



CY 2011 Plan Benefit Package (PBP) Software Training for Beginners

Examples

Section A

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Section A-1

Organization Legal Name: SACRO-24 Local PPO Contract Number: Z5596

Organization Marketing Name: SACRO-24 Local PPO Plan ID: 002

Organization Web Site: www.PLMW-H5596-002.com Segment ID: 0

Plan Name: MA-PD A/B DS (PPO)

Organization Type: Local CCP

Plan Type: Local PPO

Is this a network plan?

Is this an Employer-Only plan? No

Enrollee Type:

☒ Part A and Part B
☐ Part B only

Do you cover Hospice Care?

☐ Yes
☐ No

You must answer this question. If you answer "Part B only," you must respond to the Hospice question. All other variables are pre-populated from HPMS.

Section A

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Section A-2

Indicate CY 2011 total estimated monthly Medicare membership for this plan:

Does this Plan have a CMS-approved Continuation Area?

☐ Yes ☐ No

Does this Plan have the same cost sharing in the Continuation Area for the services included?

☐ Yes ☐ No, describe

Notes (Describe Continuation Area)

Do you intend to participate in the PLATINO program?

☐ Yes ☐ No

Is this a Special Needs Plan?

Yes

Special Needs Plan Type:

Dual-Eligible

Special Needs Institutional Type:

Percentage:

Exclusive

Population:

All Duals

You must answer this question, and the 'child' questions, if applicable. All other variables are pre-populated from HPMS.

Section A

File Help	
<div><<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Section A-3</div>	
Pharmacy Web Address:	Formulary Web Address:
<input type="text" value="www.BonniePharmacy.com"/>	<input type="text" value="www.BonnieFormulary.com"/>
Online Provider Directory Web Address:	
<input type="text" value="www.BonnieLocalPPO.com"/>	
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	Extension:
<input type="text" value="(703)-243-1100"/>	<input type="text" value="10000"/>
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	Extension:
<input type="text" value="(703)-243-1101"/>	<input type="text" value="20001"/>
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	Extension:
<input type="text" value="(703)-243-2992"/>	<input type="text" value="10000"/>
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	Extension:
<input type="text" value="(703)-243-2992"/>	<input type="text" value="20000"/>
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	Extension:
<input type="text" value="(703)-243-2992"/>	<input type="text" value="10000"/>
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	Extension:
<input type="text" value="(703)-243-2992"/>	<input type="text" value="20000"/>
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	Extension:
<input type="text" value="(703)-243-2992"/>	<input type="text" value="10000"/>

Section A

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Section A-4

Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	Extension:	Section A Notes Notes (Optional):
(703)-243-2992	20000	
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	Extension:	
(703)-243-1103	40003	
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	Extension:	
(703)-243-1102	30002	
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	Extension:	
(703)-243-2992	40000	
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	Extension:	
(703)-243-2992	30000	
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	Extension:	
(703)-243-2992	40000	
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	Extension:	
(703)-243-2992	30000	
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	Extension:	
(703)-243-2992	40000	
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	Extension:	
(703)-243-2992	30000	

Exit using these buttons.

Section B

1. Enhanced benefits

Do you offer any Mandatory or Optional Supplemental Benefits?

- ☐ Yes
☐ No

Select enhanced benefits:

☐ Routine Footcare

Select type of benefit for Routine Footcare:

- ☐ Mandatory
☐ Optional

Is this benefit unlimited for Routine Footcare?

- ☐ Yes
☐ No

Indicate number of Routine Footcare visits:

Exit (No Validate)

Go To: #7 Podiatry Services - Base 1

Select the Routine Footcare periodicity:

- ☐ Every three years
☐ Every two years
☐ Every year
☐ Every six months
☐ Every three months
☐ Other, describe

2. Max plan benefit coverage

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

- ☐ Every three years
☐ Every two years
☐ Every year
☐ Every six months
☐ Every three months
☐ Other, describe

3. Max enrollee out-of-pocket costs

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

Section B

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7 Podiatry Services - Base

4. Coinsurance

Is there an enrollee Coinsurance?

Indicate Minimum Coinsurance percentage for Routine Footcare:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

5. Deductible

Is there an enrollee Deductible?

Indicate Deductible Amount:

6. Co-payment

Is there an enrollee Copayment?

Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:

Indicate Minimum Copayment amount per visit for Routine Footcare:

Indicate Maximum Copayment amount per visit for Routine Footcare:

Section B

7. Authorization

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7 Podiatry Services - Base 3

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

- ☐ None
- ☐ Primary Care Physician (Internist/Family Practice, General Practice)
- ☐ Physician Specialist
- ☐ Organization Medical Director/Utilization Management/Utilization Review
- ☐ Other, describe

Is a referral required for Podiatrist Services?

☐ Yes

☐ No

Notes (Optional):

Notes

8. Referral

Notes

Section B Example

Home Health: Min-Max Coinsurance for benefits

Enrollee pays 0-10% for Medicare-covered benefits; 20% for respite care

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #6 Home Health Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Maximum Plan Benefit Coverage is not applicable for this Service Category.

Do you offer any Mandatory or Optional Supplemental Benefits?

☒ Yes
☐ No

Select enhanced benefit:
☒ Respite Care, describe

Select type of benefit for Respite Care:

☒ Mandatory
☐ Optional

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

☐ Yes
☒ No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

☐ Every three years
☐ Every two years
☐ Every year
☐ Every six months
☐ Every three months
☐ Other, describe

Is there an enrollee Coinsurance?

☒ Yes
☐ No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

0

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

10

Indicate Minimum Coinsurance percentage for Respite Care:

20

Indicate Maximum Coinsurance percentage for Respite Care:

20

Section B Example

SNF: Copay intervals for Medicare-covered stay

Enrollee pays \$0 for first 20 days; then \$100/day up to 100 days = 2 intervals

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF - Base 5

Is there an enrollee Copayment?

☒ Yes
☐ No

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)

☐ Yes
☒ No

Indicate Copayment amount for Medicare-covered stay:

0.00

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 Medicare-covered stay (e.g.: 1 to 20; 21 to 100):

Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
0.00	1	20
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
100.00	21	100
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:

Indicate the number of day intervals for Additional Days:

☐ Zero (No Copayment per Day)
☐ One
☐ Two
☐ Three

Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999):

Copayment Amt Interval 1:	Begin Day Interval 1:	End Day Interval 1:
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:

Note: This Plan does not use Medicare-defined cost shares [select No]; and this Plan does not have a per stay charge [enter 0]

Section C

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - General - US - Base 1

Do you offer a US Visitor/Travel Program?

☒ Yes
☐ No

Select type of benefit for the US Visitor/Travel program:

☐ Mandatory
☐ Optional

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 Acute:
1b: Inpatient Hospital Psychiatric:
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:
7f: Podiatry Services:
7g: Other Health Care Professional:
7h: Psychiatric Services:
7i: Physical Therapy and Speech/Language Pathology Services:
8a: Outpatient Diag Procs/Tests/Lab Services:

7a: Primary Care Physician Services:
7b: Chiropractic Services:
7c: Occupational Therapy Services:
7d: Physician Specialist Services:
7e: Mental Health Specialty Services:
7f: Podiatry Services:
7g: Other Health Care Professional:
7h: Psychiatric Services:
7i: Physical Therapy and Speech/Language Pathology Services:
8a: Outpatient Diag Procs/Tests/Lab Services:
8b1: Diagnostic Radiological Services:
8b2: Therapeutic Radiological Services:
8b3: Outpatient X-Rays:
9a: Outpatient Hospital Services:
9b: Ambulatory Surgical Center (ASC) Services:
9c: Outpatient Substance Abuse:
9d: Cardiac Rehabilitation Services:
10a: Ambulance 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

If you offer a V/T benefit, you must answer this question, and the 'child' questions that become enabled.

Section C

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate)

Is the cost sharing for this benefit the same as in Section B?

☐ Yes
☐ No

Is there an enrollee Coinsurance for V/T - US Inpatient Hospital Services?

☐ Yes
☐ No

Select the type of V/T - US Inpatient Hospital Services Benefit with Coinsurance:

☐ (1a) Inpatient Hospital - Acute
☐ (1b) Inpatient Psychiatric Hospital

Do you charge the Medicare-defined cost shares for Inpatient Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

☐ Yes
☐ No

Indicate Coinsurance percentage for V/T - US Inpatient Hospital - Acute stay:

☐ Three

Indicate the coinsurance percentage and day interval(s) for V/T - US Inpatient Hospital - Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Coinurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Your response to this question will determine what other cost share questions become enabled.

Section C

Enter the number of groups to describe cost sharing.

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - Number of Groups - US

Indicate the number of Visitor/Travel - US groupings offered (excluding Inpatient Hospital Services):

3

The PBP will generate data entry screens for the number of groups you created.

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - Groups - US - Base 1 (3)

Enter Label for this Group (Optional):

Select the service categories included for this Group:

- 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:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech/Language Pathology Services:
- 8a: Outpatient Diag Procs/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:
- 8b3: Outpatient X-Rays:
- 9a: Outpatient Hospital Services:
- 9b: Ambulatory Surgical Center (ASC) Services:

Is the cost sharing for this benefit the same as in Section B?

☐ Yes

☐ No

Is there a V/T Coinsurance for this Group?

☐ Yes

☐ No

Enter Minimum Coinsurance Percentage for this Group:

Enter Maximum Coinsurance Percentage for this Group:

Is there a V/T Copayment for this Group?

☐ Yes

☐ No

Section C Example

Visitor/Travel benefit: Outpatient Group(s) Cost Shares
Enrollee pays 40% for all Outpatient services except Vision and Hearing;
50% for Vision and Hearing services

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - Number of Groups - US

Indicate the number of Visitor/Travel - US groupings offered (excluding Inpatient Hospital Services):

2

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - Groups - US - Base 1 (1)

Enter Label for this Group (Optional):

Group 1

Select the service categories included for this Group:

- 9b: Ambulatory Surgical Center (ASC) Services:
- 9c: Outpatient Substance Abuse:
- 9d: Cardiac Rehabilitation Services:
- 10a: Ambulance Services:
- 10b: Transportation Services:
- 11a: DME:
- 11b: Prosthetics/Medical Supplies:
- 11c: Diabetes Monitoring Supplies:
- 12: End-Stage Renal Disease:
- 13a: Blood:
- 13b: Acupuncture:
- 13c: Over the Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:
- 14a: Health Education/Wellness:
- 14b: Immunizations:
- 14c: Routine Physical Exams:
- 14d: Pap Smears and Pelvic Exams:
- 14e: Prostate Screening:
- 14f: Colorectal Screening:
- 14g: Bone Mass Measurement:
- 14h: Mammography Screening:
- 14i: Diabetes Monitoring:
- 14j: Nutrition Therapy for Diabetes and Renal Disease:
- 15: Medicare Part B Rx Drugs:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:

Is the cost sharing for this benefit the same as in Section B?

☐ Yes
☒ No

Is there a V/T Coinsurance for this Group?

☒ Yes
☐ No

Enter Minimum Coinsurance Percentage for this Group:

40

Enter Maximum Coinsurance Percentage for this Group:

40

Is there a V/T Copayment for this Group?

☐ Yes
☒ No

Enter Minimum Copayment Amount for this Group:

Enter Maximum Copayment Amount for this Group:

Section C Example

Visitor/Travel benefit: Outpatient Group(s) Cost Shares
Enrollee pays 40% for all Outpatient services except Vision and Hearing;
50% for Vision and Hearing services

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - Groups - US - Base 1 (2)

Enter Label for this Group (Optional):
Group 2 Vision and Hearing Services

Select the service categories included for this Group:

- 9b: Ambulatory Surgical Center (ASC) Services:
- 9c: Outpatient Substance Abuse:
- 9d: Cardiac Rehabilitation Services:
- 10a: Ambulance Services:
- 10b: Transportation Services:
- 11a: DME:
- 11b: Prosthetics/Medical Supplies:
- 11c: Diabetes Monitoring Supplies:
- 12: End-Stage Renal Disease:
- 13a: Blood:
- 13b: Acupuncture:
- 13c: Over the Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:
- 14a: Health Education/Wellness:
- 14b: Immunizations:
- 14c: Routine Physical Exams:
- 14d: Pap Smears and Pelvic Exams:
- 14e: Prostate Screening:
- 14f: Colorectal Screening:
- 14g: Bone Mass Measurement:
- 14h: Mammography Screening:
- 14i: Diabetes Monitoring:
- 14j: Nutrition Therapy for Diabetes and Renal Disease:
- 15: Medicare Part B Rx Drugs:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:

Is the cost sharing for this benefit the same as in Section B?
☐ Yes
☒ No

Is there a V/T Coinsurance for this Group?
☒ Yes
☐ No

Enter Minimum Coinsurance Percentage for this Group:
50

Enter Maximum Coinsurance Percentage for this Group:
50

Is there a V/T Copayment for this Group?
☐ Yes
☒ No

Enter Minimum Copayment Amount for this Group:

Enter Maximum Copayment Amount for this Group:

Section D

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Plan Deductible (In-Network)

Is there an In-Network Plan Deductible?

☒ Yes
☐ No

Do you charge the Medicare-defined Part B Deductible amount?

☐ Yes
☒ No

Indicate In-Network Plan Deductible Amount:

100.00

Select the benefits that apply to the In-Network Deductible:

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

Indicate plan-level deductibles.

Service Categories to which

3: Comprehensive Outpatient Rehabilitation Facility (CORF):
5: Partial Hospitalization:
6: Home Health Services:
7a: Primary Care Physician Services:
7b: Chiropractic Services:

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

☐ Yes
☒ No

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

10b: Transportation Services:
13b: Acupuncture:
13c: Over The Counter (OTC) Items:
13d: Meal Benefit:
13e: Other 1:
13f: Other 2:
14a: Health Education/Wellness:
16a: Preventive Dental:
16b: Comprehensive Dental:
17a: Eye Exams:
17b: Eye Wear:
18a: Hearing Exams:
18b: Hearing Aids:

If you do not charge the Part B deductible amount, enter the deductible for your plan and indicate which services apply.

Section D

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Max Enrollee Cost Limit (In-Network)

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost? Select all of the In-Network Medicare-covered Service Categories that are Excluded from the In-Network Maximum Enrollee Out-of-Pocket Cost

☒ Yes
☐ No

CMS' recommended maximum out-of-pocket for Medicare-covered services for CY2011 is \$3400.

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

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

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

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

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

☒ Yes
☐ No

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

☐ Yes
☒ No

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

4a: Emergency Care:
5: Partial Hospitalization:
6: Home Health Services:
7a: Primary Care Physician Services:
7b: Chiropractic Services:
7c: Occupational Therapy Services:
7d: Physician Specialist Services:
7e: Mental Health Specialty Services:
7f: Podiatry Services:

10b: Transportation Services:
13b: Acupuncture:
13c: Over The Counter (OTC) Items:
13d: Meal Benefit:
13e: Other 1:
13f: Other 2:
14a: Health Education/Wellness:
16a: Preventive Dental:
16b: Comprehensive Dental:
17a: Eye Exams:
17b: Eye Wear:

Indicate plan-level maximum enrollee out-of-pocket costs.

If the max does not apply to all services, indicate which services are EXCLUDED.

Section D

Indicate plan-level maximum benefit coverage amount (Non-Medicare benefits).

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

Is there a Maximum Plan Benefit Coverage Amount?

- ☒ Yes
☐ No

Indicate Maximum Plan Benefit Coverage Amount:

10000.00

Select Maximum Plan Benefit Coverage Amount Periodicity:

- ☐ Every three years
☐ Every two years
☒ Every year
☐ Every six months
☐ Every three months
☐ Other, describe

Select the benefits that apply to the Maximum Plan Benefit Coverage Amount:

- ☒ In-Network Non-Medicare-covered benefits
☒ Out-of-Network Non-Medicare-covered benefits

Indicate which services apply.

Max Plan Benefit Coverage

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

- ☐ Yes
☐ No

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

10b: Transportation:
13b: Acupuncture:
13c: Over The Counter (OTC) Items:
13d: Meal Benefit:
13e: Other 1:
13f: Other 2:

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

- ☐ Yes
☐ No

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

10b: Transportation Services:
13b: Acupuncture:
13c: Over The Counter (OTC) Items:
13d: Meal Benefit:
13e: Other 1:
13f: Other 2:
14a: Health Education/Wellness:
16a: Preventive Dental:
16b: Comprehensive Dental:

Section D Example

Max Enrollee Out-of-Pocket Cost Limit (In-Network) = \$3,000
per year; applies to all Medicare-covered benefits EXCEPT Eye Exams
and Eyewear. Does NOT apply to Plan's non-Medicare benefits

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Max Enrollee Cost Limit (In-Network)

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

☒ Yes
☐ No

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2011 is \$3400.

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

3000.00

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

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

☒ In-Network Medicare-covered benefits
☐ In-Network Non-Medicare-covered benefits

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

☐ Yes
☒ No

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

14c: Routine Physical Exams:
14d: Pap Smears and Pelvic Exams:
14e: Prostate Screening:
14f: Colorectal Screening:
14g: Bone Mass Measurement:
14h: Mammography Screening:
14i: Diabetes Monitoring:
14j: Nutrition Therapy for Diabetes and Renal Disease:
15: Medicare Part B Rx Drugs:
16b: Comprehensive Dental:
17a: Eye Exams:
17b: Eye Wear:
18a: Hearing Exams:

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

☐ Yes
☒ No

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

10b: Transportation Services:
13b: Acupuncture:
13c: Over The Counter (OTC) Items:
13d: Meal Benefit:
13e: Other 1:
13f: Other 2:
14a: Health Education/Wellness:
16a: Preventive Dental:
16b: Comprehensive Dental:
17a: Eye Exams:
17b: Eye Wear:

Section Rx

General 1 screen

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Select the type of benefit

Does your plan offer a Medicare Prescription drug (Part D) benefit?

Select the type of drug benefit:

☐ Defined Standard Benefit

☐ Actuarially Equivalent Standard

☐ Basic Alternative

☒ Enhanced Alternative

Indicate number of Tiers in your Part D benefit:

Indicate # tiers

Do you have a basic Part D plan (DS, AE, BA) that provides required prescription drug coverage to beneficiaries in the service area covered by this EA plan?

☐ Yes

☐ No

Does this EA plan have a zero dollar Part D premium that satisfies (for this service area) the regulatory requirement at 42CFR §423.104 (f)(3)(i) to provide required prescription drug coverage?

☐ Yes

☐ No

Select network components

Describe the components of your network:

☐ In-Network Retail Pharmacy

☐ In-Network Preferred/Non-Preferred Retail Pharmacy

☐ Out-of-Network Pharmacy

☐ Mail Order Pharmacy

☐ Mail Order Preferred/Non-Preferred Pharmacy

☐ Long Term Care Pharmacy

A plan should specify both preferred and non-preferred mail order pharmacy locations at the time of enrollment.

Answer all questions.

Are there quantity limits on certain prescription drugs?

☐ Yes

☐ No

Is prior authorization required for certain prescription drugs?

☐ Yes

☐ No

Do any drugs in your formulary require a step therapy plan?

☐ Yes

☐ No

Section Rx

General 2 screen

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Medicare Rx General 2

Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?

☐ Yes
☐ No

If you select "Yes" to "Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?", you must indicate these specific medications in a flat file which will be uploaded to the Submission Module on June 16, 2010.

OTC Medication Attestation statement

☐ Per the CY2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.

Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?

☐ Yes
☐ No

With respect to OTCs, a Step Therapy protocol is one that requires the use of the OTC product prior to receiving a prescription formulary drug. This is in contrast to a general utilization management strategy that offers OTCs as alternatives to prescription formulary drugs but without a requirement to try the OTC first. All OTC drugs used in either a Part D Step Therapy Protocol or a general utilization management strategy must appear in an OTC supplemental file. However, only those OTCs used in a Step Therapy Protocol must be documented in the Step Therapy Criteria text files submitted with the formulary files.

Do you offer a free first fill (i.e. \$0 copayment) for any drugs?

☐ Yes
☐ No

Example: If your plan offers a \$0 copay for the first fill of a Lipitor prescription, you should answer 'yes' to 'Do you offer a free first fill for any drugs' and indicate the RxCUI for Lipitor in the flat file which will be uploaded to the Submission Module on June 16, 2010.

Do you prorate cost sharing for partial fills of a new prescription to provide a 'trial supply' of a new medication?

☐ Yes
☐ No

Prorating cost sharing refers to a reduction in the cost share of a new prescription for a new medication not previously taken by the beneficiary, for which the beneficiary is only getting a partial fill for reasons such as determining tolerability to the new medication. This does not refer to scenarios where the pharmacy is out of stock of the new medication and therefore can only supply a partial fill or the beneficiary can only afford a partial fill at the time of dispensing.

Does this plan offer national prescription coverage?

☐ Yes (the beneficiary can use this plan to get their prescription drugs nationally)
☐ No (prescription coverage only in certain areas of the country)

Answer all applicable questions.

Section Rx

Defined Standard

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Defined Standard - ICL and OOP Threshold

Defined Standard Benefit Screen

Medicare-defined Part D Deductible Amount

Medicare-defined Part D Coinsurance Amount

Medicare-defined Part D Initial Coverage Amount

Medicare-defined Part D Annual Out-of-Pocket Cost Threshold

Medicare-defined Cost Shares Applicable Beyond the Annual Out-of-Pocket Cost Threshold Charged on a Drug-by-Drug basis

NO data entry is required on this screen.

Section Rx

Rx Deductible Screen

For the Basic and Enhanced Alternative benefits, a plan may charge the Part D deductible or specify another amount.

Do you charge the Medicare-defined Part D Deductible amount?

- ☐ Yes
☐ No, enter amount
☐ No Deductible

Enter Deductible Amount:

Does the Deductible apply to all tiers?

- ☐ Yes
☐ No

Indicate each tier for which the deductible will NOT apply (please note that the deductible will not apply to any of the drugs on each tier selected):

- ☐ Tier 1
☐ Tier 2
☐ Tier 3
☐ Tier 4
☐ Tier 5
☐ Tier 6

sharing for all locations?

- ☐ Yes
☐ No

Indicate the type of cost sharing structure for this tier(s) until the deductible is reached:

- ☐ Coinsurance
☐ Copayment

You must indicate the plan's Out-of-Network cost sharing structure.

Indicate the Out-of-Network cost sharing structure for this plan:

- ☐ In-Network Copay/Coinsurance (No Differential)*
☐ In-Network Copay/Coinsurance plus a differential between the OON billed charge and the In-Network allowable
☐ In-Network Copay/Coinsurance with Limited Days Supply

*If a plan chooses this option and does not utilize either a differential in cost sharing or a differential in days supply for out of network coverage, CMS' expectation is that the plan is monitoring for appropriate out of network use with either a post authorization process or alternate review tool.

Section Rx

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Alternative - Excluded Drugs and Pre-ICL

Are any excluded drugs part of your supplemental coverage (e.g., benzodiazepines, barbiturates)? (Enhanced Alternative ONLY)

☐ Yes
☐ No

How do you apply your cost sharing before the Initial Coverage Limit (ICL) is reached?

☐ No cost sharing
☐ Medicare-defined Part D Coinsurance Amount
☐ Cost Share Tiers

Do you offer reduced Part D cost sharing as part of your supplemental coverage?

☐ Yes
☐ No

Indicate the area(s) throughout the Part D benefit where the reduced Part D cost sharing is reflected:

☐ Reduced deductible
☐ Reduced pre-ICL cost shares
☐ Raised ICL
☐ Reduced gap coverage cost shares
☐ Reduced post-threshold cost shares

For the Enhanced Alternative benefit, you must indicate if any Medicare-excluded drugs are part of the supplemental coverage, and if the plan offers reduced Part D cost sharing as part of the supplemental coverage.

You may choose to apply different cost sharing for drugs up until the ICL is reached. Depending on the Part D benefit type, you can either select No cost sharing, the Medicare-defined Part D coinsurance amount, or indicate cost sharing for drug tiers. If you select cost sharing, you will enable drug entry screens for each drug tier.

Section Rx

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Alternative - ICL

Do you apply the Medicare-defined Part D Standard Initial Coverage Limit (ICL) Amount?

☐ Yes
☐ No, enter amount
☐ No ICL (Full Gap Coverage)

Enter Initial Coverage Limit (ICL) Amount:

Rx ICL Screen: Under the Basic and Enhanced Alternative, you may use the pre-defined ICL or specify a plan-designated ICL amount.

OOP Threshold screen (below): The annual out-of-pocket cost threshold amount is a Medicare-defined Part D amount, so no data entry is required. You may choose to apply different cost sharing for drugs beyond the threshold. You may select the Medicare-defined Post Threshold cost shares, no cost sharing, or indicate cost sharing for tiers. If you select cost sharing, you will enable drug entry screens for each drug tier.

Medicare-defined Part D Annual Out-of-Pocket Cost Threshold

How do you apply your cost sharing beyond the Medicare-defined Part D Annual Out-of-Pocket Cost Threshold?

☐ No cost sharing
☐ Medicare-defined Post Threshold Cost Shares
☐ Cost Share Tiers

Section Rx

Rx – General Location/Supply Screen

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: General Location/Supply

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

Enter number of days for:

	1-Month	3-Month	Other Day
In-Network Retail Pharmacy	<input type="text"/>	<input type="text"/>	<input type="text"/>
In-Network Preferred Retail Pharmacy	<input type="text"/>	<input type="text"/>	<input type="text"/>
In-Network Non-Preferred Retail Pharmacy	<input type="text"/>	<input type="text"/>	<input type="text"/>
Out-of-Network Pharmacy	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mail Order Pharmacy	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mail Order Preferred Pharmacy	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mail Order Non-Preferred Pharmacy	<input type="text"/>	<input type="text"/>	<input type="text"/>
Long Term Care Pharmacy	<input type="text"/>		

Are all of the drugs on your formulary available with an extended day supply?

☐ Yes ☐ No

For example, you chose a 3-month supply at the In-Network Retail Pharmacy and/or you have an other day supply greater than your one month supply. You must answer "yes" to this question if all of the drugs on this tier are available at the extended day(s) supply.

Defined Standard plans and plans that do not enter cost share tiers must indicate their pharmacy locations and supply amounts on this screen.

In-Network Non-Preferred Retail Pharmacy - three month supply
 In-Network Non-Preferred Retail Pharmacy - other day supply
 Out-of-Network Pharmacy - one month supply
 Out-of-Network Pharmacy - other day supply
 Mail Order Pharmacy - one month supply
 Mail Order Pharmacy - three month supply
 Mail Order Pharmacy - other day supply
 Mail Order Preferred Pharmacy - one month supply
 Mail Order Preferred Pharmacy - three month supply
 Mail Order Preferred Pharmacy - other day supply
 Mail Order Non-Preferred Pharmacy - one month supply
 Mail Order Non-Preferred Pharmacy - three month supply
 Mail Order Non-Preferred Pharmacy - other day supply
 Long Term Care Pharmacy - one month supply

Section Rx Example

Medicare Part D benefit

- Pre-ICL Tiers:
 - Tier 1:
 - Generic drugs
 - Part D drugs only
 - Not an injectable only tier
 - Not a specialty tier
 - This is the exceptions tier for generic drugs
 - Label = Generic
 - In-Network Pharmacy has 31 day supply for \$5 copay
 - Out-of-Network Pharmacy has 15 day supply for \$5 copay
 - Long Term Care Pharmacy has 31 day supply for \$5 copay
- Gap Coverage (Enhanced Alternative):
 - Tier 1 covered in the gap, but not all drugs

Section Rx Example

File Help Tiers

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Alternative - Pre-ICL Tier Type (1)

Tier Drug type(s):

- ☒ Generic
- ☐ Preferred Generic
- ☐ Non-Preferred Generic
- ☐ Brand
- ☐ Preferred Brand
- ☐ Non-Preferred Brand

Tier Includes:

- ☒ Part D Drugs Only
- ☐ Excluded drugs only (e.g., benzos, barbiturates)
- ☐ Both Part D and Excluded Drugs

Injectable Drugs Only Tier?

- ☐ Yes
- ☒ No

Specialty Tier

- ☐ Yes
- ☒ No

Each plan must indicate one specific cost-sharing tier from its PBP at which it will adjudicate all non-formulary drugs approved through the formulary exceptions process. Although CMS generally allows Part D sponsors to apply only one level of cost sharing from an existing formulary tier to all approved formulary exceptions, sponsors may also elect to apply a second less expensive level of cost sharing for all approved formulary exceptions for generic drugs, so long as this second level is also associated with an existing formulary tier and is uniformly applied to all approved formulary exceptions for generic drugs. When designating the exceptions tier in a PBP submission, sponsors can enter only one level of cost sharing. Thus, a sponsor that has established a second (less expensive) level of cost sharing should indicate the more expensive cost-sharing tier of the two tiers as its Exceptions Tier.

Is this Tier your Exceptions Tier?

- ☒ Yes
- ☐ No

When developing your plan's cost share tier structure, you should utilize standard industry practices. Tier 1 should be considered the lowest cost-sharing tier available to beneficiaries. Any and all subsequent tiers within the cost share tier structure should be higher cost-sharing tiers in ascending order. For example, drugs in Tier 3 should have a higher cost-share for beneficiaries than drugs in Tier 2.

The screenshot shows the "Tier Label Selection" dialog box. On the left, there are instructions: "If the Tier is your Specialty Tier then you must choose the Tier Label Name: Specialty Tier Drugs", "If the Tier is a Supplemental Drug Tier, you must specify that this is a Supplemental Tier. You can choose Supplemental Drugs, Supplemental Brand Drugs (must have selected a 'Brand' descriptor), or Supplemental Generic Drugs (must have selected a 'Generic' descriptor).", and "If the Tier includes Injectable Drugs then you can choose 'Injectable Drugs' as your Tier Label or you can choose one of Tier Label Names based on the criteria listed in the variable help." Below these is a note: "For other Tier Label Selection options, right-click on the Tier Label Selection and view the Variable Help."

On the right, under the heading "Tier Label Selection (Choose ONLY One):", there is a list of radio button options:

- ☐ Brand Drugs
- ☐ Generic Drugs
- ☐ Generic and Brand Drugs
- ☐ Generic and Preferred Brand Drugs
- ☐ Generic and Non-Preferred Brand Drugs
- ☐ Generic, Preferred Brand and Non-Preferred Brand Drugs
- ☐ Injectable Drugs
- ☐ Non-Preferred Generic and Preferred Brand Drugs
- ☐ Non-Preferred Generic, Preferred Brand and Non-Preferred Brand Drugs
- ☐ Preferred Brand Drugs
- ☐ Preferred Brand and Non-Preferred Brand Drugs
- ☐ Preferred Generic Drugs
- ☐ Preferred Generic and Brand Drugs
- ☐ Preferred Generic and Preferred Brand Drugs
- ☐ Preferred Generic and Non-Preferred Brand Drugs

A yellow callout box points to the list with the text: "On-screen label provides information about selecting a tier label."

At the bottom, a "Warning" dialog box is displayed with a red X icon and the message: "For Item 'Tier Label Selection (Choose ONLY One)': Brand Drugs cannot be selected when Brand drugs are not offered on this tier."

On-screen label provides information about selecting a tier label.

OK

Section Rx Example

File Help Tiers

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Alternative - Pre-ICL Tier Locations (1)

Enter number of days for:

	1-Month	3-Month	Other Day
In-Network Retail Pharmacy	31		
In-Network Preferred Retail Pharmacy			
In-Network Non-Preferred Retail Pharmacy			
Out-of-Network Pharmacy			15
Mail Order Pharmacy			
Mail Order Preferred Pharmacy			
Mail Order Non-Preferred Pharmacy			
Long Term Care Pharmacy	31		

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

Select all Location/supply amount(s) that apply for this Tier:

- In-Network Retail Pharmacy - one month supply
- In-Network Retail Pharmacy - three month supply
- In-Network Retail Pharmacy - other day supply
- In-Network Preferred Retail Pharmacy - one month supply
- In-Network Preferred Retail Pharmacy - three month supply
- In-Network Preferred Retail Pharmacy - other day supply
- In-Network Non-Preferred Retail Pharmacy - one month supply
- In-Network Non-Preferred Retail Pharmacy - three month supply
- In-Network Non-Preferred Retail Pharmacy - other day supply
- Out-of-Network Pharmacy - one month supply
- Out-of-Network Pharmacy - other day supply
- Mail Order Pharmacy - one month supply
- Mail Order Pharmacy - three month supply
- Mail Order Pharmacy - other day supply
- Mail Order Preferred Pharmacy - one month supply
- Mail Order Preferred Pharmacy - three month supply
- Mail Order Preferred Pharmacy - other day supply
- Mail Order Non-Preferred Pharmacy - one month supply
- Mail Order Non-Preferred Pharmacy - three month supply
- Mail Order Non-Preferred Pharmacy - other day supply
- Long Term Care Pharmacy - one month supply

Are all of the drugs on your formulary for this tier available with an extended day supply?

☐ Yes ☐ No

For example, you chose a 3-month supply at the In-Network Retail Pharmacy and/or you have an other day supply greater than your one month supply. You must answer "yes" to this question if all of the drugs on this tier are available at the extended day(s) supply.

Section Rx Example

File Help Tiers

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Alternative - Pre-ICL Tier Copayment (1)

	1-Month	3-Month	Other Day
Copayment for In-Network Retail Pharmacy	5.00		
Copayment for In-Network Preferred Retail Pharmacy			
Copayment for In-Network Non-Preferred Retail Pharmacy			
Copayment for Out-of-Network Pharmacy			5.00
Copayment for Mail Order Pharmacy			
Copayment for Mail Order Preferred Pharmacy			
Copayment for Mail Order Non-Preferred Pharmacy			
Copayment for Long Term Care Pharmacy	5.00		

Section Rx Example

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Alternative - Gap Coverage

Do you offer Gap Coverage?

☒ Yes
☐ No

Select the tiers that include gap coverage (select all that apply):

☒ Tier 1
☐ Tier 2
☐ Tier 3
☐ Tier 4
☐ Tier 5
☐ Tier 6

Section Rx Example

File Help Tiers

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Alternative - Gap Tier Type (1)

Tier Drug type(s):
Generic

Tier Includes:
Part D Drugs Only

Injectable Drugs Only Tier?
No

Specialty Tier
No

Each plan must indicate one specific cost-sharing tier from its PBP at which it will adjudicate all non-formulary drugs approved through the formulary exceptions process. Although CMS generally allows Part D sponsors to apply only one level of cost sharing from an existing formulary tier to all approved formulary exceptions, sponsors may also elect to apply a second less expensive level of cost sharing for all approved formulary exceptions for generic drugs, so long as this second level of cost sharing is less than the cost sharing for the existing formulary tier and is applied to all approved formulary exceptions for generic drugs. Thus, a sponsor that elects to apply a second level of cost sharing should indicate the two tiers as its

Is this Tier your Exceptions Tier?
Yes

When developing your plan's cost share tier structure, you should utilize standard industry practices. Tier 1 should be considered the lowest cost-sharing tier available to beneficiaries. Any and all subsequent tiers within the cost share tier structure should be higher cost-sharing tiers in ascending order. For example, drugs in Tier 3 should have a higher cost-share for beneficiaries than drugs in Tier 2.

In gap tiers, Tier Type, Tier Label, and Tier Location data are pre-populated from Pre-ICL tier.

Section Rx Example

File Help Tiers

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Alternative - Gap Tier Label (1)

Tier Label Selection Options:

If the Tier is your Specialty Tier then you must choose the Tier Label Name: Specialty Tier Drugs

If the Tier is a Supplemental Drug Tier, you must specify that this is a Supplemental Tier. You can choose Supplemental Drugs, Supplemental Brand Drugs (must have selected a "Brand" descriptor), or Supplemental Generic Drugs (must have selected a "Generic" descriptor).

If the Tier includes Injectable Drugs then you can choose "Injectable Drugs" as your Tier Label or you can choose one of Tier Label Names based on the criteria listed in the variable help.

For other Tier Label Selection options, right-click on the Tier Label Selection and view the Variable Help.

Tier Label Selection (Choose ONLY One):

Generic Drugs

Section Rx Example

File Help Tiers

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: Alternative - Gap Tier Coverage (1)

To what extent are any Pre-ICL covered drugs on this tier covered through the gap?

☐ All drugs on this tier are covered through the gap (Full Tier Gap Coverage)

☒ Some drugs from this tier are covered through the gap (Partial Tier Gap Coverage)

Are you offering any excluded drugs as part of your gap coverage?

☐ Yes

☐ No

Does the gap coverage on this tier only include excluded drugs?

☐ Yes

☐ No

The gap coverage supplemental file may not include any drugs from a tier that is fully covered in the gap.

If you select that gap coverage is for a partial tier, you must submit a gap supplemental file for drugs on the partially covered tier with the exception of excluded drugs which cannot be included on gap supplemental file.

In gap tiers, if you indicate Partial Tier Gap Coverage, you may have to submit a gap supplemental file.