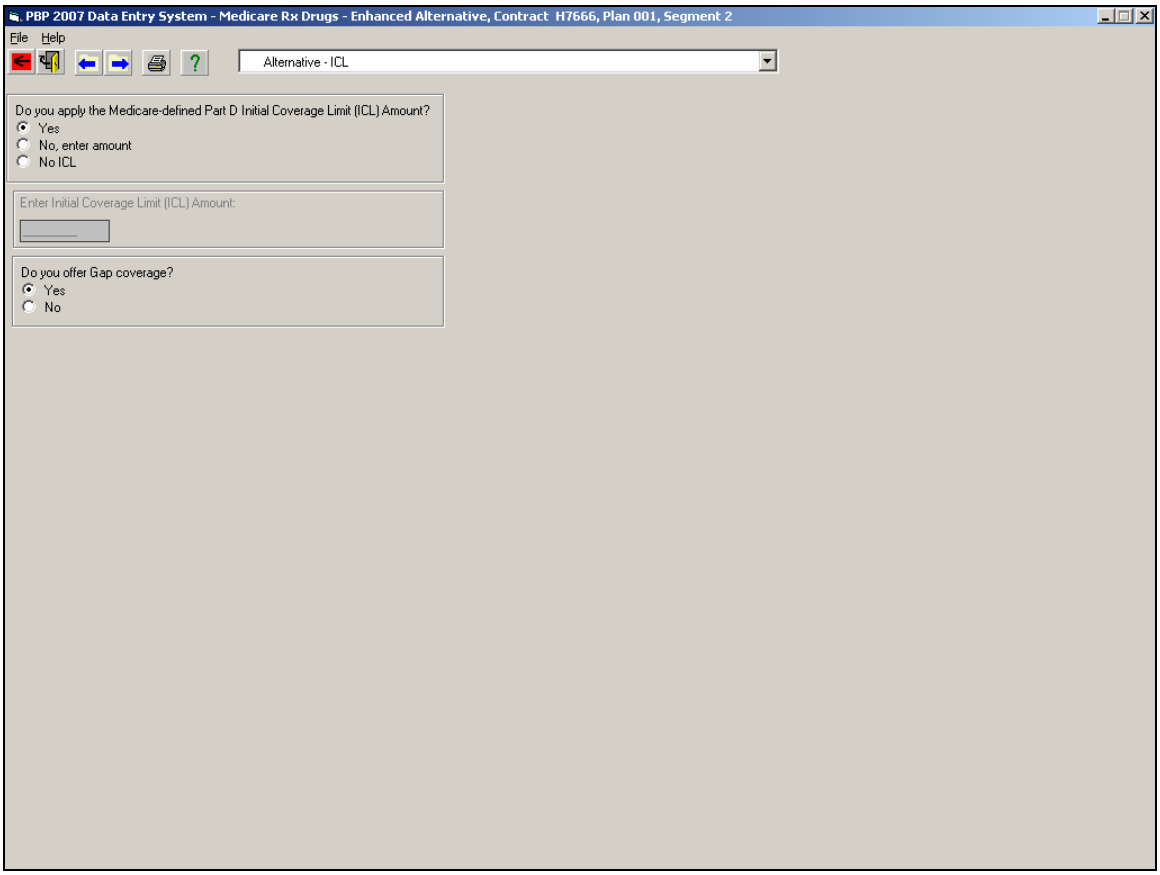
ENHANCED ALTERNATIVE – TIER 3 – ALTERNATIVE PRE-ICL COPAYMENT SCREEN

1. The copayment fields for the selected location/supply amounts will be enabled. Enter the appropriate copayment amount into these fields.



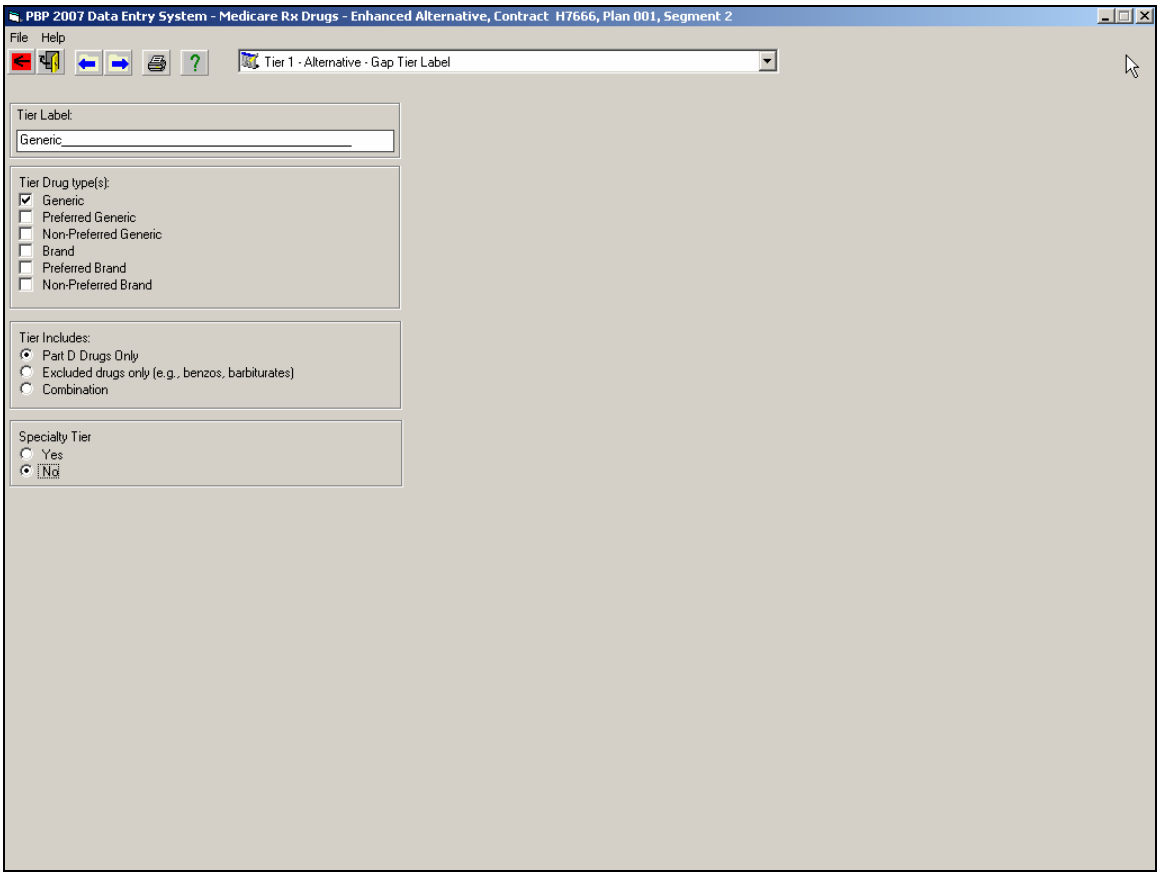
ENHANCED ALTERNATIVE –ICL SCREEN

1. Select ‘Yes’ that the plan applies the Medicare-defined ICL.
2. Select ‘Yes’ to indicate the plan offers Gap coverage.



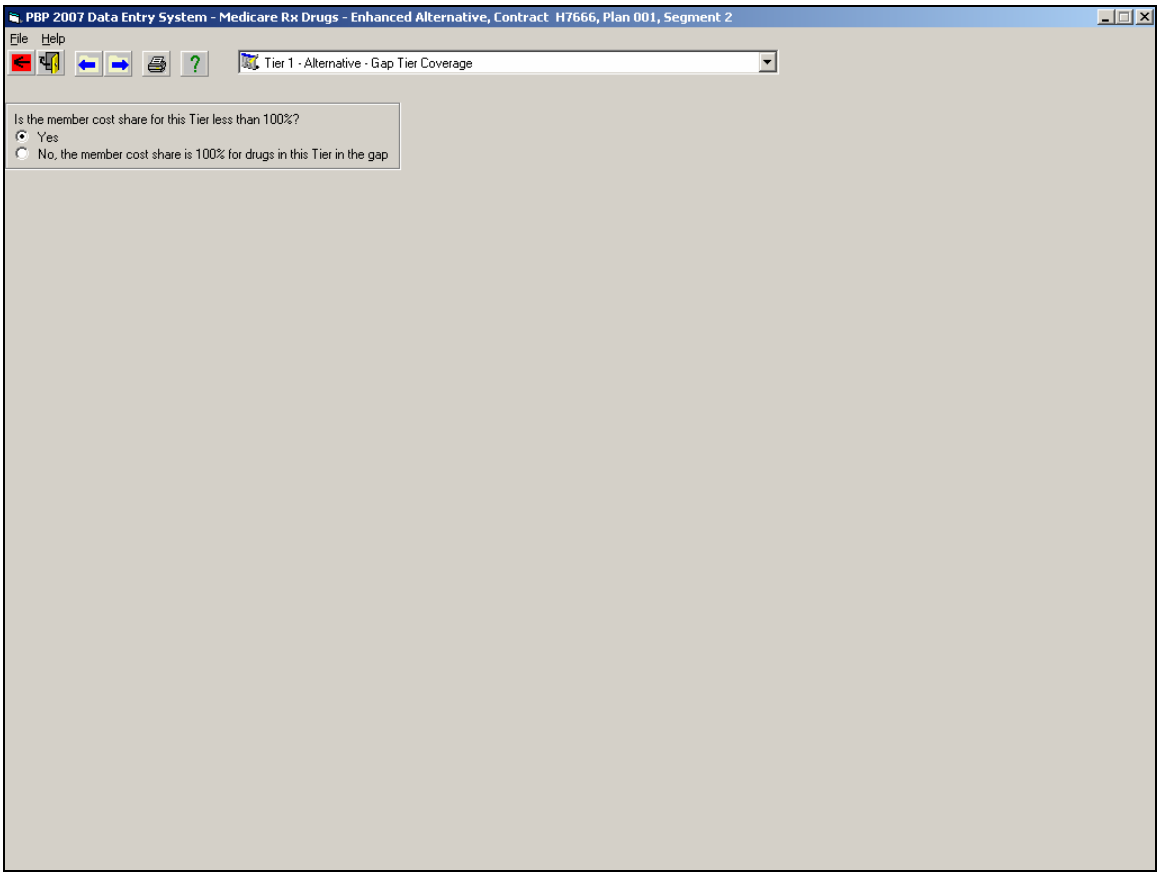
ENHANCED ALTERNATIVE – TIER 1 – ALTERNATIVE GAP TIER LABEL SCREEN

1. The Tier Label is Generic (must be consistent with pre-ICL).
2. The drug type is Generic (must be consistent with pre-ICL).
3. Tier includes Part D drugs only (must be consistent with pre-ICL).
4. The specialty tier indicator is 'No' (must be consistent with pre-ICL).



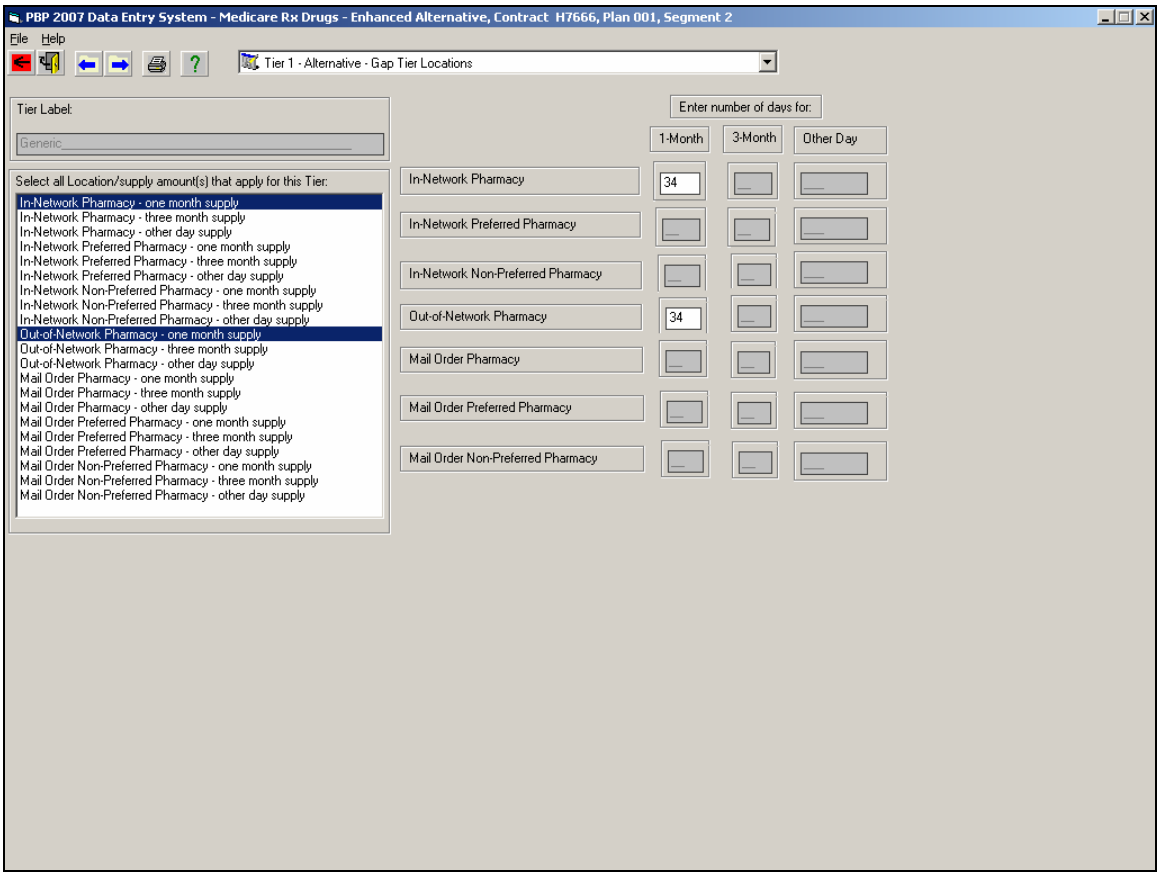
ENHANCED ALTERNATIVE – TIER 1 – ALTERNATIVE GAP TIER COVERAGE SCREEN

1. Indicate that these drugs are covered: select “Yes’ to indicate that the cost share for this tier is less than 100% in the gap.



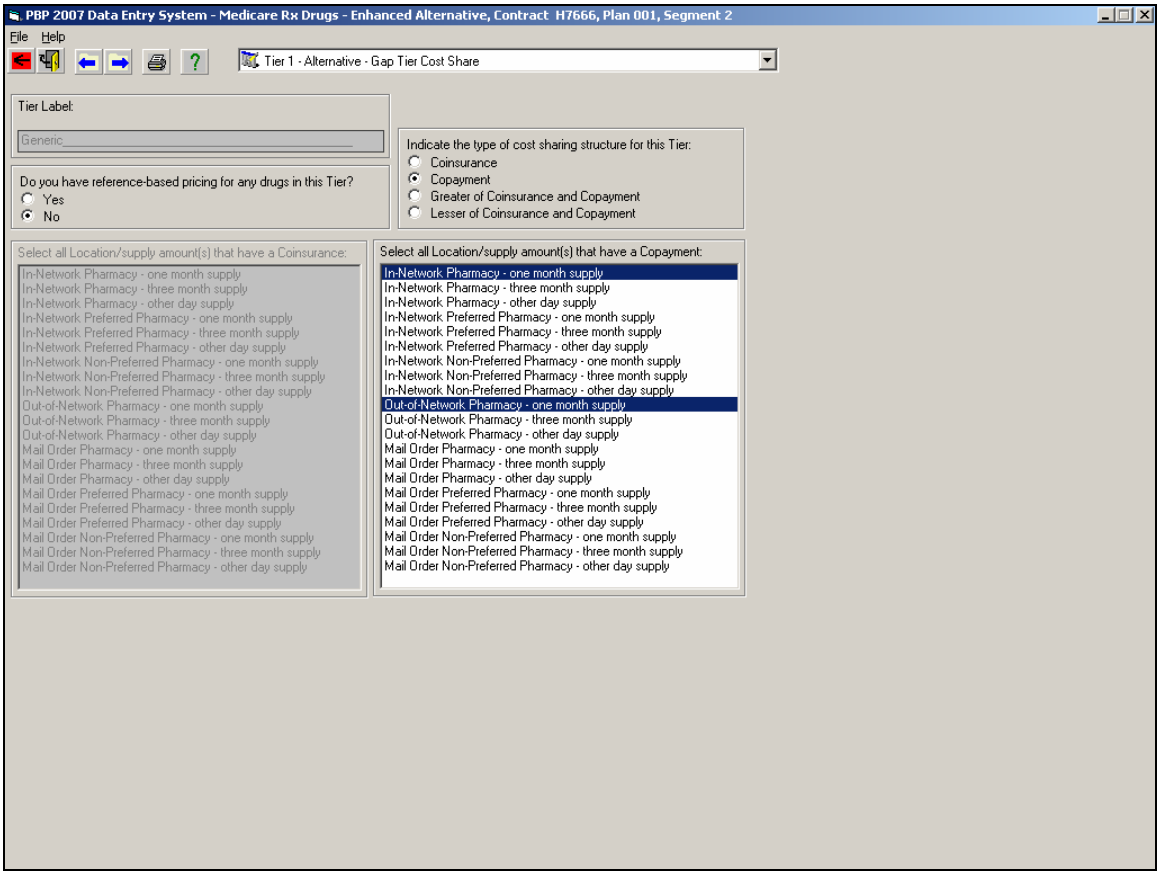
ENHANCED ALTERNATIVE – TIER 1 – ALTERNATIVE GAP TIER LOCATIONS SCREEN

1. Select the locations/supply amounts for these drugs covered in the Gap, and enter the corresponding number of days.



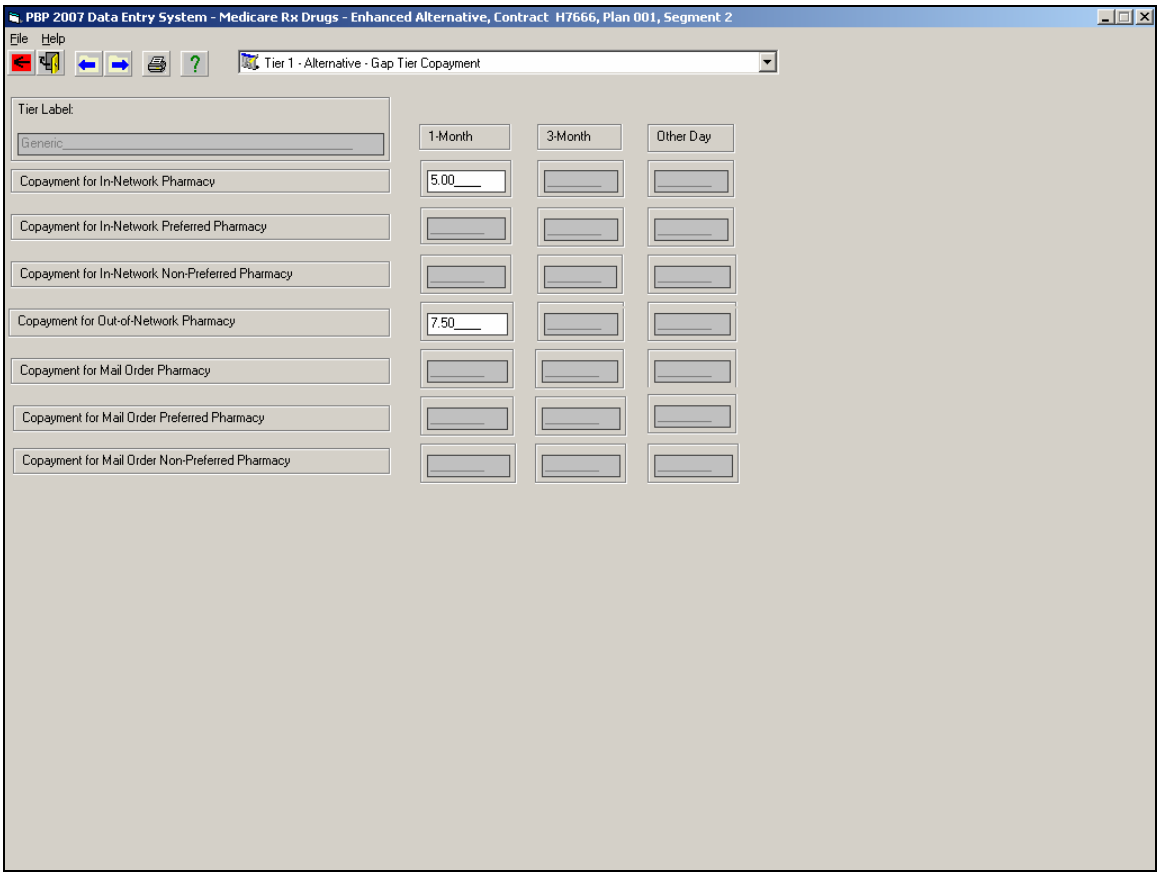
ENHANCED ALTERNATIVE – TIER 1 – ALTERNATIVE GAP TIER COST SHARE SCREEN

1. Select ‘No for reference-based pricing for drugs in this tier.
2. Select ‘Copayment’ for the cost sharing structure.
3. Select the location/supply amounts that have a Copayment.



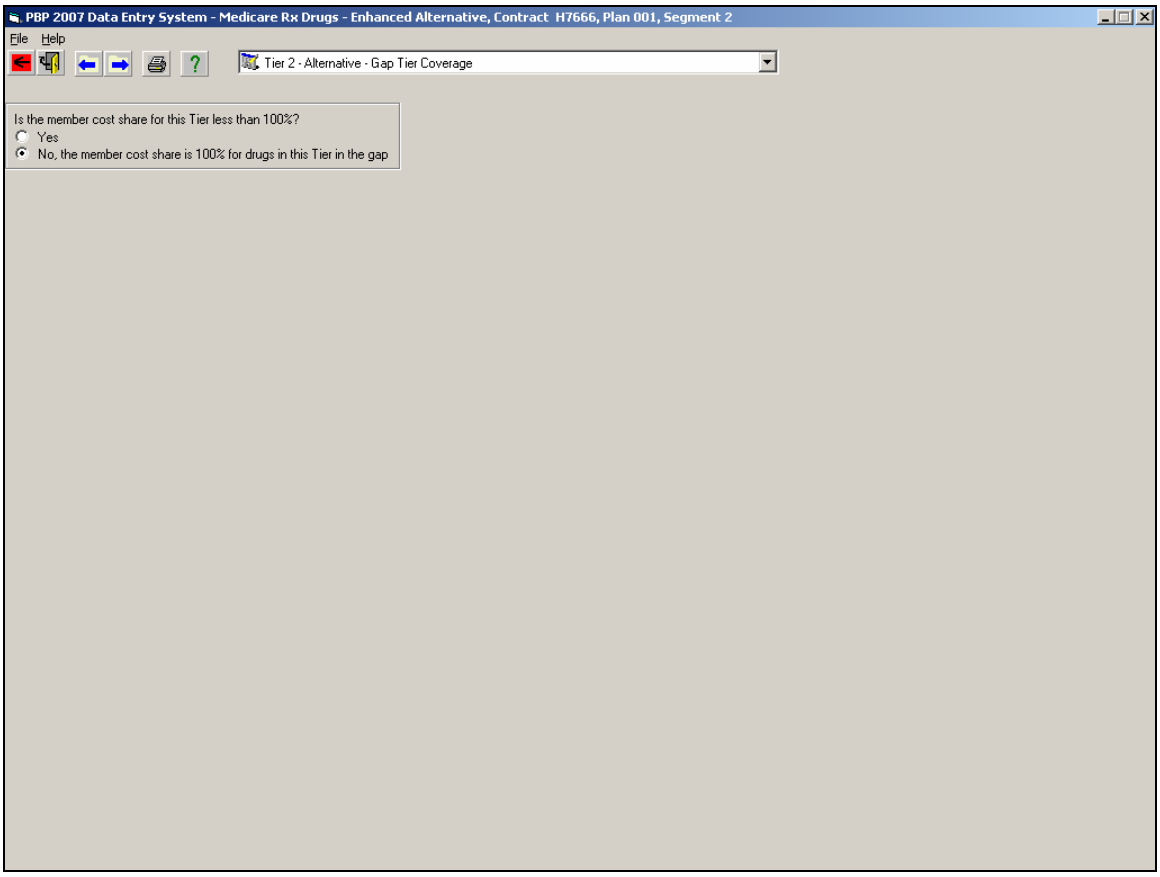
ENHANCED ALTERNATIVE – TIER 1 – ALTERNATIVE GAP TIER COPAYMENT SCREEN

1. The copayment fields for the selected location/supply amounts will be enabled. Enter the appropriate copayment amount into these fields.



ENHANCED ALTERNATIVE – TIER 2, 3 – ALTERNATIVE GAP TIER COVERAGE SCREEN

1. Indicate that these drugs are NOT covered in the gap: select 'No' to indicate that the cost share for drugs in this tier is 100% in the gap.



ENHANCED ALTERNATIVE –ALTERNATIVE OOP THRESHOLD SCREEN

1. The Out-of-Pocket Cost Threshold is a Medicare-defined amount.
2. Indicate that the plan uses Medicare-defined cost shares above the Threshold.