CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN SPRING CONFERENCE
Sheraton Baltimore City Hotel, April 20-21, 2010
Verbatim Transcript
CY 2011 Plan Benefit Package (PBP) Software Training for Beginners

Part 1

THIS IS THE PBP 2011
BEGINNERS TRAINING.

MY NAME IS SARA SILVER.

I'VE PROBABLY WORKED
WITH SEVERAL OF YOU

OVER THE PAST COUPLE OF YEARS
ON THE PBP SOFTWARE.

IF YOU'RE NEW AND YOU'VE NOT
ATTENDED THIS TRAINING BEFORE

OR IF YOU'RE NEW
TO THE SOFTWARE,

THIS IS DEFINITELY
THE PLACE TO BE.

LET'S SEE. I'M GONNA GO AHEAD
AND INTRODUCE

THE TWO PRESENTERS TODAY.

YOU'RE IN
MORE-THAN-CAPABLE HANDS.

THIS IS TED BLOSS.
HE'S FROM FU ASSOCIATES.

AND TERI DEUTSCH
FROM GALILEO HEALTH PARTNERS.

AND WE ARE GONNA BE GOING
THROUGH THE BEGINNER PBP.

WE'RE GONNA GO THROUGH EACH OF
THE SECTIONS OF THE SOFTWARE

AND JUST GO OVER

A VERY BASIC OVERVIEW

OF EACH OF THE SECTIONS,

THE TYPE OF DATA ENTRY
YOU SHOULD BE EXPECTING...

SOME OF THE REPORTS
AVAILABLE TO YOU,

AND SOME OF
THE SOFTWARE FUNCTIONALITY

THAT WILL BE USEFUL WHEN
COMPLETING THE PBP SOFTWARE.

WE HAVE A LOT TO COVER
IN A SHORT PERIOD OF TIME,

SO TO KIND OF GO OVER
THE WAY THIS IS GONNA WORK,

THERE'S GONNA BE
A PRESENTATION.

THAT'S GONNA BE
ABOUT 2 1/2 HOURS.

AND THEN AFTER THE PRESENTATION,

WE'RE GOING TO HOLD QUESTIONS
THAT YOU MAY HAVE,

SO IF YOU HAVE QUESTIONS
DURING THIS PRESENTATION,

WE'D APPRECIATE IT
IF YOU JUST TOOK A NOTE

AND THEN AT THE END, WE DO HAVE A
30-MINUTE SECTION BLOCKED OFF.

SO COME UP TO
THE TWO MICROPHONES

ON BOTH SIDES OF THE ROOM,

AND WE'RE GOING TO ADDRESS
THE QUESTIONS THAT WAY.

WE DO HAVE A LOT
OF POLICY PEOPLE HERE.

THERE ARE GOING TO BE

A LOT OF POLICY PEOPLE

HELPING ANSWER THOSE QUESTIONS,

AND WE'LL DO THOSE INTRODUCTIONS
WHEN WE DO THE Q&A PORTION.

LET'S SEE. SOMETHING ELSE
I WANTED TO MENTION.

AT THE END OF
THE SLIDE PRESENTATION,

THERE ARE SOME CONTACTS LISTED.

YESTERDAY THERE WERE
SOME CONTACTS ALSO LISTED

FROM THE PART "C"
AND THE PART "D" TEAMS,

SO PLEASE USE THOSE AS WELL.

I THINK THERE ARE
ALSO GENERAL MAILBOXES

THAT THEY WANT YOU TO SEND
THE QUESTIONS TO.

SO YOU KNOW, THE TECHNICAL
CONTACTS ARE STILL ACCURATE,

BUT FOR THE PART "C"
AND PART "D" POLICY QUESTIONS,

I THINK THERE WAS SOME UPDATED
CONTACTS PRESENTED YESTERDAY.

AND LASTLY BEFORE WE BEGIN,

I JUST WANTED TO LET
YOU ALL KNOW THAT ON APRIL 9

THERE WAS AN HPMS MEMO RELEASED
ABOUT AND ONLINE PBP TRAINING,

SO IF AFTER TODAY YOU'RE STILL
FEELING A LITTLE OVERWHELMED

AND YOU WANT SOME
ADDITIONAL INFORMATION,

YOU CAN TAKE THAT TRAINING
AT ANY TIME.

IT'S GONNA BE POSTED

UNTIL WE POST THE 2012 VERSION
OF THE ONLINE TRAINING,

SO YOU'LL BE ABLE TO ACCESS THAT
AT YOUR OWN CONVENIENCE

AND START AND STOP THE
PRESENTATION WHENEVER YOU'D LIKE

AND IF THERE ARE MEMBERS
OF YOUR ORGANIZATION

THAT WANTED TO ATTEND
THIS TRAINING BUT COULDN'T,

I WOULD RECOMMEND THAT
THEY ACCESS THAT TRAINING.

THAT WOULD BE A HELPFUL
FIRST STEP FOR THEM.

AND WITH THAT, I'M GOING
TO TURN IT OVER TO TED.

Ted: THANKS.

GOOD MORNING, EVERYONE.

TO START WITH,

THE PBP WE'RE ACTUALLY GONNA START
TALKING ABOUT--HPMS.

I KNOW THAT WE DID TALK ABOUT THIS A
LITTLE BIT YESTERDAY,

SO THIS IS AT
A VERY HIGH LEVEL

BUT IT'S JUST TO HELP
BRING TOGETHER

FOR EVERYONE IN THE ROOM HOW
THE PBP INTERACTS WITH THE HPMS.

AFTER WE GO OVER THAT,

WE'RE GONNA GO OVER
ALL OF THE FEATURES OF THE PBP--

HOW TO ENTER DATA INTO THE PBP

AND JUST SORT OF DESCRIBE
THE FUNCTIONALITY

OF WHAT THE PBP IS
AND HOW IT WORKS

AND HOW IT'S GONNA RELATE
TO THE SUMMARY BENEFITS,

AND THEN WE'RE GONNA WRAP IT UP
WITH GOING FROM,

"OK, I'VE DONE ALL MY WORK
IN THE PBP.

HOW DO I GET
ALL OF THIS INFORMATION

BACK UP INTO HPMS
WHERE I CAN SEE IT?

AND THEN AT THE END,
AS SARA SAID,

WE'LL HAVE OUR LIST OF CONTACTS.

SO LET'S START WITH THE HPMS,

WHICH IS ON LINE.

IT'S YOUR CENTRAL REPOSITORY

FOR ALL OF YOUR ORGANIZATION
AND PLAN DATA.

AND THAT'S WHERE YOU'RE
GONNA CREATE YOUR PLANS.

SO ALL OF YOUR PLANS
ARE CREATED ON THE HPMS,

AND THAT'S DONE
IN THE BID SUBMISSION MODULE.

THE PBP SOFTWARE PACKAGE

IS SOMETHING THAT YOU'RE GONNA
GET TO FROM THE HPMS,

BUT YOU'RE ACTUALLY
GONNA DOWNLOAD THAT

ONTO YOUR COMPUTERS.

SO YOU CAN EITHER DOWNLOAD IT
JUST FOR YOURSELF

OR IF YOU'RE WORKING
IN A NETWORK ENVIRONMENT

WITH OTHER FOLKS
AT YOUR ORGANIZATION,

YOU CAN DOWNLOAD IT
AND SHARE IT WITH THEM

SO THEY CAN HELP YOU
WITH DATA ENTRY

AND HELP YOU WITH MANAGING
ALL OF YOUR PLANS

IF YOU HAVE A LOT OF PLANS.

ANY INFORMATION
THAT YOU ENTER IN THE HPMS,

SPECIFICALLY YOUR ORG
AND PLAN SPECIFIC INFORMATION,

IS GONNA BE DOWNLOADED
FROM HPMS INTO THE PBP.

SO YOU'RE GONNA SEE IT THERE.

EVERYTHING'S GONNA BE
AS YOU ENTERED IT.

THE ONLY THING THAT YOU'LL
HAVE TO DO IN THE PBP ITSELF

IS JUST LOOK AT IT
AND VERIFY IT.

SO THIS IS HOW YOU'RE
ACTUALLY GOING TO GO

AND DOWNLOAD THE SOFTWARE.

YOU'RE GONNA GO TO
THE BID 2011 START PAGE,

AND YOU'RE GONNA COMPLETE
THESE STEPS.

IT'S REALLY VERY SIMPLE,

AND THE WEB PAGE WILL
WALK YOU THROUGH IT.

THE FIRST STEP IS JUST
TO DOWNLOAD THE SOFTWARE.

IT IS PRETTY LARGE,
SO IT WILL TAKE A LITTLE WHILE

IF YOU HAVE A SLOWER CONNECTION,

BUT IT'S JUST ONE FILE.

IT'S JUST ONE LARGE FILE
YOU'RE GONNA DOWNLOAD.

AND IT'S A SELF-RUNNING AND
SELF-EXTRACTING INSTALL FILE,

SO YOU'LL DOWNLOAD IT
EITHER TO YOUR DESKTOP

OR WHEREVER YOU WANT
TO DOWNLOAD IT TO.

CLICK ON IT, RUN IT,

AND IT WILL INSTALL THE SOFTWARE
ON YOUR MACHINE.

IT'S NOT GONNA INSTALL
IT IN A NETWORK.

IT'S GONNA INSTALL IT
ON YOUR MACHINE.

FROM THERE YOU'RE GONNA SET UP
YOUR PLAN-SPECIFIC INFORMATION,

AND YOU'RE GONNA EDIT YOUR
PLAN-MARKETING INFORMATION.

IN THE PBP,

YOU'RE GONNA SEE ALL OF
THIS INFORMATION DOWNLOADED,

AND WHEN YOU DO THAT,
IT'S A ONE-TIME THING.

THE PBP DOESN'T TALK CONSTANTLY
BACK AND FORTH TO HPMS.

SO YOU'RE GONNA WANT TO MAKE SURE

THAT ANYTHING YOU'VE DONE

AT THIS ORGANIZATION LEVEL
ON HPMS,

WHICH IS DONE IN
THE CONTRACT MANAGEMENT MODULE,

IS DONE CORRECTLY

'CAUSE IF YOU NEED
TO MAKE A CHANGE,

YOU'RE GONNA HAVE TO REDOWNLOAD
SOME INFORMATION TO THE PBP.

SO IT'S VERY IMPORTANT THAT

YOU'VE DONE ALL OF YOUR WORK
ON HPMS

AND YOU'VE CHECKED IT
BEFORE YOU GET, YOU KNOW,

TO THE PROCESS OF DOWNLOADING AND
ENTERING INFORMATION

INTO THE PBP...

BECAUSE THE LAST STEP
IS DOWNLOAD

ALL OF YOUR
PLAN-SPECIFIC INFORMATION.

THAT'S WHAT THE DOWNLOAD
PLAN-SPECIFIC INFORMATION PAGE

LOOKS LIKE ON THE HPMS.

SO THAT'S...WHERE YOU'LL GO,
WHAT YOU'LL SEE,.

AND IF YOU HAVE
ANYTHING THAT YOU'VE DONE

INCOMPLETE OR IS INCORRECT,

THERE ARE GONNA BE
MESSAGES UP THERE.

THE BOTTOM OF THE SCREEN

WHERE WE HAVE THE ARROW

AND THE CUTOUT.

THAT'S GONNA GIVE YOU
ERROR MESSAGE

AND INSTRUCTIONS
ON WHAT IS INCOMPLETE

AND WHAT YOU NEED TO UPDATE

SO THAT YOU CAN START USING
THE PBP.

ALL RIGHT, NOW LET'S TALK ABOUT
WHAT THE PBP IS.

OK.

OK, SO A BRIEF OVERVIEW
OF THE SOFTWARE.

BASICALLY THE PBP WAS DESIGNED

SO THE BENEFITS
COULD BE STANDARDIZED

FOR THE BENEFICIARIES
WHEN THEY'RE COMPARING PLANS.

IT ALSO IS USED TO FACILITATE
THE REVIEW PROCESS FOR CMS

BECAUSE ALL THE INFORMATION
IS COLLECTED IN THE SAME WAY

SO THEY CAN COMPARE
AND REVIEW THE BIDS.

SOME OF THE INFORMATION
THAT IS ENTERED INTO THE PBP

IS THEN GENERATED IN
THE SUMMARY OF BENEFITS, OK?

AND THAT INFORMATION ALSO GETS
CARRIED TO OTHER CMS WEBSITES

INCLUDING THE MEDICARE
OPTIONS COMPARE

AND PLAN FINDER.

AND THERE ARE ALSO DATA REPORTS
THAT WE'LL TOUCH UPON LATER

THAT ARE USED TO REVIEW
THE INFORMATION ON HPMS.

YOU CAN GO TO HPMS,
LOOK AT THE REPORTS,

AND CMS ALSO USES THOSE REPORTS

WHEN THEY'RE REVIEWING
MARKETING MATERIALS.

Part 2

Woman:
SO WE'LL TALK A LITTLE BIT

ABOUT SOME OF THE FEATURES
IN THE SOFTWARE

THAT'LL HELP YOU GET STARTED
ON YOUR DATA ENTRY.

COUPLE THINGS WE'LL LOOK AT--
FILE PATHS, OK?

WHEN YOU FIRST GO
INTO THIS SOFTWARE,

IT'S GONNA ASK YOU TO SET UP
A BACKUP PATH.

WE'LL JUST TOUCH UPON
A MULTI-USER ENVIRONMENT

IF YOU WANT TO SET THAT UP
AT YOUR ORGANIZATION.

WE'LL GO OVER
THE MANAGEMENT SCREEN.

WE'LL TALK ABOUT WHAT THE DATA
ENTRY SCREEN LOOKS LIKE,

DIFFERENT TYPES OF HELP THAT
ARE AVAILABLE IN THE SOFTWARE,

SOME RULES AND VALIDATIONS THAT ARE
CONTAINED IN THE SOFTWARE

THAT SORT OF HELP PREVENT YOU FROM
ENTERING ERRONEOUS DATA,

OK, AND WE'LL TALK ABOUT
SOMETHING ELSE

THAT'S REALLY HELPFUL
WHEN YOU FIRST GET STARTED,

IS THE YEAR-TO-YEAR PLAN
COPY FUNCTION,

SO IF YOU HAVE DATA FROM 2010
THAT YOU WANT TO USE

TO POPULATE SOME PLANS IN 2011,

SO YOU DON'T HAVE TO RE-ENTER
THAT INFORMATION,
YOU CAN DO THAT, OK?

SO WHEN YOU FIRST
GO INTO THE SOFTWARE

AFTER YOU'VE DOWNLOADED
THE SOFTWARE,

YOU'VE DOWNLOADED YOUR PLAN
INFORMATION FROM HPMS,

AND YOU FIRST GO IN
AND OPEN IT UP,

IT'S GONNA ASK YOU TO SET UP
A BACKUP PATH, OK,

SO YOU HAVE TO ESTABLISH THAT
BEFORE IT'LL LET YOU MOVE ON

TO THE MANAGEMENT SCREEN

AND THEN PROCEED TO DO
ANY DATA ENTRY, OK,

AND LET ME JUST MENTION
ONE OTHER THING.

AS WE GOT THROUGH THE SLIDES,
WE'RE GONNA
TALK ABOUT THE BID MANUAL.

EVERYTHING THAT WE GO THROUGH

IS DESCRIBED IN DETAIL
IN THE BID MANUAL,

AND THAT'S AVAILABLE

ON THE HPMS WEB SITE, OK?

THAT GOES THROUGH THE DATA ENTRY
FOR EVERY SECTION IN DETAIL,

AND IT GIVES A LOT OF EXAMPLES,
SO IF YOU'RE EVER CONFUSED

ABOUT HOW TO DO SOMETHING,
YOU CAN LOOK AT THE BID MANUAL

AS WELL AS REFER
TO THE ON-LINE TRAINING

THAT SARA MENTIONED PREVIOUSLY.

TALKING ABOUT
THE SET FILE PATHS AGAIN,

YOU WOULD JUST CLICK ON
THE PREFERENCES...

[CLEARS THROAT]

AND THEN GO TO THE PATHS, OK?

YOU CAN ALSO SET
THE COLOR SCHEME IN THE SOFTWARE

SO YOU CAN TELL WHICH VARIABLES
IMPACT THE SUMMARY OF BENEFITS.

THERE'S A RED-BLUE COLOR SCHEME,
SO IF YOU GO TO THE PREFERENCES,

OPTIONS, YOU CAN CLICK ON
"USE THE RED-BLUE COLOR SCHEME"

SO YOU CAN SEE
THE VARIABLES THAT IMPACT

THE SUMMARY OF BENEFITS.

JUST REAL BRIEFLY,
IF YOU WANT TO SET THE PBP UP

IN A NETWORK ENVIRONMENT,
YOU CAN DO THAT.

THAT MEANS YOU WOULD PUT IT
IN ONE PLACE,

LIKE ON YOUR NETWORK,
AND THEN YOU CAN HAVE

DIFFERENT PEOPLE ACCESSING
DIFFERENT SECTIONS.

THIS IS DESCRIBED IN DETAIL
IN THE BID MANUAL,

SO WE'RE NOT REALLY GONNA GO
INTO IT TODAY, OK,

BUT IF YOU WANT TO SET UP
THIS TYPE OF SITUATION,

YOU CAN DO THAT.

OK.

BASICALLY, YOUR MAIN POINT
OF OPERATION

IS GONNA BE
THE MANAGEMENT SCREEN.

THIS WILL SHOW YOU THE CONTRACTS
AND THE PLANS

THAT YOU'RE RESPONSIBLE FOR.

IT'S GONNA ALSO SHOW YOU
DIFFERENT STATUSES

AS YOU PROCEED THROUGH
YOUR DATA ENTRY,

SO ANYTIME YOU'RE LOOKING
AT A CERTAIN CATEGORY

OR A SECTION,
IT WILL SHOW YOU EITHER NEW

IF IT HASN'T BEEN TOUCHED YET,

INCOMPLETE IF YOU'VE GONE AND YOU'RE
DONE SOME DATA ENTRY

BUT HAVEN'T COMPLETED IT,
OR, ONCE IT'S DONE

AND IT'S COMPLETE, IT'LL
SHOW YOU A COMPLETE STATUS, OK?

SO IT DOES SORT OF WORK WITH YOU
AS YOU PROCEED

THROUGH YOUR DATA ENTRY
PROCESS, OK?

THERE ARE DIFFERENT DATA ENTRY
SECTIONS THAT BECOME AVAILABLE

BASED ON YOUR PLAN TYPE.

SO THERE'LL BE SOME SECTIONS
THAT YOU MIGHT SEE

IF YOU'RE A PPO THAT YOU WON'T SEE IF
YOU'RE A PFFS, OK?

BASICALLY, SECTION "A,"
AS TED MENTIONED BEFORE,

IS THE ONE THAT CONTAINS
A LOT OF THE INFORMATION

THAT YOU'VE ENTERED IN HPMS
AND THEN DOWNLOADED--

YOUR ORGANIZATION INFORMATION,
YOUR PLAN INFORMATION.

SECTION "B" IS WHERE YOU'RE GONNA
ENTER INFORMATION

FOR YOUR IN-NETWORK BENEFITS,
SO PRETTY MUCH EVERY PLAN TYPE

IS GONNA DO SECTION "B,"
I THINK,

WITH ONE OR TWO EXCEPTIONS.

SECTION "C" IS FOR THE
OUT-OF-NETWORK-TYPE BENEFITS,

SO PPOs WILL SEE

AN OUT-OF-NETWORK BENEFITS
SECTION THERE.

AN HMO/POS PLAN WILL SEE

A POINT OF SERVICE
BENEFITS SECTION,

AND PRETTY MUCH
EVERYBODY WILL SEE

A VISITOR/TRAVEL

BENEFITS SECTION, OK,

SO, AGAIN, THAT'S SORT OF BASED
ON YOUR PLAN TYPE.

SECTION "D" IS WHERE YOU'RE GONNA
ENTER PLAN-LEVEL COSTS--

PLAN-LEVEL DEDUCTIBLE,

PLAN-LEVEL ENROLLEE
OUT-OF-POCKET CAP,

OP. SUPP. BENEFITS--

AND THEN Rx IS WHERE YOU WOULD
ENTER YOUR PART "D" BENEFIT

IF YOU'RE OFFERING THAT.

BASICALLY, THIS IS A PICTURE
OF THE DATA ENTRY SCREEN.

YOU CAN SEE THE TITLE ROW
AT THE TOP, THE MENU BAR.

THERE ARE A COUPLE BUTTONS
WHERE YOU CAN USE

TO TOGGLE BETWEEN SCREENS.

THERE IS A EXIT (VALIDATE)
AND EXIT (NO VALIDATE).

IF YOU WANT TO USE
THE EXIT (VALIDATE),

THAT'S GONNA RUN ALL THE RULES
AND THE VALIDATIONS

FOR THAT PARTICULAR SECTION,

MAKE SURE ALL THE DATA ENTRY
IS COMPLETE,

AND THAT EVERYTHING HAS BEEN
ENTERED APPROPRIATELY,

AND IF THERE ARE ANY PROBLEMS,
IT'LL GIVE YOU

SOME ERROR MESSAGES
OR SOME WARNINGS

TO SAY, "SOMETHING
DOESN'T LOOK RIGHT,"

OR, "YOU FORGOT TO ENTER
SOMETHING,"

AND IT'LL TELL YOU EXACTLY
WHERE THAT IS, OK?

IF YOU'RE WORKING ON A SECTION
AND YOU WANT

TO GET OUT TEMPORARILY,
YOU CAN USE EXIT (NO VALIDATE).

THAT'LL JUST TAKE YOU BACK
TO THE MANAGEMENT SCREEN, OK--

NO HARM, NO FOUL--

AND THEN YOU CAN SEE
THE DATA ENTRY WINDOWS

WHERE ALL YOUR VARIABLES ARE.

DEPENDING ON
YOUR BENEFITS STRUCTURE,

YOU'RE GONNA SEE SOME VARIABLES
THAT ARE ENABLED

THAT YOU HAVE TO ANSWER AND OTHER
ONES THAT ARE GRAYED OUT,

SO, FOR EXAMPLE, IF IT ASKS YOU
IF YOU HAVE A CO-PAYMENT

FOR A CERTAIN BENEFIT
AND YOU SAY NO,

THEN THE CO-PAYMENT FIELDS
UNDERNEATH THAT

WILL BE GRAYED OUT.

YOU DON'T HAVE TO DO
ANY MORE DATA ENTRY THERE.

PRETTY MUCH EVERYTHING THAT'S
ENABLED HAS TO BE ANSWERED, OK?

THE ONLY EXCEPTION IS IF SOMETHING IS
MARKED OPTIONAL,

AND EVEN THEN, THERE'S
AN EXCEPTION TO THAT

BECAUSE IF IT HAS TO DO
WITH A QUESTION

WHERE YOU SELECT AN ANSWER
THAT SAYS, "OTHER, DESCRIBE,"

THEN THAT INDICATES YOU'RE GONNA
TALK ABOUT SOMETHING,

EXPLAIN SOMETHING
IN THE NOTES FIELD.

GENERALLY, THE NOTES FIELDS
ARE OPTIONAL,

BUT IN, LIKE, THE CASE
WHERE YOU SELECT AN ANSWER

AS "OTHER, DESCRIBE," THEN
THE NOTES BECOMES MANDATORY,

AND SO THE SOFTWARE
WILL KNOW TO CHECK

FOR SOME TEXT
IN THAT NOTES FIELD, OK?

THERE AREN'T TOO MANY
OPTIONAL FIELDS.

THERE'S A MULTITUDE
OF HELP AVAILABLE TO YOU

IN THE SOFTWARE ITSELF.

THERE ARE SOME GENERAL SERVICE
CATEGORY DESCRIPTIONS,

AND THIS IS IN SECTION "B."

SO IF YOU ARE IN B6,
HOME HEALTH,

YOU CAN FIND OUT GENERALLY
WHAT KIND OF BENEFITS

ARE COVERED UNDER HOME HEALTH.

THERE'S ALSO A BOX
THAT YOU CAN CLICK ON

THAT'LL TELL YOU BRIEFLY

WHAT MEDICARE COVERS
FOR THAT CATEGORY,

AND THEN IT'LL GIVE YOU
SOME REFERENCES

WHERE YOU CAN GO AND CHECK
FOR MORE DETAILED INFORMATION

ABOUT MEDICARE-COVERED BENEFITS
FOR THAT CATEGORY, OK?

THERE'S VARIABLE HELP,

SO IF YOU RIGHT-CLICK
ON A PARTICULAR VARIABLE,

IT MIGHT GIVE YOU
SOME ADDITIONAL INFORMATION

ABOUT HOW TO ANSWER
THAT QUESTION.

THERE ARE A LOT
OF ON-SCREEN LABELS,

ESPECIALLY IN THE Rx SECTION,
THAT WILL SORT OF GIVE YOU

SOME GUIDANCE ABOUT WHAT
THE QUESTION IS ASKING FOR

AND WHAT THE INFORMATION
IS BEING COLLECTED, OK,

AND THEN THERE'S
GENERAL SYSTEM HELP

THAT EXPLAINS
HOW THE FUNCTIONS WORK,

WHAT DIFFERENT FEATURES ARE,
AND IF YOU GET STUCK

ON SOMETHING, YOU CAN ALWAYS
GO THERE TO LOOK UP,

YOU KNOW, HOW TO SORT OF RESOLVE
YOUR PROBLEM.

Part 3

SO OUR SERVICE CATEGORY
DESCRIPTION AGAIN,

A DESCRIPTION
ABOUT SORT OF GENERALLY

WHAT DOES THAT SERVICE
CATEGORY CONTAIN, OK?

SO YOU'LL CLICK ON--

ONCE YOU'RE IN
THE SERVICE CATEGORY, OK,

YOU GO INTO IN SECTION "B."

CLICK ON THE SERVICE CATEGORY.

GO TO THE HELP, AND THEN CLICK ON
CATEGORY DESCRIPTION, OK?

AND YOU'LL SEE THAT POP-UP BOX.

THAT'LL EXPLAIN THAT.

WITHIN THE CATEGORIES
THAT CONTAIN

MEDICARE-COVERED BENEFITS,

THE FIRST THING YOU'LL SEE
ON THE FIRST SCREEN

IS A BOX UP AT THE TOP
THAT SAYS "CLICK HERE"

FOR A DESCRIPTION.

IF YOU CLICK ON THAT,
THEN YOU'LL SEE A POP-UP

THAT'LL SHOW YOU WHAT MEDICARE
COVERS IN THAT CATEGORY.

VARIABLE HELP. IF YOU'RE ON THE
QUESTION AND YOU RIGHT CLICK,

THEN YOU'LL SEE THIS LITTLE
VARIABLE HELP POP-UP, OK?

SO IT MAY CONTAIN
ADDITIONAL INFORMATION

ABOUT HOW YOU CAN
ANSWER THE QUESTION.

IT ALSO CONTAINS
THE VARIABLE NAME

IN CASE YOU NEED TO REFER
TO THAT FOR SOMETHING.

ON-SCREEN LABELS.
AGAIN, ADDITIONAL GUIDANCE

OR EXPLANATIONS ABOUT WHAT KIND OF
DATA ENTRY IS PERMITTED,

WHAT'S NOT PERMITTED,
OR FURTHER GUIDANCE, OK?

A LOT OF THESE--

THERE'S A LOT OF ON-SCREEN LABEL
HELP IN THE RX SECTION

AS WE MENTIONED.

OK, AND SYSTEM HELP.

IF YOU'RE
ON THE MANAGEMENT SCREEN

AND YOU CLICK ON THE HELP,

THEN YOU CAN ACCESS
THE GENERAL HELP SCREEN.

LIKE WE SAID, IT'LL GO AND
DESCRIBE A LOT MORE IN DETAIL

ABOUT THE FUNCTIONALITY, OK?

AND THERE'S ALSO
AN ABOUT HELP.

THIS WILL GIVE YOU
VERSION INFORMATION.

WHEN YOU GO TO DO YOUR UPLOAD,

HPMS WILL ONLY ACCEPT THE MOST
RECENT VERSION OF THE SOFTWARE

THAT'S BEEN ISSUED,

AND WE DON'T ANTICIPATE
HAVING ANY PROBLEMS,

BUT IF EVER YOU NEED
TO CHECK SOMETHING,

THE ABOUT HELP WILL GIVE YOU

THE DATES
AND THE VERSION NUMBERS, OK?

DATA EDIT RULES.

THESE ARE THINGS, FOR EXAMPLE,

IF YOU'RE ENTERING
A CO-INSURANCE AMOUNT,

YOU CAN'T ENTER ANYTHING
GREATER THAN 100, OK?

IT WON'T LET YOU DO THAT.

OK, YOU CAN'T ENTER A MINIMUM
LESS THAN ZERO.

YOU CAN'T ENTER A MAXIMUM
THAT'S LOWER THAN THE MINIMUM

THAT YOU ENTERED, OK?

SO THESE ARE SORT OF
BEHIND-THE-SCENES RULES

THAT WILL SORT OF CHECK YOUR DATA
ENTRY AS YOU GO ALONG.

EXIT VALIDATIONS.

WHEN YOU'RE FINISHED
WITH A SECTION

AND YOU WANT TO
HAVE IT COMPLETED,

YOU WILL CLICK ON EXIT VALIDATE.

THE SOFTWARE WILL GO THROUGH ALL
THE VARIABLES IN THAT SECTION.

MAKE SURE EVERYTHING THAT HAD
TO BE ANSWERED WAS ANSWERED,

MAKE SURE THAT THERE

AREN'T ANY PROBLEMS

WITH ANY OF THE ANSWERS, I MEAN,
AS MUCH AS IT CAN.

AND IF IT DOES FIND A PROBLEM,

IT'LL GIVE YOU A LIST
OF ERROR MESSAGES.

SOMETIMES IT'LL GIVE YOU
A WARNING.

A WARNING IS JUST SAYING
THAT THERE MAY BE A PROBLEM,

THAT YOU WANT TO GO BACK
AND DOUBLE CHECK SOMETHING.

BUT THAT'S NOT GONNA PREVENT YOU
FROM COMPLETING THAT SECTION.

AND ERROR MESSAGE
DOES PREVENT YOU

FROM COMPLETING
THAT SECTION, OK?

SO IF YOU CONTINUE TO EXIT

AND GO BACK
TO THE MANAGEMENT SCREEN,

THAT SECTION IS MARKED
AS INCOMPLETE

UNTIL YOU GO BACK
AND RESOLVE THOSE ERRORS.

OK. YEAR-TO-YEAR PLAN COPY.

IF YOU HAVE YOUR 2010 DATA BASE

AND YOU WANT TO USE SOME OF THE
PLAN INFORMATION FROM LAST YEAR

TO SORT OF GET YOU KICK STARTED
ON YOUR 2011 DATA ENTRY,

YOU CAN USE
THE YEAR-TO-YEAR PLAN COPY.

THE SOFTWARE'S GONNA LOOK
FOR THAT DATA BASE,

SO YOU HAVE TO HAVE IT
IN YOUR PBP2010 OR 2011 FOLDER

BECAUSE THOSE ARE THE ONLY
TWO PLACES IT'S GONNA CHECK.

SO UNDER THE ACTIONS MENU,

IT'S THE COPY PLAN
FROM THE PREVIOUS YEAR.

OK, IF YOU CAN'T FIND IT,
PRIOR YEAR DATA,

YOU'LL GET THE MESSAGE SAYING
IT CAN'T FIND IT.

ONE IMPORTANT THING

IS THAT IT CAN ONLY COPY
ONE PLAN TO ONE PLAN AT A TIME.

OK? YOU CAN'T TAKE
ONE 2010 PLAN

AND COPY IT TO MULTIPLE
2011 PLANS.

BUT WE HAVE SORT OF
A WORK-AROUND FOR YOU

THAT I'LL TALK ABOUT
IN A MINUTE, OK?

ONE THING THAT'S
IMPORTANT TO REMEMBER

IS THAT IF YOU'VE STARTED
YOUR 2011 DATA ENTRY

AND THEN YOU USE THIS
PRIOR YEAR COPY FUNCTION,

IT WILL OVERWRITE YOUR DATA, OK?

SO YOU WANT TO DO THIS FIRST
TO GET YOU STARTED

AND THEN GO AND CONTINUE
WITH YOUR 2011 DATA ENTRY.

SO THIS IS JUST BASICALLY WALKING YOU
THROUGH THE STEPS.

YOU WOULD SELECT
YOUR SOURCE PLAN

AND WHICH PLAN YOU WANT TO COPY IT
INTO FOR THE CURRENT YEAR.

BECAUSE THERE ARE CHANGES
EVERY YEAR IN THE SOFTWARE

IT CAN'T COPY EVERYTHING,
SO FOR 2011,

IT'S ONLY GONNA COPY SECTION "A" AND
SOME SECTION "B" DATA, OK?

YOU CAN'T COPY ANY DATA
FROM SECTION "C"

BECAUSE THERE WERE SO MANY
CHANGES THERE FROM SECTION "D"

AND FROM THE RX SECTION.

SO THOSE DATA WON'T BE COPIED.

SO ONCE YOU'VE DONE YOUR COPY,
IT'LL ASK YOU TO CONFIRM,

AND THEN WHEN YOU GO
BACK INTO YEAR 2011,

YOU LOOK
AT THE MANAGEMENT SCREEN,

YOU'LL SEE CHANGES
IN THE STATUS

FOR THE SECTIONS
THAT YOU COPIED, OK?

SO SECTION "B" IS PRETTY MUCH
THE LARGEST SECTION.

THAT'S WHERE MOST OF YOUR
DATA ENTRY WILL PROBABLY BE,

SO IT WILL COPY
MOST OF THE SECTION "B" DATA.

THERE'S SOME NEW AREAS
IN SECTION "B"

THAT OBVIOUSLY WON'T GET COPIED

```
BECAUSE THEY DIDN'T EXIST
LAST YEAR,

SO YOU'LL HAVE TO GO BACK IN
AND COMPLETE THAT DATA ENTRY.

BUT WE ALSO ENCOURAGE YOU
TO GO INTO EACH SECTION

AND, YOU KNOW, DOUBLE CHECK,

MAKE SURE THAT THE DATA
THAT YOU COPIED

IS CORRECT FOR THE CURRENT YEAR.

COPY TIP. SINCE THE YEAR-TO-YEAR
COPY ONLY ALLOWS YOU

TO DO ONE PLAN TO ONE PLAN,

WHAT YOU CAN DO IS,
IF YOU HAVE MULTIPLE PLANS

THAT HAVE VERY SIMILAR BENEFITS,

YOU CAN DO A ONE-TO-ONE
PRIOR-YEAR PLAN COPY,

AND THEN USE
THE REGULAR COPY FUNCTION

TO COPY THAT 2011 PLAN
TO OTHER 2011 PLANS, OK?

SO THERE YOU CAN DO ONE TO MANY,

AND WE'LL TALK ABOUT THAT
A LITTLE BIT MORE LATER ON.

SO THERE IS SORT OF
A WORK-AROUND.
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Part 4

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Man: WE LEARNED ALL ABOUT
HOW TO DO THINGS WITH IT.

NOW WE'RE GONNA
START DOING IT.

SO YOU'RE NOT GONNA
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START SECTION "A"

UNTIL YOU ENTERED ALL YOUR DATA
ON HPMS,

YOU DOWNLOADED THE PBP,

YOU DOWNLOADED YOUR PLAN'S
SPECIFIC INFORMATION INTO THE PBP,

AND NOW THIS IS WHERE
YOU WANT TO START.

YOU DO NOT HAVE TO DO
THE SECTIONS OF THE PBP IN ORDER.

WE RECOMMEND YOU PROBABLY DO.

IT MAKES A LOT OF SENSE TO DO
SECTION "A," THEN "B,"

THEN "C," THEN "D,"

BUT THE ONLY THING
YOU'RE REQUIRED TO DO

IS COMPLETE SECTION "A" FIRST,

AND THEN YOU CAN PUT
YOUR DATA ENTRY

INTO ANY OF THE OTHER SECTIONS
IN ANY ORDER THAT YOU WANT.

SECTION "A" IS JUST GONNA HAVE YOUR
GENERAL PLAN INFORMATION,

AND ALMOST EVERYTHING
IN THE SECTION IS GONNA BE

DATA THAT YOU ENTERED IN HPMS
AND THAT WE'RE DOWNLOADING

INTO THE PBP.

THE DATA ENTRY IS
EXTREMELY LIMITED

AND AS I SAID BEFORE,

YOU HAVE TO COMPLETE
THIS SECTION FIRST,

SO THAT MEANS YOU'RE GONNA HAVE TO

EXIT WITH VALIDATION.

THAT RUNS THOSE EDIT CHECKS
THAT TERRY TALKED ABOUT,

AND ONCE YOU RUN AND EXIT
WITH VALIDATION,

EVERYTHING'S OK, THEN THE STATUS IS
GONNA CHANGE TO COMPLETED,

AND ALL OF THE OTHER SECTIONS WILL
HAVE BEEN GRAYED OUT.

YOU WOULDN'T HAVE BEEN ABLE
TO GO IN TO ENTER THE DATA.

THOSE WILL ALL BECOME ENABLED

SO YOU'LL BE ABLE TO MOVE FORWARD
WITH ENTERING DATA

IN ANY OF THOSE.

THERE'S A COUPLE OF FIELDS
IN SECTION "A"

THAT ARE GONNA IMPACT THE DATA
ENTRY THAT CAN BE DONE

THROUGHOUT THE REST OF THE PBP,

AND BECAUSE OF THAT,
THAT ALSO IMPACTS

WHAT SB SENTENCES ARE
GONNA BE GENERATED.

THE PLAN TYPE,
THE NETWORK INDICATOR

ARE GONNA--IT'S GONNA AFFECT
SECTIONS "C" AND "D"

AS WELL AS THE SB SENTENCES
OF THOSE SECTIONS.

AND THE ENROLLEE TYPE,
PART "A" AND "B"

OR PART "B" ONLY,

THAT'S GONNA AFFECT
YOUR SECTION "B:"

INPATIENT HOSPITAL
AND SNF DATA ENTRY.

AND THE SPECIAL NEEDS PLAN,

WHICH IS A FIELD THAT YOU'RE
ACTUALLY GONNA DOWNLOAD.

IT'S SOMETHING THAT YOU'RE
GONNA ANSWER IN THE PBP.

THAT'S GONNA AFFECT HOW YOUR
SB SENTENCES ARE GENERATED.

IF YOU HAVE ANY QUESTIONS
ABOUT HOW THIS WORKS,

WITHIN THE BID MANUAL IS
A PBP DATA ENTRY MATRIX,

AND THAT'S A NICE CHART.

IT LAYS OUT HOW ALL OF
THIS INFORMATION AFFECTS

WHAT AREA OF THE PBP YOU ARE GONNA
HAVE TO FILL OUT,

WHAT WILL BE ENABLED,
WHAT WON'T BE ENABLED.

SO NOW WE'RE GOING TO ACTUALLY
SWITCH SLIDE DECKS

OVER TO SOME EXAMPLES
THAT WE HAVE FOR YOU.

AND THESE ARE JUST TO SHOW YOU,
YOU KNOW, SOME ACTUAL SCREENS

SO YOU KNOW, OK, YOU KNOW,

TAKE A CONCEPT AND APPLY IT TO
THE TOOL ITSELF.

SO HERE WE ARE, SECTION "A."

THIS IS THE FIRST SCREEN
YOU'RE GONNA GO INTO,

AND DOWN THERE
ON THE BOTTOM LEFT

YOU'LL SEE THERE'S
AN ENROLLEE-TYPE QUESTION.

YOU'LL SEE IT'S A RED VARIABLE,

AND MAY BE HARD TO SEE
ON THE SLIDE,

BUT YOU CAN SEE
THAT IT IS ENABLED,

SO YOU HAVE TO ANSWER IT.

ALL OF THE OTHER DATA
ON THIS SCREEN

IS GRAYED OUT, SO IT'S DATA THAT YOU
PREVIOUSLY ENTERED IN HPMS.

WE'VE DOWNLOADED IT
INTO THE PBP,

AND IT'S THERE
JUST FOR YOU TO REVIEW.

YOU DON'T HAVE TO DO
ANYTHING WITH IT.

BUT ANOTHER REASON WE MAKE
YOU DO SECTION "A" FIRST,

IT'S BECAUSE WE WANT YOU TO REVIEW
ALL THIS INFORMATION NOW.

MAKE SURE IT'S RIGHT

BECAUSE IF YOU HAVE TO MAKE
ANY CHANGES,

YOU'RE GONNA HAVE TO GO BACK
TO HPMS TO MAKE THOSE CHANGES.

BUT ON THIS SCREEN,

YOU'RE JUST GONNA ANSWER
YOUR ENROLLEE-TYPE QUESTION.

PART "A," "B," OR PART "B" ONLY.

THEN ON THE SECOND SCREEN,
SECTION A2.

YOU CAN SEE UP
ON THE UPPER RIGHT,

AND WE HAVE THE SCREEN NAMES
ALWAYS DISPLAYED

AND THE DROP-DOWN LIST THERE.

WE HAVE A QUESTION ABOUT THE
CMS-APPROVED CONTINUATION AREA.

AND WE'RE HIGHLIGHTING
THIS QUESTION BECAUSE

IT'S WHAT WE CALL
THE PARENT-CHILD VARIABLE

OR PARENT-CHILD QUESTION.

YOU'RE GONNA SEE THESE
THROUGHOUT THE REST OF THE PBP.

DEPENDING ON HOW
YOU ANSWER THIS,

THE QUESTION BELOW IT
MAY OR MAY NOT BE ENABLED.

SO RIGHT NOW,
WHEN YOU HAVEN'T ANSWERED IT,

IT'S NOT ENABLED.

IF YOU WERE TO SAY "YES"
TO THIS QUESTION,

THEN THE QUESTION BELOW IT

ASKING YOU TO DESCRIBE
YOUR CONTINUATION AREA

BECOMES ENABLED.

YOU SAY "NO,"
THEN IT'S NOT ENABLED.

THERE'S 4 SECTIONS--
OR 4 SCREENS, EXCUSE ME,

IN SECTION "A."

THESE ARE THE ONLY TWO ARES
WHERE THERE'S DATA ENTRY.

THE REST IS GOING TO BE
JUST FOR YOUR REVIEW,

SO IT'S AN EASY SECTION
TO EXIT VALIDATE,

BUT IT'S AN IMPORTANT ONE

BECAUSE IT'S A LOT
OF CONTACT INFORMATION

AND YOU KNOW, YOU DON'T WANT
THAT TO BE WRONG,

THAT'S FOR SURE.

HERE'S THE THIRD SCREEN.

AS YOU CAN SEE, EVERYTHING
IS GRAYED OUT.

IT'S GOT ALL OF
YOUR PHONE NUMBERS ON IT.

AND THEN THE FOURTH SCREEN
WE'RE ALSO GONNA HAVE

YOUR WEB ADDRESSES ON IT.

THE EXIT VALIDATION BUTTONS
ARE AT THE TOP.

THE FAR RIGHT BUTTON
IS EXIT WITH VALIDATION--

OR EXCUSE ME,
IS EXIT WITHOUT VALIDATION.

IF YOU CLICK ON THAT ONE,

YOU'RE NOT GONNA
BE ABLE TO MOVE FORWARD

AND ENTER DATA
ON THE REST OF THE PBP.

YOU NEED TO CLICK
THE EXIT WITH VALIDATION BUTTON.

SO NOW WE'RE GOING TO TALK ABOUT
ORGANIZATION

AND PLAN UPDATED DATA.

ANY CHANGES THAT NEED
TO BE MADE

ORG/PLAN DATA HAVE TO BE MADE
IN THE HPMS.

IT CANNOT BE MODIFIED, CHANGED
AT ALL IN THE PBP.

SO YOU'RE GONNA HAVE TO GO
BACK TO HPMS

TO MAKE THESE UPDATES

AND THEN REDOWNLOAD YOUR DATA.

WE TALKED ABOUT THAT BEFORE.

TO DO THAT, YOU'RE GONNA GO TO THE
CONTRACT MANAGEMENT MODULE

AND THERE YOU'RE GONNA BE ABLE TO
MAKE MARKETING NAME CHANGES,

CONTRACT SERVICE AREA CHANGES,

OR WEB ADDRESS CHANGES.

IF YOU NEED TO MAKE A CHANGE
TO ANY OTHER FIELD,

YOU'RE NOT GONNA HAVE ACCESS
TO DO THAT.

YOU'RE GONNA HAVE
TO CONTACT CMS.

EITHER THE CENTRAL OFFICE
OR YOUR ACCOUNT MANAGER,

AND THEY CAN MAKE
THOSE CHANGES FOR YOU.

IN THE BID SUBMISSION MODULE,

THAT'S WHERE YOU'RE
GOING TO ADD OR DELETE

PLANS AND/OR SEGMENTS.

YOU'RE GOING TO MAKE CHANGES
TO YOUR PLAN TYPE,

YOUR PLAN NAME,
YOUR GEOGRAPHIC NAME,

YOUR PLAN SERVICE AREA

OR ANY CUSTOMER SERVICE
CONTACT INFORMATION.

THERE'S TWO WAYS YOU CAN DO IT.

YOU CAN EITHER JUST
LOG INTO HPMS DIRECTLY

FROM YOUR WEB BROWSER
AND MAKE THOSE CHANGES

OR IF YOU'D LIKE, THE PBP WILL
ACTUALLY GET YOU THERE AS WELL.

UNDER THE ACTION MENU,

THERE IS AN UPDATE PLAN
INFORMATION OPTION.

WHEN YOU CLICK ON THAT,
WHAT'LL HAPPEN IS

THE PBP IS GONNA OPEN UP,

SOMETHING THAT'S GONNA BE
SIMILAR TO WEB BROWSER.

IT'S GONNA CONNECT YOU
RIGHT INTO HPMS.

YOU'RE STILL GONNA HAVE TO USE YOUR
LOG-ON CREDENTIALS

TO GET ACCESS TO YOUR DATA,

BUT IT'S GONNA TAKE YOU
RIGHT INTO THERE,

AND YOU CAN WALK THROUGH
MAKING ANY OF THE UPDATES

THAT YOU ARE GONNA NEED TO MAKE.

ONCE YOU MAKE THOSE UPDATES,

WE'RE GONNA HAVE TO
GET THAT INFORMATION

BACK DOWN ITO THE PBP.

SO WHAT'S GONNA HAPPEN IS
UP ON HPMS,

WE'RE GONNA CREATE
A NEW ZIP FILE,

AND IT'S GONNA BE NAMED
UPDATPBP2011_,

AND THEN IT'S GONNA HAVE A DATE
AND TIME STAMP.

YOU'RE GONNA SAVE THAT FILE
INTO THE SAME DIRECTORY

WHERE YOU'VE INSTALLED
THE PBP SOFTWARE.

THE DEFAULT IS
C:/PROGRAM FILES/PBP2011,

BUT YOU, OF COURSE,
CAN CHANGE THAT.

IF YOU CHANGE IT, YOU'RE JUST
GONNA NEED TO SAVE IT

AT THE SAME PLACE YOU HAVE
THE PBP INSTALLED FROM.

SO YOU'VE DONE
ALL OF THOSE STEPS.

WE'RE GONNA GO
BACK INTO THE PBP NOW,

AND ON THE MANAGEMENT SCREEN
YOU'RE GONNA CLICK OK.

IT'S GONNA ASK YOU IF YOU WANT TO
UPDATE YOUR PLAN INFORMATION.

THEN IT'S GONNA ALSO SORT OF
ASK YOU OR HAVE YOU CONFIRM

THAT YOU MOVED
THESE NEW DATA BASES

WHICH ARE IN THAT ZIP FILE

INTO THE SAME DIRECTORY
WHERE YOU INSTALLED THE PBP

AND HAVE YOU CLICK OK AGAIN.

IF YOU JUST CLICK THROUGH THESE

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WITHOUT PUTTING
THE ZIP FILE THERE,

YOU'RE GONNA GET
A LITTLE ERROR MESSAGE.

IT'S GONNA TELL YOU
YOU NEED TO GO OUT AND FIND

THE ZIP FILE
AND PUT IT IN THE FOLDER.
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Part 5

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NOW TERRY WILL GUIDE US
THROUGH SECTION B.

OK. SECTION B.
THE BIGGEST SECTION.

BASICALLY, THIS IS WHERE
YOU'RE GONNA DESCRIBE

YOUR IN-NETWORK
PLAN BENEFITS, OK,

SO LIKE WE SAID,
ALMOST EVERY PLAN

WE'LL HAVE TO ENTER DATA
IN SECTION B.

ON THE MANAGEMENT SCREEN,
WHEN YOU LOOK AT

THE SECTION B WINDOW
AND YOU SCROLL THROUGH THAT,

YOU'LL SEE 18--
FOR THE MOST PART,

YOU'LL SEE 18
SERVICE CATEGORIES.

WHEN YOU GO IN TO EACH ONE
OF THOSE SERVICE CATEGORIES,

YOU CAN SEE MORE THAN
ONE SUBCATEGORY,

SO FOR EXAMPLE, CATEGORY 14
IS CALLED PREVENTIVE SERVICES.
```

WHEN YOU GO INTO CATEGORY 14,

THAT'S BROKEN DOWN
INTO 10 SUBCATEGORIES,

AND EACH ONE WILL
REQUIRE DATA ENTRY.

SO THAT'S WHY WE SAY THERE ARE 18
MAJOR SERVICE CATEGORIES

THAT ARE DIVIDED INTO
ABOUT 52 SUBCATEGORIES.

MOST OF THEM CONTAIN
MEDICARE COVERED BENEFITS.

THERE ARE 3 OR 4 THAT DON'T, OK,

SO THOSE ARE ONLY
IF YOU'RE OFFERING

SOMETHING OVER AND ABOVE
MEDICARE, OK?

FOR THE ENHANCED BENEFIT,
PRETTY MUCH EVERY CATEGORY

OR MOST OF THE CATEGORIES
WILL ASK YOU,

FOR THIS CATEGORY,
DO YOU OFFER SOMETHING OVER AND ABOVE MEDICARE?

DO YOU OFFER ANY
ENHANCED BENEFITS?

AND AT THAT POINT,
YOU CAN INDICATE YES OR NO.

IF YOU INDICATE YES,
THEN IT'LL ASK YOU TO GIVE--

PROVIDE SOME MORE DESCRIPTION
ABOUT WHAT YOU'RE COVERING, OK?

AND IF IT'S A MANDATORY--
AHEM--BENEFIT

OR IF IT'S AN OPTIONAL BENEFIT.

IF YOU ARE A COST PLAN
AND YOU'RE NOT OFFERING

THE PART D BENEFIT,

YOU WILL BE ABLE TO DO
SOME OUTPATIENT DRUG ENTRY

IN CATEGORY B-20.

I THINK LAST YEAR,
NOBODY USED THAT CATEGORY,

BUT IT'S AVAILABLE.

SO IN EACH CATEGORY
IN SECTION B,

THE SETUP IS
PRETTY MUCH THE SAME.

IT HAS THE SAME FLOW.

SO WHEN YOU FIRST GET IN
ON THE FIRST SCREEN,

AGAIN YOU'LL SEE THAT BOX
WHERE YOU CAN LOOK AT

THE MEDICARE COVERED
BENEFIT DESCRIPTION

AND THEN IT'LL ASK YOU, ARE YOU
OFFERING ANY ENHANCED BENEFITS?

AND IF YOU ARE,
THEN YOU HAVE A COUPLE FIELDS

THAT WILL BE ENABLED THAT
YOU'LL HAVE TO ANSWER.

THEN MOST OF THE CATEGORIES
WILL ASK YOU

IF THERE IS A MAXIMUM DOLLAR AMOUNT
THAT YOU'RE COVERING.

THAT ONLY PERTAINS TO
NON-MEDICARE BENEFITS, OK,

SO IF YOU'RE OFFERING SOMETHING
OVER AND ABOVE MEDICARE,

IT'LL ASK YOU IF THERE'S
A SPECIFIC CAP

FOR THAT SERVICE CATEGORY, OK,
FOR THAT BENEFIT.

ALL RIGHT?
AGAIN, THIS IS ALL AT THE CATEGORY LEVEL.

IS THERE A MAXIMUM ON
WHAT THE ENROLLEE HAS TO PAY OUT OF POCKET?

IS THERE COINSURANCE
THAT THE ENROLLEE HAS TO PAY

FOR THE BENEFITS THAT ARE CONTAINED
IN THIS CATEGORY?

AND DEPENDING ON
THE CATEGORY ITSELF,

IT CAN BE SOMETHING AS SIMPLE
AS ONE SINGLE AMOUNT.

IT CAN BE A MIN-MAX RANGE

IF THE CATEGORY COVERS A LOT OF
DIFFERENT BENEFITS,

LIKE THE DIAGNOSTIC LAB.

THERE'S A WHOLE SET OF BENEFITS
THAT ARE COVERED IN THAT CATEGORY,

SO YOU CAN ENTER
A MIN-MAX RANGE.

IF IT'S ONE OF
THE INPATIENT HOSPITAL OR THE SKILLED NURSING CATEGORIES,

YOU CAN DESCRIBE COST SHARES
AT THE INTERVAL LEVEL.

SO FOR CERTAIN DAYS,
THERE'S ONE COST.

FOR DIFFERENT DAYS,
THERE'S A DIFFERENT COST.

IT'S VERY CATEGORY-SPECIFIC ABOUT
HOW THE DATA ENTRY

IS SORT OF SET UP.

IT'LL ASK YOU IF THERE'S
A SPECIFIC DEDUCTIBLE,

AGAIN, FOR THAT CATEGORY.

IF YOU DON'T DO COINSURANCE,
DO YOU CHARGE COPAYMENT AMOUNTS,

AND IS THERE ANY AUTHORIZATION
THAT'S REQUIRED,

AND THEN YOU CAN SELECT
FROM THE DIFFERENT TYPES THAT ARE PROVIDED,

AND IS THERE A REFERRAL
THAT'S REQUIRED?

LIKE WE SAID,
MOST CATEGORIES HAVE

ALL OF THESE "BIG 8" QUESTIONS.

SOME MAY NOT HAVE
ONE OR THE OTHER

DEPENDING ON WHAT IS CONTAINED
IN THAT CATEGORY,

BUT MOST OF THEM--IT'LL ALL
FOLLOW THE SAME FLOW.

AND THEN EACH CATEGORY
WILL HAVE A NOTES FIELD,

AND LIKE WE SAID,
FOR THE MOST PART

THE NOTES IS AN OPTIONAL FIELD
UNLESS DURING YOUR DATA ENTRY

INSIDE THAT CATEGORY,

YOU SELECT AN OPTION THAT SAYS,
"OTHER--DESCRIBE."

THEN THE SOFTWARE'S
GONNA LOOK FOR

SOME KIND OF EXPLANATION
IN THAT NOTES FIELD.

OK? SO WE'LL GO THROUGH
A COUPLE EXAMPLES

OF THE SECTION B DATA ENTRY.

SO THIS IS PODIATRY SERVICES.

WE WOULD FIRST GO--THIS IS
OUR BASE ONE SCREEN.

SO THE FIRST QUESTION
ON THE TOP LEFT,

"DO YOU OFFER ANY MANDATORY OR
OPTIONAL SUPPLEMENTAL BENEFITS?"

OK, SO, ANYTHING
OVER AND ABOVE MEDICARE

YOU WOULD INDICATE
HERE, ALL RIGHT?

SO YOU'LL GO THROUGH
THOSE QUESTIONS.

IF YOU SAY NO,
THEY'LL REMAIN GRAYED OUT,

AND IF YOU SAY YES,
THEN THEY'LL BE ENABLED

AND YOU'LL HAVE TO DO
THAT ADDITIONAL DATA ENTRY.

THEN THE SECOND QUESTION:
IS THERE A MAXIMUM

PLAN BENEFIT COVERAGE AMOUNT?

AGAIN, FOR THIS
SPECIFIC CATEGORY.

THE THIRD QUESTION,
IS THERE A MAXIMUM--

WHAT THE ENROLLEE
HAS TO PAY OUT OF POCKET,

AGAIN FOR THIS
SPECIFIC CATEGORY.

ARE THERE ANY COINSURANCES
THAT THE ENROLLEE HAS TO PAY?

IS THERE A DEDUCTIBLE?
IS THERE A COPAYMENT AMOUNT?

AND UNDERNEATH
THE COST SHARE QUESTIONS,

THE COINSURANCE AND THE COPAY,

THERE'LL BE DIFFERENT
DATA ENTRY FIELDS

FOR THE MEDICARE
COVERED BENEFITS

AND FOR THE ENHANCED BENEFITS.

SO IF YOU'RE ONLY OFFERING
THE MEDICARE COVERED BENEFIT,

THEN ONLY THOSE FIELDS
WILL BE ENABLED.

IF YOU'RE OFFERING SOMETHING OVER
AND ABOVE MEDICARE,

THEN MORE FIELDS
WILL BE ENABLED.

AND THE LAST SET OF QUESTIONS,
THE AUTHORIZATION,

IS THERE ANY
AUTHORIZATION REQUIRED

FOR THE SERVICES
IN THIS CATEGORY,

AND THEN YOU CAN
SELECT ONE OR MORE

OF THE OPTIONS
THAT ARE AVAILABLE.

IS THERE ANY REFERRAL REQUIRED,
AND THEN THE NOTES FIELD.

SO A REAL QUICK EXAMPLE.

WE'LL LOOK AT HOME HEALTH, OK,

AND THIS--IT'LL SHOW YOU
A MIN-MAX DATA ENTRY.

SO IN OUR EXAMPLE,
WE'RE GONNA SAY THAT

FOR HOME HEALTH,
THE ENROLLEE PAYS

BETWEEN ZERO AND 10% FOR

THE MEDICARE COVERED BENEFITS

AND 20% FOR RESPITE CARE.

SO ON THE FIRST SCREEN,
WHERE IT SAYS,

"DO YOU OFFER ANY MANDATORY
[INDISTINCT] BENEFITS?"

WE WOULD INDICATE YES.

WE WOULD SELECT THE RESPITE CARE

AND THEN INDICATE THAT THAT'S
A MANDATORY BENEFIT.

AND THEN OVER ON THE RIGHT-HAND
SIDE OF THE SCREEN,

YOU CAN SEE IS THERE
AN ENROLLEE COINSURANCE?

NOW YOU CAN SEE THAT THOSE
QUESTIONS ARE ALL RED,

SO THAT MEANS THEY FEED INTO THE
SUMMARY OF BENEFITS SENTENCES.

SO THIS DATA ENTRY WILL GENERATE

INFORMATION IN THE SUMMARY
OF BENEFITS.

SO WE SAID, YES, WE DO
HAVE A COINSURANCE,

SO WE WOULD ENTER--
FOR THE FIRST ONE,

THE MINIMUM COINSURANCE FOR
MEDICARE WE WOULD ENTER IS ZERO.

FOR THE MAXIMUM AMOUNT,
WE WOULD PUT IN 10.

AND THEN SINCE WE SAID WE'RE ALSO
OFFERING RESPITE CARE, OK,

20%, WE WOULD PUT IN
THE 20% FOR BOTH.

SO YOU CAN ENTER THE SAME AMOUNT
FOR BOTH MIN AND MAX.

OK, THE ONLY THING--THE RULES THAT
ARE BEHIND THE SCENES

THAT THE SOFTWARE IS GONNA CHECK
IS TO MAKE SURE THAT, AGAIN,

THAT THE NUMBERS
SORT OF MAKE SENSE,

THE MIN-MAX WITH EACH OTHER.

ANOTHER EXAMPLE OF HOW
THE INTERVALS WORK,

WE'RE GONNA LOOK AT
SKILLED NURSING FACILITY, OK,

SO IF WE'RE CHARGING ZERO
FOR THE FIRST 20 DAYS

AND $100 A DAY UP TO 100 DAYS,

WE WOULD INDICATE TWO INTERVALS,

AND THESE EXAMPLES ARE STRICTLY
FOR ILLUSTRATION PURPOSES ONLY,

OK, JUST TO SORT OF SHOW YOU

HOW THE DATA ENTRY
FIELDS WORK, OK?

THIS IS NOT ANYTHING
THAT, YOU KNOW,

WE WOULD RECOMMEND
YOU FOLLOWING.

IT'S JUST FOR AN EXAMPLE.

SO IN THIS CATEGORY,
ONCE WE GO THROUGH THE [INDISTINCT] SCREENS

AND WE GET TO
THE COPAYMENT FIELD,

WE WOULD ANSWER YES,
WE ARE OFFERING A COPAYMENT

OR THE ENROLLEE DOES HAVE TO PAY
A COPAYMENT AMOUNT.

WE ARE NOT CHARGING

THE MEDICARE DEFINED AMOUNT,

SO THERE ARE A COUPLE
SECTIONS WHERE

IT WILL ASK YOU ARE YOU
CHARGING THE SAME AS MEDICARE?

SINCE THE MEDICARE DEFINED AMOUNTS
AREN'T PROVIDED

UNTIL THE END OF THE SUMMER,
EARLY FALL,

YOU DON'T HAVE TO HAVE
ANY SPECIFIC DATA ENTRY.

YOU DON'T HAVE
TO ENTER THE AMOUNT. YOU CAN JUST SAY YES,

WE'RE GONNA CHARGE
THE SAME AS MEDICARE.

IN OUR EXAMPLE, WE'RE CHARGING
SOMETHING DIFFERENT,

SO WE WOULD SAY NO, AND THEN

WE WOULD INDICATE THAT WE WERE
OFFERING TWO INTERVALS,

SO WE WOULD ENTER
A ZERO COPAYMENT AMOUNT

FOR THE FIRST INTERVAL

AND ENTER THE BEGIN DAY AS ONE
AND THE END DAY AS 20, OK,

SO THE ENROLLEE HAS A ZERO COPAY
FOR THE DAYS ONE THROUGH 20,

BUT DAYS 21 THROUGH 100, OK,

THERE'S A $100 COPAY.

SO THAT'S OUR SECOND INTERVAL.

SO THOSE ARE
OUR EXAMPLES

TO SORT OF SHOW YOU
SOME OF THE DIFFERENT WAYS

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THAT YOU CAN ENTER
THE COST SHARING IN SECTION B.

AND AGAIN, IT'S GONNA
VARY BY CATEGORY

DEPENDING ON SORT OF
THE SET OF BENEFITS

THAT'S CONTAINED
IN THAT CATEGORY.
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Part 6

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TED WILL TALK
ABOUT SECTION C NOW.

SECTION C. THIS IS...

WHERE YOU'RE GOING TO ENTER
YOUR OUT-OF-NETWORK BENEFITS

OR YOUR POINT-OF-SERVICE
BENEFITS

AND WHETHER OR NOT YOU HAVE
A VISITOR/TRAVEL PROGRAM.

THIS IS WHERE THAT MATRIX
WE TALKED ABOUT EARLIER THAT'S IN THE BID SUBMISSION MANUAL,

THIS IS WHERE THAT REALLY
COMES INTO PLAY

BECAUSE YOU'RE ONLY GOING
TO SEE THE SECTION-C SCREENS

THAT ARE APPROPRIATE
FOR YOUR PLAN TYPE,

SO IF YOU EXPECT
TO BE ABLE TO ENTER, SAY,

A POINT-OF-SERVICE OPTION
AND YOU'RE NOT ABLE TO,

CHECK YOUR PLAN TYPE,
CHECK THAT MANUAL.

IT SHOULD MAKE SENSE TO YOU.

SO LET'S TALK
ABOUT OUT-OF-NETWORK SERVICE CATEGORIES.
```

PPO AND FULL NETWORK PFFS PLANS

HAVE TO OFFER THE SAME BENEFITS
IN-NETWORK AND OUT-OF-NETWORK.

SO THIS IS WHERE YOU'RE GOING
TO SEE THOSE OUT-OF-NETWORK SERVICE CATEGORIES

AND WHERE YOU'RE GOING TO ENTER
THAT DATA FOR YOUR OFFERING.

IF YOU ARE NOT A FULL-NETWORK
PPO OR PFFS PLAN

AND YOU'RE COVERING
OUT-OF-NETWORK BENEFITS,

YOU CAN SUB-SET THE ENTIRE LIST
OF BENEFIT CATEGORIES

THROUGH THE USE OF A PICK LIST,
AND WE'LL LOOK AT THAT IN A LITTLE BIT.

FOR POINT-OF-SERVICE OFFERINGS,

IT'S A SIMILAR SET-UP TO

WHAT WE JUST SAW IN SECTION B,

SO YOU CAN OFFER IT MANDATORY

OR OPTIONAL.

YOU CAN SELECT

SERVICE CATEGORIES FOR

THE POINT-OF-SERVICE OFFERING,

AND YOU CAN HAVE A COVERAGE

LIMIT, AN OUT-OF-POCKET LIMIT,

DEDUCTIBLE, AUTHORIZATION,

REFERRAL--ALL THOSE QUESTIONS

ARE GOING TO BE THERE,

SO THE SAME TYPE OF DATA ENTRY

THAT YOU JUST DID IN SECTION B,

YOU'RE GOING TO SEE
THE SAME TYPES OF THINGS HERE

IN SECTION C FOR
THE POINT-OF-SERVICE SCREENS.

AND THEN, FOR VISITOR/TRAVEL,

A LITTLE BIT LESS DATA ENTRY,
BUT STILL SIMILAR:

MANDATORY OR OPTIONAL
COVERAGE LIMIT,

AUTHORIZATION, OR REFERRAL.

FOR 2011, A CHANGE--
THERE'S ONLY A U.S. OFFERING.

THERE IS NO FOREIGN
VISITOR/TRAVEL, SO IF YOU ARE FAMILIAR WITH THE 2010 SOFTWARE,

WHICH, I KNOW MOST OF YOU
PROBABLY ARE NOT--YOU WON'T SEE THOSE SET OF SCREENS AT ALL.

THEY DON'T EXIST THIS YEAR.

SO LET'S SORT OF TALK
ABOUT INPATIENT HOSPITAL

AND SKILLED NURSING FACILITIES
AND HOW WE'RE GOING TO SHOW

THE COST SHARE STRUCTURE
HERE IN SECTION C.

YOU STILL HAVE YOUR CO-INSURANCE
AND CO-PAYMENT OPTIONS,

AND YOU CAN STILL CHOOSE
MEDICARE-DEFINED COSTS.

YOU ALSO ARE ABLE TO PUT IN
A SINGLE AMOUNT PER STAY,

SO, YOU KNOW, $500 NO MATTER
HOW LONG THE STAY IS,

OR YOU CAN DO VARIABLE
DATA ENTRY WITH INTERVALS

LIKE WE JUST SAW IN THE EXAMPLE
THAT TERRY SHOWED IN SECTION B.

SO--AND THEN, OF COURSE,
THERE IS A DEDUCTIBLE AS WELL.

FOR YOUR OUTPATIENT SERVICES,
YOU'RE GOING TO PUT TOGETHER WHAT'S CALLED GROUPS,

AND THESE GROUPS
ARE WHERE YOU'RE GOING TO WANT TO PUT TOGETHER

ALL OF YOUR SERVICES THAT
YOU'RE GOING TO HAVE THE SAME COST-SHARING STRUCTURE FOR.

SO THERE WILL BE A PICK LIST
AND YOU CAN PICK AND CHOOSE FROM ALL OF THE SERVICE CATEGORIES,

WHICH YOU HAVE THE SAME
COST SHARE STRUCTURE FOR.

YOU'RE GOING TO CREATE A GROUP,
PUT THEM ALL IN THAT ONE GROUP,

AND THEN YOU ONLY HAVE
TO DO YOUR DATA ENTRY FOR THE COST-SHARING ONE TIME.

AND YOU CAN HAVE UP
TO 15 GROUPS, SO THAT COVERS EVERY SCENARIO WE'VE EVER SEEN,

AS FAR AS THE DIFFERENT
COST SHARE STRUCTURES FOR ALL THE SERVICES.

AND THE COST SHARE STRUCTURE
THERE IS CO-INSURANCE AND CO-PAYMENTS,

MIN AND MAXES,
AND DEDUCTIBLES AVAILABLE.

SO NOW WE'RE GOING TO LOOK
AT A COUPLE OF SCREENS,

JUST TO SEE WHAT ALL
OF THIS REALLY LOOKS LIKE.

OK, SO HERE WE ARE.
WE'RE IN SECTION C,

AND WE'RE LOOKING
AT A VISITOR/TRAVEL BENEFIT.

THE FIRST QUESTION IS
SIMPLY DO YOU OFFER IT?

IF YOU DON'T, YOU SAY NO,
EVERYTHING ELSE IS GRAYED OUT, BUT HERE WE'RE SAYING YES,

AND THE CHILD QUESTIONS, WHICH
ARE ALL OF THE OTHER QUESTIONS ON THE SCREEN, BECOME ENABLED.

SO YOU'RE GOING TO BE ABLE
TO CHOOSE IT AS MANDATORY OR OPTIONAL.

YOU CAN SEE BELOW THE BUBBLE
THERE ON THE LEFT-HAND SIDE OF THE SCREEN

ARE ALL OF THE DIFFERENT
SERVICE CATEGORIES,

SO THAT'S WHERE YOU'RE GOING
TO PICK AND CHOOSE THEM.

ON THE RIGHT-HAND SIDE
OF THE SCREEN IS WHERE WE'RE GOING

TO HAVE OUR MAXIMUM
PLAN BENEFIT COVERAGE AND SOME INTERVALS FOR HOW OFTEN:

EVERY YEAR, EVERY OTHER YEAR,
EVERY 6 MONTHS, THOSE TYPES OF THINGS.

IF YOU ARE OFFERING THIS
WITH THE SAME COST-SHARING AS WHAT YOU DID IN SECTION B,

YOU'RE NOT GOING TO HAVE
TO ENTER ANY OF YOUR SECTION-B INFORMATION AGAIN.

YOU DON'T HAVE TO MIRROR THAT;
YOU CAN JUST SAY THAT, YES, YOU'RE GOING TO OFFER IT

WITH THE SAME COST-SHARING, AND
THAT'S GOING TO LEAVE THE REST OF THESE QUESTIONS DISABLED.

IF YOU SAY NO AND YOU HAVE
DIFFERENT COST-SHARING, THIS IS WHERE YOU'RE GOING TO ENTER IT.

SO THIS IS THE SCREEN
WHERE YOU'RE CREATING GROUPS.

THE FIRST THING YOU HAVE
TO DO IS KNOW HOW MANY GROUPS YOU WANT TO CREATE.

WHEN YOU CREATE THOSE GROUPS,
WHAT'S GOING TO HAPPEN IS

THE PBP IS GOING TO CREATE
THE SCREENS BEHIND IT FOR YOU

TO PUT IN YOUR DATA ENTRY
FOR ALL THOSE GROUPS,

SO AFTER YOU ENTER THE NUMBER
OF GROUPS UP IN THE "GO TO,"

OUR LITTLE NAVIGATION BAR THERE,
WHEN YOU CLICK DOWN ON IT,

YOU'RE GOING TO HAVE EACH
OF THE GROUPS NUMBERED OUT, ONE THROUGH HOWEVER MANY YOU HAVE.

IN THIS CASE SCENARIO,
I BELIEVE WE HAVE 3 THAT WE'RE PUTTING IN THERE.

SO YOU'RE GOING TO HAVE
THE 3-GROUP SCREEN

FOR YOU TO PUT IN ALL
YOUR COST-SHARE INFORMATION ABOUT EACH GROUP.

BUT ON THIS SCREEN,
ALL YOU'RE DOING IS SAYING HOW MANY GROUPS ARE THERE,

THEN ON THE BOTTOM--THIS IS
ACTUALLY TWO SCREENS WITH THE BUBBLES COVERING IT UP--

WE SEE WHAT THE FIRST GROUP
SCREEN IS GOING TO LOOK LIKE.

SO ON THIS SCREEN,
YOU'RE GOING TO NAME THE GROUP-- THAT'S PUTTING IN A LABEL--

AND THEN THERE'S THE PICK LIST
THERE FOR YOU TO CHOOSE

WHICH SERVICE CATEGORIES ARE
INCLUDED IN THE GROUP.

SO IF YOU'RE IN GROUP ONE,
YOU'RE GOING TO NAME IT

AND THEN YOU'RE GOING TO SCROLL
THROUGH AND IT'S, YOU KNOW,

JUST CONTROL AND CLICK
TO CHOOSE WHICH ONES YOU ARE GOING TO INCLUDE.

THEN ON THE RIGHT-HAND SIDE,
THAT'S WHERE WE GET INTO SOME OF THE COST-SHARING,

SO THE CO-INSURANCE,
CO-PAYMENTS.

SO THIS IS JUST TO GIVE
AN EXAMPLE HERE.

WE'VE GOT--VISITOR/TRAVEL STILL
IS WHAT WE'RE TALKING ABOUT.

YOU CAN SEE THAT WE'RE
CHOOSING IN OUR PICK LIST

EVERYTHING DOWN TO...EYE EXAMS.

SO EVERY OTHER SERVICE
CATEGORY WE'VE CHOSEN,

AND WE'RE GOING TO HAVE
THE ENROLLEE PAY 40% FOR ALL OUTPATIENT SERVICES

AND 50% FOR THE VISION
AND HEARING.

WELL, EVERYTHING
ABOVE WHAT WE'VE CHOSEN IS THE OUTPATIENT SERVICES,

AND THE VISION AND HEARING ARE
THE ONES WE HAVE NOT SELECTED.

SO WE'RE IN THIS GROUP
WHERE WE'RE LOOKING AT THE 40%.

SO WE'VE SELECTED ALL
OF THOSE SERVICE CATEGORIES,

THEN HERE ON THE RIGHT SIDE,
WE'VE ANSWERED YES TO CO-INSURANCE,

AND IN THE MIN
AND THE MAX, WE PUT 40%.

HERE'S OUR OTHER GROUP,
WHERE WE HAVE OUR VISION AND HEARING SERVICES.

SO WE'VE ONLY SELECTED
VISION AND HEARING ON THE LEFT-HAND SIDE.

WE'VE NAMED THE GROUP VISION
AND HEARING, AND WE HAVE, AGAIN, ON THE RIGHT-HAND SIDE,

CHOSEN CO-INSURANCE
AND THIS TIME WE'VE ADDED 50% IN THE MIN AND THE MAX.

IF YOU WANTED TO HAVE A RANGE,
OF COURSE YOU WOULD ENTER THAT AS APPROPRIATE.

Part 7

ALL RIGHT, TERI'S GONNA TALK
ABOUT SECTION "D" A LITTLE BIT.

OK, SO WE'VE GONE
THROUGH SECTION "B,"

WHICH IS DETAILED
IN-NETWORK BENEFIT DATA ENTRY.

SECTION "C," WHICH IS, FOR THE
MOST PART, OUT-OF-NETWORK--

SOME DETAIL, SOME LESS
DETAILED DATA ENTRY.

AND AGAIN, MOST OF THAT'S
AT THE BENEFIT LEVEL.

SECTION "D" IS PLAN
LEVEL COST SHARES.

SO THIS IS WHERE YOU WOULD ENTER
YOUR PLAN LEVEL DEDUCTIBLE,

THE ENROLLEE OUT-OF-POCKET
MAXIMUM, ANY MAXIMUM

BENEFIT COVERAGE AMOUNTS THAT
APPLY TO NON-MEDICARE COVERED

BENEFITS, AGAIN,
AT THE PLAN LEVEL.

FOR COST PLANS THAT DO NOT
DO BPTs, HERE THEY CAN ENTER

THEIR PLAN PREMIUM AND
PREMIUM REDUCTION INFORMATION.

AND FOR PRIVATE FEE PLANS
THAT DO BALANCE BILLING,

THAT'S WHERE YOU WOULD
ENTER THIS INFORMATION.

WHEN YOU DO A PLAN-LEVEL
DEDUCTIBLE, IT'S GONNA LET YOU

SELECT TO WHICH SERVICE
CATEGORIES DOES THAT DEDUCTIBLE APPLY, OK?

SO IT DOESN'T NECESSARILY HAVE

TO APPLY ACROSS THE BOARD.

AND ALSO, AGAIN, DEPENDING
ON YOUR PLAN TYPE AND YOUR

NETWORK INDICATOR--SO THAT'S
INFORMATION THAT'S FROM

SECTION "A"--IT'S GONNA
GENERATE DIFFERENT SCREENS.

SO IF YOU ARE A REGIONAL PPO,
FOR EXAMPLE, YOU'RE GONNA GET

SCREENS THAT COVER A
COMBINED DEDUCTIBLE AMOUNT.

SO IN-NETWORK AND
OUT-OF-NETWORK TOGETHER.

IF YOU'RE AN HMO, YOU'LL SEE A
SCREEN THAT SAYS, "IN-NETWORK"

BECAUSE BASICALLY YOU ONLY
HAVE IN-NETWORK BENEFITS.

AGAIN, FOR PPOs, YOU'LL SEE
SOME OUT-OF-NETWORK SCREENS,

AND IF YOU ARE A NON-NETWORK
PRIVATE FEE PLAN, YOU'LL SEE

SCREENS THAT SAY, "GENERAL"

BECAUSE THE NETWORK
CONCEPT DOESN'T REALLY EXIST.

SO YOU CAN ALWAYS LOOK IN
THAT NAVIGATION BAR AND SEE

WHERE YOU ARE,
AND YOU'LL SEE, YOU KNOW,

THIS INFORMATION: IN-NETWORK,
OUT-OF-NETWORK, OR GENERAL.

MAXIMUM ENROLLEE OUT-OF-POCKET
COST--THE SCREENS, AGAIN,

FOR THIS ARE VERY SIMILAR,
DEPENDING ON YOUR PLAN TYPE AND YOUR NETWORK INDICATOR.

BUT THE DIFFERENCE HERE IS
THAT WHEN YOU ENTER AN AMOUNT

AND IT ASKS YOU, "DOES
THIS APPLY TO EVERYTHING?"

IF YOU SAY, "NO,"
THEN IT'S GONNA SAY,

"OK. TELL ME SPECIFICALLY
WHICH CATEGORIES ARE EXCLUDED.

WHICH CATEGORIES ARE
YOU NOT INCLUDING UNDER THIS OUT-OF-POCKET COST?"

SO THAT THEN GETS FED INTO THE
SUMMARY OF BENEFITS, AND IT

BECOMES VERY TRANSPARENT TO THE
ENROLLEE WHAT'S NOT INCLUDED.

SO THAT'S DIFFERENT THAN THE
DEDUCTIBLE AND THE MAXIMUM

PLAN BENEFIT COVERAGE,
WHICH ASKS YOU, "WHICH CATEGORIES ARE INCLUDED?"

THIS ONE SPECIFICALLY ASKS YOU
WHICH CATEGORIES ARE EXCLUDED.

HERE'S OUR DEDUCTIBLE SCREEN.

YOU CAN SEE WE HAVE BOTH
RED AND BLUE VARIABLES.

"IS THERE AN IN-NETWORK
PLAN DEDUCTIBLE AMOUNT?" "YES."

AND THEN IT'S GONNA ASK YOU, "DO
YOU CHARGE THE MEDICARE AMOUNT?"

OK, AGAIN, SINCE WE DON'T KNOW
WHAT THAT IS, WE DON'T HAVE

A SPECIFIC DOLLAR AMOUNT IN
THE SOFTWARE, BUT WHEN THE

SENTENCES GET GENERATED
THERE WILL BE PLACEHOLDERS,

AND THEN IN THE FALL
THEY'LL GET UPDATED.

IF YOU DON'T CHARGE THE SAME
AS MEDICARE, YOU CAN PUT

IN YOUR OWN AMOUNT,
AND THEN IT WILL SAY,

"OK, DOES THIS
APPLY TO THE IN-NETWORK

"MEDICARE-COVERED BENEFITS?

DOES IT ALSO APPLY TO THE
NON-MEDICARE COVERED BENEFITS?"

AND THERE YOU CAN
SELECT ONE OR BOTH, OK?

WHICHEVER ONE IS
APPLICABLE FOR YOUR PLAN.

IF YOU SAY, "IT DOESN'T APPLY
TO EVERYTHING," THEN, AGAIN,

YOU CAN SELECT THE
DIFFERENT SERVICE CATEGORIES.

MAXIMUM ENROLLEE OUT-OF-POCKET
COST--AGAIN, THIS IS GONNA GO

THROUGH SORT OF THE SAME
SERIES OF QUESTIONS,

BUT INSTEAD OF INDICATING
WHICH SPECIFIC CATEGORIES ARE

INCLUDED IF YOU DON'T COVER
EVERYTHING, IT'S GONNA ASK

YOU, "OK, WHAT'S NOT--WHAT'S
NOT INCLUDED UNDER THIS?"

SO YOU SEE THE WORD
"EXCLUDED" IN CAPITAL LETTERS.

AND ALL THE QUESTIONS
HERE ARE RED,

SO EVERYTHING
GOES INTO THE S.B.

AGAIN, IF YOU'RE OFFERING
SOME BENEFITS OVER AND ABOVE

MEDICARE AND THERE'S SORT OF
A PLAN LEVEL DOLLAR CAP

ON THOSE, YOU WOULD ENTER THAT

HERE IN SECTION "D," AND THEN

YOU CAN, AGAIN, ENTER THE
AMOUNT AND SELECT WHICH

CATEGORIES ARE--THAT APPLIES TO.

SO, A QUICK EXAMPLE: IF WE
HAVE AN OUT-OF-POCKET COST

LIMIT IN-NETWORK OF
$3,000, WE'D ANSWER,

"YES, WE HAVE THAT."
ENTER THE 3,000.

IT APPLIES TO OUR IN-NETWORK
MEDICARE-COVERED BENEFITS,

BUT NOT EVERYTHING IS INCLUDED.

OK, WE ARE EXCLUDING OUR
EYE EXAMS AND OUR EYEWEAR.

SO THEN, IN THE "PICK"
LIST ON THE RIGHT-HAND SIDE

WE WOULD SELECT
THOSE 2 CATEGORIES.

ONE MORE THING ABOUT SECTION
"D": IF YOU ARE OFFERING

RIDERS, OPTIONAL SUPPLEMENTAL
PACKAGES, YOU WOULD CREATE

THOSE PACKAGES
IN THIS SECTION

AFTER YOU DO THE
PLAN LEVEL COST SHARING.

SO IN SECTION "B," IN THE
DIFFERENT SERVICE CATEGORIES

WHERE YOU CAN ENTER ENHANCED
BENEFITS, YOU CAN INDICATE

THAT THOSE SPECIFIC
BENEFITS ARE OPTIONAL.

YOU CAN ALSO CREATE SOME
OPTIONAL BENEFITS

IN SECTION "D."

THERE ARE 9 SORT OF MORE
POPULAR CATEGORIES THAT--WHERE

OPTIONAL BENEFITS ARE CREATED
AT, YOU KNOW, CHIROPRACTIC,

PODIATRY, THE VISION
CATEGORIES, THE HEARING

CATEGORIES, AND THE
DENTAL CATEGORIES.

SO FOR THOSE YOU
CAN CREATE, ACTUALLY,

MULTIPLE--MULTIPLE
BENEFITS STEP-UPS, OK?

SO YOU CAN HAVE MORE THAN
ONE PACKAGE THAT CREATE--THAT

CONTAINS THAT CATEGORY,
AND THEN YOU CAN CHANGE YOUR

DATA ENTRY IN THAT
CATEGORY AS YOU SORT OF

STEP UP THAT BENEFIT.

SO THAT'S ALL IN SECTION "D."

AND PLUS, IF YOU ARE LIKE A
PPO OR ANOTHER PLAN TYPE THAT

DOES OUT-OF-NETWORK BENEFITS
AND YOU HAVE TO OFFER THE SAME

BENEFITS IN-NETWORK AS
OUT-OF-NETWORK, IF YOU

CREATE OPT SUPP BENEFITS AND
YOU'RE OFFERING THEM IN-NETWORK,

THEN YOU'RE GONNA ALSO HAVE
THE OUT-OF-NETWORK SCREENS

TO INDICATE WHETHER
THE COST SHARING IS THE SAME

OR IF IT'S DIFFERENT.

SO THAT'S A REAL BRIEF

OVERVIEW OF SECTION "D."

Part 8

OK, SO NOW WE'RE REALLY
SWITCHING GEARS.

WE GET SECTION RX, AND...

IT CAN BE LONG, DEPENDING
ON HOW MUCH DATA ENTRY YOU HAVE TO DO.

SO THE 4 PART-D COVERAGE TYPES:
DEFINED STANDARD, A.E.,

BASIC ALTERNATIVE,
ENHANCED ALTERNATIVE.

AS YOU SORT OF LOOK
THROUGH THESE SCREENS,

DEPENDING ON WHICH
COVERAGE TYPE YOU ARE,

IT'S GOING TO DETERMINE
HOW MUCH DATA ENTRY YOU ACTUALLY ARE GOING TO HAVE TO DO,

AND AS WE SORT OF
GO DOWN THAT LIST, IT GETS MORE DETAILED.

SO WE'RE SORT OF GOING TO TALK
TO...TODAY MORE THINKING ABOUT,

OK, YOU'RE AN ENHANCED
ALTERNATIVE,

SO WE CAN LOOK AT EVERYTHING
THAT IS POSSIBLY THERE.

EACH PLAN CAN ONLY DEFINE
ONE PART-D COVERAGE TYPE IN THE SOFTWARE.

SO THE FIRST SCREEN IS

OUR GENERAL SCREEN NUMBER ONE.

THAT'S WHERE YOU'RE GOING TO

DEFINE YOUR DRUG TYPE BENEFIT,

AND UNLESS YOU'RE IN

A DEFINED STANDARD PLAN,

IT'S ALSO WHERE YOU'RE GOING

TO TALK ABOUT HOW MANY TIERS

YOU HAVE.

IF YOU'RE AN ENHANCED

ALTERNATIVE PLAN, YOU ALSO HAVE

TO INDICATE WHETHER OR NOT

THIS PLAN IS YOUR BASIC PLAN

OR IF THERE'S ANOTHER ONE

THAT...IS YOUR BASIC PLAN,

IS GOING TO COVER THE SAME

SERVICE AREA AS THE PLAN YOU'RE

TALKING ABOUT CURRENTLY

IN THE PBP.

WE'RE ALSO GOING TO TALK

ABOUT THE COMPONENTS OF

OUR PHARMACY NETWORK.

ALL OF THE LOCATIONS

ARE CHOSEN HERE,

AND THAT DATA ENTRY IS IMPORTANT

BECAUSE THAT'S GOING TO CARRY

THROUGH LATER ON IN THE PBP.

SO WHAT YOU ANSWER HERE

IF YOU'RE A PHARMACY

NETWORK COMPONENT,

THAT'S GOING TO CARRY THROUGH.

WE'RE GOING TO SEE THAT AGAIN

AND AGAIN, REPEATED

THROUGHOUT THE PBP,

SO IF YOU MAKE A MISTAKE,

YOU'RE GOING TO WANT TO COME ALL

THE WAY BACK TO THIS FIRST

SCREEN AND MAKE THE CHANGE THERE

SO THAT IT SORT OF CASCADES

THROUGH YOUR DATA ENTRY.

IF YOU DON'T, THEN WHEN YOU TRY

TO EXIT/VALIDATE, YOU'RE GOING

TO RUN INTO SOME ERRORS THAT

YOU'RE GOING TO HAVE TO FIX.

THIS SCREEN ALSO DEALS

WITH QUANTITY LIMITS,

PRIOR AUTHORIZATION,

AND STEP THERAPY.

THE SECOND SCREEN
IS WHAT WE CALL OUR GENERAL SCREEN NUMBER 2.

THAT'S WHERE YOU'RE GOING
TO FILL IN YOUR OTCs

IF YOU HAVE A UTILIZATION
MANAGEMENT PROGRAM,

ANY LIMITED ACCESS, IF YOU'RE
OFFERING FREE FIRST FILL,

PARTIAL PRESCRIPTIONS,

AND YOU'LL INDICATE
WHETHER OR NOT THIS IS THE NATIONAL PLAN.

SO THIS CHART, HOPEFULLY,

IS PRETTY HELPFUL FOR YOU.

WHAT IT DOES ACROSS THE TOP IS

WE HAVE THE 4 PLAN TYPES,

AND THEN ON THE LEFT-HAND SIDE

WE HAVE WHAT DATA ENTRY IS

REQUIRED, SO YOU CAN SEE

THAT THE ENHANCED ALTERNATIVE...

PRETTY MUCH EVERYTHING IS

GOING TO BE REQUIRED.

BUT DEFINED STANDARD--THERE'S

NOT A LOT THAT YOU WILL ACTUALLY

BE ENTERING BECAUSE YOU'RE GOING

TO BE USING THE MEDICARE-DEFINED

COSTS, SO WE'RE NOT GOING

TO ASK YOU ANY QUESTIONS.

TIERS.

ON THAT FIRST SCREEN,
YOU'RE GOING TO DESCRIBE

HOW MANY TIERS
YOUR PLAN OFFERS.

FOR 2011, YOU ARE
LIMITED TO 6 TIERS.

PREVIOUSLY IT HAD BEEN 10,
SO THAT IS A CHANGE,

AND IF YOU TRY TO ENTER MORE
THAN 6 IN THE SOFTWARE,

IT'S GOING TO STOP YOU
RIGHT AWAY

AND MAKE YOU ENTER
SOMETHING 1 THROUGH 6.

AS YOU'RE ENTERING
YOUR TIERS IN THE PBP,

YOU'LL WANT TO ENTER YOUR TIERS IN
ASCENDING ORDER OF COST,

SO YOUR FIRST TIER IS GOING
TO BE YOUR LEAST EXPENSIVE

AND YOUR LAST TIER WILL BE
YOUR MOST EXPENSIVE

AND YOU'RE GOING
TO GO UP THROUGH THERE.

THE PBP, AS YOU ENTER TIERS,
IS GOING TO CREATE A NUMBER

FOR THEM AUTOMATICALLY,
SO THE FIRST TIER YOU ENTER

IS GOING TO BE NUMBER ONE
AND SO ON.

YOU CAN USE WHAT WE CALL
OUR TIER COPY FUNCTION,

AND THAT'S GOING
TO BE REALLY HELPFUL.

IT'S GOING TO COPY
YOUR TIER TYPE, LABEL,

LOCATION AND DAYS SUPPLIES
FROM THE TIER YOU'RE IN

TO ANY OTHER TIER YOU WANT,
SO YOU CAN TAKE THAT INFORMATION

AND COPY IT THROUGH
TO THE OTHER TIERS.

IT'S GOING TO SAVE YOU A LOT
OF TIME IN YOUR DATA ENTRY,

ESPECIALLY IF YOU'VE GOT
A PLAN WITH 6 TIERS,

YOU KNOW, AND ALL OF YOUR
DAYS SUPPLIES, OF COURSE,

ARE GOING TO--YOU CARRY THOSE
THROUGH IN THE SAME QUANTITY

AT THE SAME LOCATION,

IT'LL SAVE YOU SOME TIME.

IF YOU'VE ENTERED TIERS PRE-ICL,

THE LABEL AND LOCATION
THAT YOU ENTER PRE-ICL

IS GOING TO CARRY FORWARD, SO
IF YOU'RE OFFERING GAP COVERAGE

AND/OR YOU'RE OFFERING TIERS
IN THE POST-CATASTROPHIC AREA,

THAT INFORMATION'S GOING
TO CARRY THROUGH.

SO THIS IS ANOTHER PLACE
WHERE WHAT YOU DO FIRST

CARRIES THROUGH IN THE PBP,
SO IT'S IMPORTANT

THAT IF YOU'VE GOT PRE-ICL
AND GAP TIERS

THAT YOU GET THE DATA RIGHT
IN THE PRE-ICL TIERS

BECAUSE YOU'RE NOT GOING
TO BE ABLE TO CHANGE IT IN THE GAP TIERS,

AND IF YOU WANT TO CHANGE IT, YOU'RE
GOING TO HAVE TO GO BACK

TO THE PRE-ICL TIERS
TO MAKE THOSE CHANGES.

WITHIN ENTERING A TIER,
WE HAVE WHAT'S CALLED OUR TIER TYPE SCREEN.

ON THIS SCREEN, YOU'RE GOING TO
ENTER IN YOUR DRUG INFORMATION

ABOUT WHAT TYPES OF DRUGS
ARE INCLUDED AND WHETHER OR NOT

THESE ARE ONLY PART-D DRUGS,
ONLY EXCLUDED DRUGS,

OR IF IT'S A TIER
THAT COMBINES BOTH.

NEW THIS YEAR,
YOU CAN INDICATE

THAT THE TIER OFFERS
INJECTABLE DRUGS ONLY.

ALSO, YOU'LL BE INDICATING
WHETHER OR NOT

THIS IS YOUR SPECIALTY
OR YOUR EXCEPTIONS TIER.

ONCE YOU ENTER THAT,

THE NEXT SCREEN IS WHAT WE CALL
OUR TIER LABEL SCREEN.

THIS IS WHERE
YOU'RE GOING TO CHOOSE

WHAT THE NAME OF THE TIER IS.

IN PREVIOUS YEARS,

WHAT WAS AVAILABLE WAS
A FREE-FORM TEXT BOX.

FOR THIS YEAR, WHAT WE'VE DONE IS
WE'VE CREATED A PICK LIST

OF POSSIBLE TIER LABELS.

BASED ON WHAT YOU'VE ENTERED
ON YOUR TIER TYPE SCREEN

IS GOING TO DETERMINE
WHAT YOUR TIER LABEL CAN BE.

THIS IS GOING TO BE
WHERE YOU MIGHT WANT TO USE

WHAT WE DESCRIBED EARLIER,
WHICH IS THE VARIABLE HEALTH.

IF YOU RIGHT-CLICK
ON THAT TIER LABEL SELECTION,

IT'S GOING TO SHOW YOU
ALL OF THE RULES

THAT GOVERN WHAT TYPE
OF TIER LABEL,

WHAT NAME YOU CAN CHOOSE BASED
ON WHAT YOU'VE DONE BEFORE.

SO YOU CAN LOOK AND SEE, "OK,

I KNOW THAT I HAVE

A SPECIALTY TIER,"

SO YOU CAN SCROLL DOWN
IN THAT VARIABLE HEALTH,

FIND WHAT LABEL IS APPROPRIATE,

AND THEN MAKE YOUR SELECTION
ON THE SCREEN.

TIER LOCATION SCREEN.

SO WE'VE GOT A TIER LABEL NAME;
NOW WE'RE GOING TO SELECT

WHAT LOCATIONS, WHAT PHARMACIES,

AND THE DAYS SUPPLY AMOUNTS.

SO THIS IS WHERE WHATEVER
YOU PREVIOUSLY DEFINED

AS YOUR PHARMACY SET-UP ON
THAT FIRST GENERAL ONE SCREEN,

THIS IS WHERE IT'S GOING TO HAVE TO
MATCH WHAT YOU SAID EARLIER.

EACH PLAN'S GOING TO BE
REQUIRED TO OFFER AT LEAST

ONE IN-NETWORK LOCATION--
EITHER A RETAIL PHARMACY

OR PREFERRED/NON-PREFERRED.

YOU ARE NOT GOING TO BE
ALLOWED TO CHOOSE

JUST A GENERAL IN-NETWORK
PHARMACY AND PREFERRED;

IT'S ONE OR THE OTHER.

IF YOU'RE EITHER JUST UNSURE
OF THE GENERALIZED

IN-NETWORK PHARMACY
OR IN-NETWORK PREFERRED,

IN-NETWORK NON-PREFERRED,
SAME FOR OUT-OF-NETWORK.

AND THEN, ALSO,

YOU'LL BE INDICATING

YOUR LONG-TERM CARE
PHARMACIES HERE.

YOU ARE GOING TO BE THEN GIVEN
YOUR COST SHARE SCREENS.

THERE WILL BE ONE SCREEN
FOR COINSURANCE, ONE SCREEN FOR CO-PAYMENT,

AND HERE YOU'RE GOING TO
INDICATE WHICH OF THOSE SCREENS WE'RE GOING TO ACTIVATE,

SO YOU'RE GOING TO TELL US
ARE YOU OFFERING A COINSURANCE, OFFERING A CO-PAYMENT,

OR YOU'RE OFFERING
A GREATER THAN/LESSER OF SITUATION.

DEPENDING ON HOW
YOU ANSWER THAT QUESTION,

THEN WE'RE GOING TO ENABLE
THE APPROPRIATE SCREENS.

AND THOSE SCREENS ARE GOING
TO HAVE FIELDS ENABLED ONLY FOR YOUR NETWORK COMPONENTS,

SO IF YOU HAVE AN IN-NETWORK
PHARMACY AND YOU'RE OFFERING A 30-DAY SUPPLY,

THAT FIELD IS GOING
TO BE AVAILABLE,

BUT IF YOU ARE ALSO OFFERING
A 3-MONTH SUPPLY

BUT YOU NEGLECTED TO MENTION THAT
FIRST WHEN YOU SET UP THE NETWORK COMPONENT,

WHEN YOU GO TO ENTER
YOUR COST-SHARE INFORMATION,

THAT'S GOING TO BE GRAYED OUT
AND NOT ENABLED.

SO THIS IS JUST ANOTHER EXAMPLE OF
WHERE WHAT YOU DO FIRST IN SECTION RX REALLY IMPACTS

HOW THE SCREENS ARE GOING
TO LOOK AND FUNCTION AS YOU GO THROUGH THEM.

Part 9

NOW WE'RE GONNA GO AHEAD AND
LOOK AT SOME OF THESE RX SCREENS

AND SORT OF TALK THROUGH
ALL THESE DIFFERENT CONCEPTS.

SO HERE IS THAT FIRST SCREEN
WE TALKED ABOUT, GENERAL 1.

SO OVER ON THE LEFT HAND SIDE
WE'RE DESCRIBING THE TYPE OF BENEFIT AND THE NUMBER OF TIERS.

OVER ON THE RIGHT HAND SIDE
IS WHERE YOU'RE DESCRIBING YOUR NETWORK COMPONENTS.

ON THIS SCREEN, ALL OF
THE QUESTIONS ARE GONNA HAVE TO BE ANSWERED.

YOU'RE NOT GONNA
SEE A LOT GRAYED OUT

ON THE FIRST 2 SCREENS
HERE IN SECTION RX.

ON GENERAL 2, AGAIN, ALL THESE
QUESTIONS ARE GONNA BE THERE.

ON THE LEFT HAND SIDE
IS WHERE YOU'RE GONNA SEE

WE DO HAVE A QUESTION ABOUT
OVER-THE-COUNTER DRUGS.

IF YOU ANSWER THAT "YES,"
THEN THE QUESTIONS BELOW IT ARE GONNA BE ENABLED.

IF YOU ARE NOT OFFERING--
IF YOU DON'T HAVE A UTILIZATION MANAGER PROGRAM

FOR OVER-THE-COUNTER DRUGS,
THEN YOU'LL SAY NO

AND THOSE QUESTIONS
WILL NOT BE ENABLED.

FOR DEFINED STANDARD PLANS,
THE NEXT SCREEN YOU SEE HERE

IS GONNA BE A SCREEN
THAT'S GONNA LIST JUST--

OK, YOU'RE A DEFINED STANDARD

PLAN. WHAT DOES THAT MEAN?

IT'S GONNA TELL YOU
THAT YOU'RE OFFERING THE MEDICARE-DEFINED COST-SHARING

FOR ALL OF THESE
DIFFERENT COMPONENTS.

SO IT'S JUST A SORT OF
DOUBLE-CHECK FOR YOU TO MAKE SURE THAT YOU KNOW

THAT THAT'S WHAT YOU'RE DOING,
AND IT'S ALSO TELLING YOU

THAT THESE SCREENS ARE
NOT GONNA APPEAR FOR YOU.

THEY'RE NOT GONNA
BE ON THE DROP-DOWN LIST.

YOU'RE NOT GONNA HAVE
ANY DATA ENTRY TO DO ON THESE SCREENS AT ALL.

HERE IS THE DEDUCTIBLE SCREEN.

OVER ON THE LEFT HAND SIDE
WE'RE ASKING IF YOU'RE CHARGING

THE MEDICARE-DEFINED
PART "D" DEDUCTIBLE AMOUNT.

BASIC AND ENHANCED ALTERNATIVE
PLANS HAVE THE OPTION OF SAYING YES TO THAT,

OR THEY CAN OFFER TO
NOT CHARGE THAT AMOUNT.

THEY CAN SPECIFY THEIR OWN
DEDUCTIBLE AMOUNT OR THEY CAN OFFER NO DEDUCTIBLE AT ALL.

THEY CAN ALSO SPECIFY WHICH
TIERS THE DEDUCTIBLE APPLIES TO.

SO YOU'RE GONNA INDICATE
THAT IT APPLIES TO ALL OF THEM

OR YOU'RE GONNA SAY NO AND
YOU'RE GONNA CHOOSE THERE WHICH TIERS IT APPLIES TO.

ON THE RIGHT HAND SIDE
IS YOUR OUT-OF-NETWORK COST-SHARING STRUCTURE.

THAT IS A QUESTION THAT
EVERYONE WILL HAVE TO ANSWER.

HERE WE HAVE
THE EXCLUDED-DRUG SCREEN.

OVER ON THE LEFT YOU'RE GONNA
BE ASKED IF EXCLUDED DRUGS

ARE PART OF YOUR
SUPPLEMENTAL COVERAGE.

THIS, AGAIN, IS ENHANCED
ALTERNATIVE PLANS, SO YOU'RE GONNA ANSWER THAT.

BELOW THAT WE HAVE
A QUESTION ABOUT

REDUCED PART "D" COST COVERAGE.

IF YOU ARE OFFERING ANY
OF THESE OFFERINGS--IF YOU'RE REDUCING THE ICL,

IF YOU'RE OFFERING GAP TIERS
OR PRE-ICL TIERS--YOU'RE GONNA HAVE TO CHECK THE BOX HERE,

AND WHAT YOU DO LATER ON IN
THE PBP IS GONNA HAVE TO MATCH.

SO IF YOU, FOR INSTANCE, SAY
THAT YOU'RE OFFERING GAP TIERS,

AND THEN WHEN WE GET TO THE
SCREEN THAT SAYS "DO YOU OVER GAP COVERAGE?" AND YOU SAY NO,

YOU'RE NOT GONNA BE ABLE TO
EXIT/VALIDATE THE PBP BECAUSE THOSE TWO AREN'T MATCHING UP.

SO HERE IS WHERE YOU'RE
SORT OF ANNOUNCING WHAT YOUR

REDUCED COST-SHARING IS,
WHAT THAT BENEFIT IS.

LATER ON IS WHERE YOU'RE GONNA
ENTER THE BENEFIT, BUT THE TWO ARE GONNA HAVE TO MATCH.

SO HERE'S THE SCREEN WHERE
WE'RE TALKING ABOUT THE INITIAL COVERAGE LIMIT.

AGAIN, BASIC AND ENHANCED
ALTERNATIVE HAVE THE OPTION OF

EITHER USING THE
MEDICARE-DEFINED ICL

OR THEY CAN SPECIFY A
DIFFERENT ICL FOR THEIR PLAN.

IF YOU'RE SPECIFYING A
DIFFERENT AMOUNT, THERE'S A BOX THERE FOR YOU TO PUT IN.

YOU ALSO HAVE THE OPTION OF
ENTIRELY ELIMINATING THE GAP

AND OFFERING FULL GAP COVERAGE.

THIS IS WHERE YOU
WOULD INDICATE THAT.

IF YOU ARE OFFERING
FULL GAP COVERAGE,

THERE WILL BE NO
TIER-GAP SCREENS FOR YOU.

WE'RE GOING TO USE
WHAT YOU ENTER PRE-ICL

FOR YOUR TIERS FOR YOUR GAP.

IF YOU ARE OFFERING GAP COVERAGE
AND YOU'RE USING A DIFFERENT ICL, THEN THE GAP SCREENS

WILL BE ENABLED AND YOU'LL
BE ABLE TO ENTER ALL OF YOUR COST-SHARE INFORMATION THERE.

DOWN BELOW, THIS IS ANOTHER
INSTANCE WHERE WE GOT SORT OF A SCREEN CUTOFF.

THIS IS ACTUALLY
A DIFFERENT SCREEN.

THIS IS WHERE YOU'RE GONNA
INDICATE WHAT YOU'RE OFFERING

PAST THE OUT-OF-POCKET
THRESHOLD: EITHER NO COST-SHARING,

THE MEDICARE-DEFINED,
OR IF YOU'RE GONNA USE COST-SHARE TIERS.

AND HERE IS WHAT THE
GENERAL LOCATION/SUPPLY SCREEN LOOKS LIKE.

SO YOU CAN SEE, WE HAVE ALL
THE DIFFERENT PHARMACY OPTIONS

LISTED ON THE LEFT HAND SIDE,
AND THEN ON THE RIGHT,

ONE-MONTH, 3-MONTH,
AND OTHER DAY SUPPLIES.

THESE ARE, AGAIN, ENABLED
AND MUST MATCH WHAT YOU'VE ENTERED PREVIOUSLY,

SO THE NETWORK STRUCTURE
HAS TO MATCH WHAT YOU SAID THERE ON GENERAL 1.

SO NOW WE'RE GONNA
RUN THROUGH AN EXAMPLE,

AND THE EXAMPLE WE'RE GONNA
LOOK AT IS A PRE-ICL TIER.

WE'RE JUST GONNA LOOK AT ONE
TIER OFFERING GENERIC DRUGS, ONLY PART "D" DRUGS.

IT'S NOT AN INJECTABLE TIER.
IT'S NOT THE SPECIALTY TIER.

IT IS GOING TO BE
THE EXCEPTIONS TIER.

WE'RE GONNA CHOOSE THE LABEL OF
"GENERIC," AND WE'RE GONNA DO

A 31-DAY SUPPLY IN-NETWORK
PHARMACY WITH $5.00 COPAY.

OUT-OF-NETWORK, WE'RE GONNA DO
15-DAY SUPPLY FOR $5.00.

AND LONG-TERM CARE, 31-DAY,
AGAIN, WITH $5.00.

WE'RE GONNA COVER THIS TIER
THROUGH THE GAP, BUT WE'RE NOT GONNA COVER

ALL OF THE DRUGS THAT ARE
ON THE TIER THROUGH THE GAP.

SO HERE WE ARE. WE'RE
ON THE TIER-TYPE SCREEN, PRE-ICL FOR TIER 1.

AND YOU CAN SEE ON THE
NAVIGATION BAR UP THERE,

THE PARENTHESIS ONE,
THAT'S HOW YOU KNOW WHAT TIER NUMBER IT IS.

AGAIN, THAT'S
GONNA BE AUTOMATICALLY PRE-POPULATED FOR YOU.

SO OVER ON THE LEFT WE'RE
CHOOSING JUST "GENERICS"-- THAT'S OUR DRUG TYPE.

WE'RE ONLY OFFERING PART "D"
DRUGS, NOT AN INJECTABLE TIER, NOT OUR SPECIALTY TIER.

THE QUESTION ON THE RIGHT
THERE IS, "IS THIS YOUR EXCEPTIONS TIER?"

AND ABOVE IT WE HAVE SOME
OF THAT ON-SCREEN HELP TO HELP DESCRIBE WHAT,

YOU KNOW, SAYING YES OR NO
TO THAT QUESTION MEANS.

AND THEN WE'RE
MOVING FORWARD HERE.

THIS IS THE TIER LABEL SELECTION
SCREEN, SO, AGAIN, WE HAVE SOME INFORMATION ON THE LEFT.

OVER ON THE RIGHT HAND SIDE
WHERE IT SAYS "TIER LABEL SELECTION, CHOOSE ONLY ONE,"

THIS IS YOUR PICK LIST.

THAT'S WHERE IF YOU'RE NOT
SURE WHICH ONES ARE GONNA BE

VALID FOR YOU, YOU CAN
RIGHT-CLICK ON THERE TO GET THAT VARIABLE HELP TO COME UP.

IT'S A POP-UP WINDOW THAT'S
GONNA DESCRIBE, OK, HOW DID YOU

SET UP THE DRUGS ON THIS TIER,
THESE ARE WHAT TIER LABELS

ARE ELIGIBLE TO BE CHOSEN.

NOW, WE'RE GONNA
CHOOSE "GENERIC" BECAUSE THAT'S OUR TIER,

BUT YOU CAN SEE DOWN
ON THE BOTTOM WE HAVE A WARNING MESSAGE.

WHAT THAT IS, IS SORT OF
ANOTHER KIND OF HELP

THAT WE HAVE BUILT IN THAT WE
DIDN'T REALLY TOUCH ON EARLIER.

THIS IS GONNA BE AN ON-SCREEN

POP-UP, SO IT'S NOT GONNA WAIT

UNTIL YOU TRY TO EXIT/VALIDATE
TO GIVE YOU THIS WARNING.

AS SOON AS YOU TRY TO
LEAVE THIS SCREEN, YOU'RE GONNA GET THIS WARNING.

SO IN THIS CASE, WE CHOSE
"BRAND" INSTEAD OF "GENERIC,"

AND THAT WARNING IS JUST
TELLING YOU, "HEY, STOP, YOU CAN'T CHOOSE BRAND

BECAUSE YOU HAVEN'T INDICATED
THAT THERE'S ANY BRAND DRUGS BEING COVERED ON THIS TIER."

SO THAT SORT OF HELPS YOU
GET THAT RIGHT UPFRONT.

BECAUSE IF WE'RE DOING THIS
PRE-ICL, THIS INFORMATION DOES CARRY FORWARD THROUGH THE GAP,

SO WE WANT TO MAKE SURE IT'S
RIGHT THE FIRST TIME, AND HERE'S WHERE WE DO IT.

IF YOU ARE ENTERING YOUR
TIER AND YOU'VE FORGOTTEN

WHAT YOU'VE DONE AND YOU CAN'T
REMEMBER, WHAT YOU CAN DO,

YOU CAN RIGHT-CLICK ON THIS
ANYWHERE IN THE DROP-DOWN LIST AND SELECT "CLEAR SELECTION."

THAT'S GONNA CLEAR OUT WHATEVER
RADIO BUTTON YOU'VE CHOSEN.

AND THEN YOU CAN GO BACK
TO THE PREVIOUS SCREEN, LOOK AT YOUR BENEFIT,

HOW IT'S BEING STRUCTURED, AND
THEN YOU CAN GO BACK FORWARD AND CHOOSE THE CORRECT LABEL.

SO HERE WE ARE. ON THE LEFT HAND
SIDE WE'RE CHOOSING THE,

SORT OF, COMPONENTS OF OUR
PHARMACY NETWORK HERE.

SO WE'VE GOT ONE-MONTH SUPPLIES
FOR OUR IN-NETWORK PHARMACY AND LONG-TERM-CARE PHARMACY,

AND THEN WE'VE GOT

THE OTHER DAY SUPPLY FOR OUT-OF-NETWORK PHARMACY.

AND CHOOSING THOSE ON THE
LEFT, IT ENABLED THOSE 3 BOXES ON THE RIGHT TO BE ACTIVATED,

SO WE PUT IN 31 DAYS,
15 DAYS, AND 31 DAYS.

AND HERE WE'RE ON
THE COPAYMENT SCREEN.

ON THIS SCREEN THE ONLY
3 BOXES THAT ARE ENABLED

ARE THE 3 THAT WE
JUST CHOSE PREVIOUSLY.

SO FOR ONE-MONTH SUPPLY,

IN-NETWORK RETAIL PHARMACY
AND LONG-TERM-CARE PHARMACY,

WE'RE PUTTING IN
OUR $5.00 FOR THOSE TWO.

AND OVER ON THE OTHER DAY
SUPPLY, WHICH, REMEMBER,

WAS OUR 15-DAY SUPPLY
FOR OUT-OF-NETWORK PHARMACY,

WE'RE ALSO CHARGING $5.00.

NOW, REMEMBER, WE WERE GONNA
OFFER THIS TIER THROUGH THE GAP,

SO HERE WE ARE ON
THE GAP COVERAGE SCREEN.

FIRST QUESTION IS, "ARE
YOU OFFERING GAP COVERAGE?"

WE ARE, AND WE'RE ONLY
GONNA CHOOSE TIER 1.

NOW, DEPENDING ON HOW YOU,
OF COURSE, STRUCTURE YOUR PLANS, YOU MAY OR MAY NOT HAVE 6 TIERS.

ON THIS SCREEN, YOU'RE ALWAYS
GONNA SEE THE 6 TIERS THERE.

BUT IF YOU ONLY HAVE, SAY,
3 OR 4 TIERS, YOU SIMPLY CAN IGNORE TIERS 5 AND 6.

YOU DON'T NEED TO WORRY
ABOUT IT. AND IF YOU DO CHECK IT

AND YOU HAVE A PLAN THAT OFFERS
LESS, WE HAVE RULES BUILT IN

SO YOU'RE NOT GONNA BE ABLE
TO MOVE PAST THIS SCREEN WITH THAT SELECTED.

SO WE'RE NOT GONNA ASK YOU TO
FILL IN COST-SHARE INFORMATION

FOR A TIER THAT DOESN'T
EXIST IN YOUR PLAN.

SO HERE WE ARE ON THE
GAP TIER-TYPE SCREEN.

SO OVER ON THE LEFT
YOU CAN SEE THAT WE'VE GOT SOME INFORMATION

THAT WE PREVIOUSLY
POPULATED PRE-ICL.

SO "WHAT TYPE OF DRUG?"
IS "GENERIC," PART "D" ONLY,

NOT INJECTABLE, NOT OUR
SPECIALTY, AND, YES, IT IS OUR EXCEPTION.

ALL OF THIS INFORMATION,
WE BROUGHT IT FORWARD

FROM THE PRE-ICL SCREEN
THAT WE WERE JUST LOOKING AT.

SO THIS IS A SCREEN THAT YOU
DON'T ACTUALLY HAVE TO PUT ANY DATA ENTRY IN ON,

BUT IT'S GONNA BE THERE
IN THE GAP, AS WELL, SO THAT YOU KNOW

WHAT TIER YOU'RE WORKING ON
AND WHAT'S ON IT.

SAME WITH THE LABEL: YOU'RE
NOT GONNA CHOOSE A NEW LABEL.

IT'S GONNA HAVE THE
SAME NAME. IT'S GONNA BE PRE-POPULATED FOR YOU.

HERE'S WHERE WE HAVE
SOME WORK TO DO.

YOU KNOW, WE'RE TALKING ABOUT
THIS TIER, AND WE'RE SAYING, OK,

ARE WE OFFERING ALL OF THE DRUGS
OR ONLY SOME OF THEM?

AND FOR OUR INSTANCE,
WE'RE ONLY GONNA OFFER SOME OF THEM THROUGH THE GAP.

IMPORTANT NOTE HERE IS THAT IF
YOU'RE INDICATING THAT YOU'RE OFFERING PARTIAL GAP COVERAGE,

YOU ARE GONNA HAVE TO SUBMIT
A SUPPLEMENTAL GAP FILE THROUGH THE FORMULARY MODULE,

AND THERE'S A NOTE HERE
ON SCREEN TO REMIND YOU OF THAT.

AND THERE ARE INSTRUCTIONS ON
THE FORMULARY MODULE ABOUT HOW EXACTLY TO SUBMIT THAT FILE.

SOMETHING ELSE I WANT
TO TOUCH ON THAT'S NOT PART OF THIS EXAMPLE

BUT THAT'S ON THIS SCREEN IS--

GRAYED OUT BELOW IT, WE HAVE 2
QUESTIONS ABOUT EXCLUDED DRUGS.

SINCE THIS WAS
A PART "D"-ONLY TIER,

THESE QUESTIONS ARE NOT ENABLED.

BUT IF YOU HAVE
A COMBO TIER WITH PART "D"

AND EXCLUDED DRUGS, THESE
QUESTIONS ARE GONNA BE ENABLED.

THE FIRST ONE IS ASKING IF
YOU'RE COVERING ANY EXCLUDED DRUGS THROUGH THE GAP.

IF YOU ANSWER YES TO THAT,
THEN WE'RE ALSO GONNA ASK YOU,

"ARE YOU ONLY COVERING EXCLUDED
DRUGS THROUGH THE GAP?"

AGAIN IF IT'S A PART "D"
TIER ONLY, THOSE QUESTIONS WILL NOT BE ENABLED.

IF YOUR TIER IS EXCLUDED
DRUGS ONLY, WE'RE NOT GONNA ASK THAT BECAUSE,

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OBVIOUSLY, YOU ARE COVERING
THEM ALL THROUGH THE GAP.
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Part 10

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HOME STRETCH.

HA HA HA.

A COUPLE MORE THINGS
WE WANT TO TALK ABOUT,

WHERE THE SOFTWARE
CAN SORT OF MAKE THINGS

A LITTLE BIT EASIER FOR YOU--

SOME...SOME THINGS
THAT YOU CAN REVIEW,

IF YOU WANT TO CHECK
YOUR DATA ENTRY.

WE'LL TALK ABOUT THE SB,

TOUCH ON THE UPLOAD.

THE BID MANUAL,

WHICH IS AVAILABLE

UNDER THE "DOCUMENTATION" LINK

ON HPMS, HAS SO MUCH DETAIL

ON HOW TO DO EVERYTHING.

IT'S REALLY, REALLY USEFUL.

SO WE WOULD ENCOURAGE YOU
TO TAKE A LOOK AT THAT.

AND ALSO, IF YOU GET STUCK,
REMEMBER, YOU CAN ALWAYS CLICK

ON THE PBP HELP.

THE PBP, WHEN YOU INSTALL
THE SOFTWARE,

IT WILL SET UP
AN ARCHIVE FOLDER. OK?
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AND IT WILL AUTOMATICALLY
STORE A BACKUP

OF EVERY UPLOAD
AND EVERY UPDATE FILE,

JUST SO THOSE
ARE ALWAYS AVAILABLE

IN CASE OF EMERGENCY.
IF THERE'S ANY PROBLEMS,

YOU CAN ALWAYS GO BACK
TO THOSE BACKUP FILES.

AND ONE THING WE'LL TALK ABOUT
AT THE VERY END--

IF YOU RUN INTO PROBLEMS
AND YOU ARE REALLY AT A LOSS,

CALL THE HELP DESK.

THE PEOPLE THERE
ARE FABULOUS,

AND SOME OF THEM
HAVE BEEN WORKING

WITH THIS SOFTWARE
FOR 10 YEARS. OK?

THEY'RE GREAT, AND IF THEY
CAN'T ANSWER YOUR QUESTION,

THEY WILL TRACK DOWN
SOMEBODY WHO CAN

AND GET BACK TO YOU
AS QUICKLY AS POSSIBLE.

WE TALKED ABOUT COPYING DATA
FROM THE PRIOR YEAR

TO SORT OF GET KICK-STARTED
ON YOUR 2011 DATA ENTRY.

IF YOU HAVE A LOT OF PLANS
THAT HAVE VERY SIMILAR BENEFITS,

YOU DON'T HAVE TO
KEEP ENTERING

THE SAME DATA
OVER AND OVER AGAIN.

YOU CAN CREATE ONE PLAN

AND ENTER ALL YOUR DATA
FOR THAT PLAN,

AND THEN WHATEVER INFORMATION
IN THAT ONE PLAN

YOU WANT TO POPULATE
IN MANY OTHER PLANS,

YOU CAN COPY THAT.

SO YOU'D USE
THE "COPY PLAN" FUNCTION.

WHAT YOU'D DO IS,
WHEN YOU HAVE THAT DATA

SUFFICIENTLY IN THAT,
YOUR SOURCE PLAN, OK?

YOU WOULD THEN SELECT THAT
AS YOUR SOURCE PLAN

AND THEN SELECT
ONE OR MORE PLANS

TO WHICH YOU WANT TO
COPY THAT DATA,

AND THEN YOU CAN
INDICATE SPECIFICALLY,

DO YOU WANT TO COPY
THE SECTION-A DATA?

DO YOU WANT TO
COPY THE SECTION-B DATA?

IF SO, WHICH CATEGORIES IN SECTION-B
DO YOU WANT TO COPY?

YOU DON'T NECESSARILY HAVE TO
COPY ALL OF THEM.

DO YOU WANT TO COPY
ANY OF THE SECTION-C DATA

OR THE SECTION-D OR RX DATA?

SO YOU CAN USE THIS
TO SORT OF REALLY STREAMLINE

YOUR DATA-ENTRY PROCESS.

YOU CAN ALSO,
IN THIS COPY FUNCTION,

ASSIGN THESE DESTINATION PLANS
TO A SPECIFIC USER.

IF THEY'RE ALL GOING TO
BE YOURS, GREAT.

IF YOU WANT TO ASSIGN
ALL THESE DESTINATION PLANS

TO ANOTHER PERSON,

IF YOU ARE SORT OF
THE SUPER-USER IN CHARGE,

YOU CAN DO THAT, AND THEN
CLICK ON THE "COPY" FUNCTION,

AND THAT WILL COPY
THE DATA.

IF YOUR SOURCE AND DESTINATION
ARE DIFFERENT PLAN TYPES,

THEN YOU JUST NEED TO KEEP
IN THE BACK OF YOUR HEAD

THAT IF DIFFERENT
SUBSECTIONS,

YOU KNOW, ARE NOT GOING TO
MATCH, THEN IT WON'T COPY.

SO IF YOU'RE COPYING
A PPO PLAN'S INFORMATION

TO A PRIVATE FEE PLAN,

YOU KNOW, LIKE THE OON SECTION
IS NOT GOING TO COPY.

PLAN MAINTENANCE--
EVERY ONCE IN A WHILE,

SOMETHING WILL HAPPEN
AND SORT OF YOU'LL GET STUCK,

OR IF YOUR SOFTWARE
INADVERTENTLY CLOSES,

THE PLAN YOU'RE WORKING ON

WILL SORT OF GET STUCK
IN AN "OPEN" STATUS,

AND WHEN YOU GO BACK IN,
YOU'LL SEE THAT THAT PLAN

HAS A LITTLE ASTERISK MARKED
ON THE MANAGEMENT SCREEN,

AND YOU WON'T BE ABLE
TO GET BACK IN THERE.

WHAT YOU'LL HAVE TO DO IS GO
TO THE PLAN MAINTENANCE FUNCTION

AND RESET IT.

SO THAT, AGAIN, IS ON THE...
IN YOUR...YOUR MENU.

YOU WOULD CLICK ON
"PLAN MAINTENANCE,"

AND IT'LL BRING YOU
TO THIS SCREEN.

YOU WOULD SELECT THE PLAN THAT'S
STUCK IN THAT "OPEN" STATUS,

HIGHLIGHT IT, AND THEN JUST
CLICK ON THE "RESET" BUTTON.

OK? THAT WILL RESET IT.

THEN WHEN YOU GO BACK
TO THE MANAGEMENT SCREEN,

IT'LL BE AVAILABLE, AND YOU'LL
BE ABLE TO GO BACK IN.

JUST SORT OF A QUICK HINT

ON HOW TO TAKE CARE
OF THAT PROBLEM.

THERE ARE A COUPLE
OF REPORTS

THAT ARE AVAILABLE

IN THE SOFTWARE.

THERE'S A DATA REPORT
THAT BASICALLY WILL SHOW YOU

EVERYTHING THAT YOU'VE ENTERED
FOR A SPECIFIC PLAN.

THERE'S A HISTORY REPORT

THAT IS SORT OF
A "WHO DID WHAT WHEN?"

IN TERMS OF DATA ENTRY.

AND THEN THERE'S THE SB.

SO IF YOU WANTED TO
GENERATE A DATA REPORT,

YOU'D CLICK ON
THE "DATA REPORT" MENU ITEM,

HIGHLIGHT THE PLAN FOR WHICH YOU
WANT TO GENERATE THAT REPORT,

AND THEN YOU CAN SELECT
WHICH SORT OF SECTIONS--

IF YOU ONLY WANT
TO LOOK AT SECTION-B,

YOU CAN JUST CLICK
ON SECTION-B.

IF YOU WANT TO INCLUDE
THE NOTES, YOU CAN.

YOU KNOW, SO YOU CAN
SORT OF PICK AND CHOOSE

WHAT YOU WANT TO LOOK AT,
AND IF YOU'RE, YOU KNOW...

WANT TO GIVE THIS
TO SOMEBODY ELSE TO REVIEW,

YOU CAN JUST
GIVE THEM, YOU KNOW,

THE SECTIONS THAT YOU
WANT TO SHOW THEM,

OR YOU CAN DO

THE WHOLE THING.

IF YOU'VE DONE ALL
THE DATA ENTRY FOR A PLAN

AND YOU WANT TO GENERATE
THE DATA REPORT,

IT'S GOING TO BE HUGE, OK?

BECAUSE IT'S GOING TO SHOW YOU,
SCREEN BY SCREEN,

VARIABLE BY VARIABLE
WHAT DATA HAS BEEN ENTERED.

IF YOU ARE TALKING
TO THE HELP DESK

ABOUT A PROBLEM
WITH YOUR DATA ENTRY,

THEY MIGHT ASK YOU
TO SEND THAT TO THEM,

OK? SO THEY CAN SORT OF SEE
WHAT YOU'VE ENTERED.

AGAIN, THE HISTORY REPORT IS
SORT OF AT A VERY HIGH LEVEL.

IT JUST SHOWS
WHO DID WHAT DATA ENTRY,

WHEN THEY DID IT,

AND WHAT SPECIFIC DATA ENTRY
THEY WORKED ON.

THE SB, THE BEST PART.

SO 2 DIFFERENT COMPONENTS.

THERE'S THE INTRODUCTION,

WHICH IS SORT OF
VERY GENERAL LANGUAGE,

AND THEN THE PLAN SENTENCES,

AND THAT IS WHAT GETS GENERATED
FROM ALL THOSE READ VARIABLES.

SO IN THE PBP, YOU WOULD SELECT

ON "SB REPORT,"

AND THEN IT'S GOING TO ASK YOU
WHAT DO YOU WANT TO LOOK AT.

SO YOU CAN SELECT
ONE OR MORE CATEGORIES.

WHAT YOU CAN DO IS, IF YOU'RE
DOING DATA ENTRY IN A CATEGORY

AND THEN YOU WANT TO SEE WHAT
SENTENCES ARE GOING TO GENERATE,

YOU CAN FINISH
YOUR DATA ENTRY

AND THEN GO GENERATE
THE SB REPORT

JUST FOR THAT CATEGORY
AND TAKE A LOOK AT IT,

SEE IF THAT'S REALLY
WHAT YOU WERE TRYING TO GET.

OR YOU CAN DO
ALL YOUR DATA ENTRY

AND THEN, YOU KNOW,
GENERATE ALL THE SECTIONS.

SO, THE INTRODUCTION--

AGAIN, WE SAID THAT'S SORT OF
SOME VERY GENERAL INFORMATION

BASED PRIMARILY
ON YOUR PLAN TYPE, AGAIN,

AND YOUR NETWORK INDICATOR
AND SOME OTHER THINGS.

THIS CONTAINS A LOT
OF THE INFORMATION, AGAIN,

THAT YOU ENTERED IN HPMS.

IT REFERS TO YOUR ORGANIZATION.
IT INCLUDES YOUR PLAN NAME.

IT INCLUDES A LOT
OF THE CONTACT INFORMATION,

YOU KNOW, FOR THE ENROLLEES
IF THEY NEED TO CALL SOMEBODY,

AND THAT TYPE OF THING.

THE PLAN SENTENCES,
AGAIN WE SAY, GET GENERATED.

THERE ARE 30...37, I THINK,
SB CATEGORIES.

IN THE BID MANUAL,
THERE IS A TABLE

THAT SHOWS YOU THE CROSSWALK
BETWEEN THE PBP CATEGORIES

AND THE SB CATEGORIES.

SO IT'LL SHOW YOU, OK,
FOR SB CATEGORY ONE,

WHICH IS PREMIUM
AND OTHER IMPORTANT INFORMATION,

IT WILL SHOW YOU
WHICH PBP CATEGORY INFORMATION

IS USED TO POPULATE THE SB
SENTENCES IN THAT CATEGORY.

WHEN SB GETS GENERATED,
AGAIN, IT WILL SHOW YOU--

IT'LL BE BY SB CATEGORY,
AND THEN IT SHOWS

THE COMPARISON
WITH ORIGINAL MEDICARE.

SO THE ORIGINAL MEDICARE
COST-SHARING INFORMATION

WILL BE THE CENTER COLUMN.

THEN THE PLAN BENEFITS
AND COST-SHARING INFORMATION

WILL BE IN THE FAR
RIGHT-HAND COLUMN.

IN THE SOFTWARE AND ALSO
ON HPMS UNDER "DOCUMENTATION"

IS THE SB CROSSWALK.

THIS IS YOUR GUIDE FOR HOW
THE SENTENCES GET GENERATED.

IT'S ORGANIZED--EACH CHAPTER
IS AN SB CATEGORY,

AND IT SHOWS YOU
THE STEP-BY-STEP DATA ENTRY

THROUGH THE PBP AS TO
HOW THE LOGIC IS INVOKED

TO GENERATE
THE SB SENTENCES.

SO BASED ON
WHAT YOU ANSWER

AND WHAT COST-SHARING
INFORMATION YOU ENTER,

IT SHOWS YOU HOW
THE SENTENCES GET GENERATED.

IT LOOKS DAUNTING,
BUT IT'S REALLY NOT.

AGAIN, SOME OF IT PULLS IN,
YOU KNOW, PLAN TYPE,

NETWORK INDICATOR,
BECAUSE THERE ARE VARIATIONS.

IF YOU'RE A SNIP PLAN,

YOU'RE GOING TO GET SLIGHTLY
DIFFERENT SENTENCE WORDING,

AS OPPOSED TO A NON-SNIP PLAN.

BUT GENERALLY SPEAKING,
IF YOU ENTER

A CO-INSURANCE OR A CO-PAY
AMOUNT FOR A CATEGORY,

IT'S GOING TO PULL IN THAT DATA
AND GENERATE A SENTENCE

SAYING, "$10 CO-PAY
FOR THIS BENEFIT."

SO THIS JUST SORT OF
WALKS YOU THROUGH

THE DATA-ENTRY QUESTIONS

IN THE ORDER IN WHICH
THEY GET ANSWERED,

AND THEN AT THE END OF THAT,
THE SENTENCE WILL GET GENERATED.

SO SOMETIMES YOU MAY DO
SOME DATA ENTRY

AND THEN GO TO THE SB REPORT
AND TRY AND GENERATE A SENTENCE,

AND NOTHING SHOWS UP,
AND IF YOU'RE WONDERING,

"WHY AM I NOT
GETTING SOMETHING?"

YOU CAN ALWAYS REFER BACK
TO THIS CROSSWALK

AND SORT OF GO THROUGH,
YOU KNOW, THE STEPS

AND ALL THE DATA ENTRY

TO MAKE SURE EVERYTHING
THAT YOU NEEDED TO ANSWER

TO GENERATE THAT SENTENCE
WAS COMPLETED.

AND IF YOU RUN INTO PROBLEMS,
AGAIN, CALL THE HELP DESK,

AND THERE ARE
A LOT OF PEOPLE

THAT KNOW AND LOVE
THIS CROSSWALK

THAT WILL, YOU KNOW,
HELP STEP YOU THROUGH IT.

AND SORT OF ONCE YOU GET IT,
THEN IT'S REALLY EASY,

NO MATTER WHAT CATEGORY
YOU'RE IN.

ALL RIGHT. THE FINAL STEP,
ONCE YOU'VE COMPLETED A PLAN,

IS YOUR UPLOAD.

BUT YOU HAVE TO DO
A COUPLE THINGS.

YOU HAVE TO VALIDATE
YOUR BID. OK?

SO MAKE SURE THAT YOU HAVE
YOUR BPT FOR YOUR PLAN.

YOU WANT TO VERIFY YOUR SB,

MAKE SURE THAT EVERYTHING
LOOKS RIGHT,

ALL THE SENTENCES
ARE CORRECT,

EVERYTHING THAT IS DISPLAYED
IS APPROPRIATE.

AND THEN ONCE YOU DO THAT,
YOU'RE READY FOR YOUR UPLOAD.

AND YOU CAN UPLOAD
ONE OR MORE PLANS AT A TIME.

OK? SO YOU CAN EITHER CLICK ON
STEP 7, THE "UPLOAD" BUTTON,

OR YOU CAN USE
THE "ACTIONS" MENU

AND CLICK ON "UPLOAD,"

AND THEN YOU GO
TO THE "UPLOAD PLAN" SCREEN.

SO IT'LL SHOW YOU
DIFFERENT STATUSES

FOR EACH PLAN OF WHERE YOU ARE
SORT OF IN YOUR UPLOAD.

IS THE PLAN READY FOR UPLOAD?
HAS THE BID BEEN VALIDATED?

HAS THE SB BEEN VERIFIED?
AND HAS THE PLAN BEEN UPLOADED?

IF YOU TRY AND UPLOAD
AND YOU HAVE A PROBLEM,

OK? YOU'RE GOING TO GET
AN ERROR MESSAGE

SAYING EITHER
IT COULDN'T FIND A BPT

OR THERE WAS
SOME OTHER PROBLEM.

IT DIDN'T PASS
ALL THE VALIDATION CHECKS

THAT IT NEEDED TO PASS
IN ORDER TO BE UPLOADED.

IF EVERYTHING IS--
ALL THE STEPS ARE COMPLETED,

THEN YOU CAN PROCEED.

HIGHLIGHT THE PLAN OR PLANS
THAT YOU WANT TO UPLOAD.

MAKE SURE THAT IT KNOWS
WHERE TO FIND THE BPT's.

AND THEN IT'S GOING TO
CREATE A ZIP FILE.

EVERYTHING IS GOING TO BE
TIME-DATE STAMPED.

IN CASE THERE'S A PROBLEM,
YOU KNOW YOU CAN ALWAYS GO BACK

AND DOUBLE-CHECK
WHAT WAS IN THERE.

SO THE "UPLOAD" FUNCTION
IS VERY SIMILAR

TO THAT "UPDATE" FUNCTION.

SO, ANYTIME YOU'RE CONNECTING
WITH HPMS,

IT'S GOING TO LOOK
FOR THE ZIP FILE,

GO TO HPMS, LOG ON,

WALK THROUGH THE UPLOAD STEPS,

UPLOAD YOUR FILE,

AND THEN WHAT YOU WANT TO DO IS
YOU WANT TO GET CONFIRMATION.

THAT'S YOUR FINAL STEP
IN THIS PROCESS.

SO YOU WANT TO MAKE SURE YOU GET
THAT CONFIRMATION NUMBER.

AND THE PBP IS GOING TO
ASK YOU TO ENTER THAT,

BECAUSE THAT'S HOW IT SAYS, "OK. THIS
HAS BEEN FINALLY COMPLETED

FOR THESE PLANS."

YOU CAN ALWAYS GO TO HPMS

AND CHECK THE STATUS
OF YOUR UPLOADS.

SO IT'LL SHOW YOU,
FOR EACH PLAN,

WHERE YOU ARE
IN THAT PROCESS.

THERE ARE A COUPLE OF REPORTS
THAT WE'RE GOING TO TALK ABOUT

WHERE YOU CAN ALWAYS
DOUBLE-CHECK

THAT WHAT YOU HAVE LOCALLY
MATCHES WHAT HPMS HAS.

SO WHEN YOU GO TO HPMS,
UNDER "PLAN BIDS,"

YOU CAN CLICK ON
"BID REPORTS,"

AND THERE IS A PLETHORA OF PBP
REPORTS THAT ARE AVAILABLE.

THERE'S THE PBP
BENEFITS REPORT,

WHICH CONTAINS

YOUR SECTION-B DATA.

OK? THERE'S THE OUT-OF-NETWORK,
P.O.S., VISITOR/TRAVEL REPORT,

WHICH IS
YOUR SECTION-C DATA.

PLAN LEVEL COST SHARES
IS YOUR SECTION-D DATA.

PART-D BENEFITS IS OBVIOUSLY
YOUR RX DATA.

OPTIONAL SUPPLEMENTAL
BENEFIT REPORT, NOTES REPORT,

AND THEN THE MEDICARE
BENEFIT DESCRIPTION REPORT

AND THE SERVICE CATEGORY REPORT.

AGAIN, THOSE ARE SORT OF
JUST TEXT REPORTS

THAT SHOW YOU WHAT WE TALKED
ABOUT PREVIOUSLY IN THE HELP.

OK? IT'LL GIVE YOU
THE DESCRIPTIONS

OF WHAT'S COVERED
UNDER EACH CATEGORY

AND WHAT MEDICARE COVERS
UNDER EACH CATEGORY.

SO SOMETIMES PEOPLE WANT TO
PRINT OUT THOSE REPORTS

AND HAVE THEM SORT OF,
YOU KNOW, AT THEIR SIDE

IN CASE THEY
WANT TO CHECK,

"OH, WELL, WHERE IS
THIS SPECIFIC BENEFIT?

WHAT CATEGORY IS IT IN?"

THE SB REPORT, AND THEN THERE
ARE A COUPLE BID STATUS REPORTS,

THE SUBMISSION STATUS
AND THE STATUS HISTORY.

SO THAT LAST ONE, AGAIN,
SHOWS YOU SORT OF,

FOR EACH PLAN, WHERE ARE YOU
IN THAT PROCESS?

AFTER YOU HAVE FINISHED
ALL YOUR UPLOAD,

IF THERE'S EVER A QUESTION,
YOU CAN SORT OF ALWAYS USE

THOSE REPORTS TO VERIFY THAT,
AGAIN, WHAT YOU HAVE LOCALLY

AND WHAT'S ON HPMS MATCH.

THERE'S ALSO SOME OTHER
CONTRACT MANAGEMENT REPORTS

THAT YOU CAN LOOK AT--

THE SERVICE AREA REPORT,

THE CONTRACT AND PLAN
INFORMATION REPORT,

AND THE PLAN CROSSWALK REPORT.

SO, YEAH, AND THESE ARE

PRIMARILY HPMS-LEVEL
INFORMATION.

AND THE MOST IMPORTANT
SLIDE COMING UP.

WHO DO YOU CONTACT
IF YOU HAVE QUESTIONS?

OK. TECHNICAL ISSUES,
YOU CAN CONTACT SARA

OR CALL THE HELP DESK.

THAT'S WHAT
THEY'RE THERE FOR.

OK? THEY LOVE
ANSWERING QUESTIONS.

```
THE MA BENEFITS CONTACTS,
THE MARKETING PEOPLE,

THE PART-D PEOPLE,
MANY OF WHOM ARE HERE.

OK. SO THIS IS
YOUR SORT OF IMPORTANT LIST.

YOU CAN PROGRAM THESE NUMBERS
INTO YOUR SPEED DIAL.
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Part 11

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ANY QUESTIONS?

MY NAME'S ROB BAUER
WITH MARION POLK COMMUNITY HEALTH PLAN,

AND THE FIRST QUESTION IS
ARE THERE ANY PLANNED UPDATES

THAT ARE GONNA BE ROLLED OUT
BEFORE THE JUNE 7 UPLOAD?

ARE THERE ANY PLANNED
SOFTWARE UPDATES

THAT WE NEED TO BE AWARE OF
OR ANYTHING?

NOPE. AS IT IS NOW
IS HOW WE THINK

IT'S GONNA BE
UNTIL THE UPLOAD.

OK. AND THEN SECONDLY,
WE HAVE A DUAL ELIGIBLE SPECIAL NEEDS PLAN,

AND WE USE THE DEFINED
STANDARD BENEFIT

IN THE Rx SECTION,
AND I NOTICED

UNDER THE TIER SELECTION
YOU DIDN'T HAVE

"ALL OTHER DRUGS"
AS A TIER LABEL,

AND I'M ASSUMING THAT'S
```

BECAUSE YOU DON'T DEFINE

THE TIERS WHEN YOU DO
A DEFINED STANDARD BENEFIT.

IS THAT CORRECT?

CORRECT.
DEFINED STANDARD

DON'T HAVE TO ENTER
ANY TIER-SPECIFIC INFORMATION.

OK. THANKS.

YEP.

YES. HELLO.
SONYA MADDOX,

BLUE CROSS BLUE SHIELD
TENNESSEE.

I'VE GOT A COUPLE
OF QUESTIONS.

THE FIRST IS
ABOUT THE UPLOAD.

IN THE PAST WHENEVER
WE'VE DONE THE UPLOAD FOR THE BID,

WE HAVE FIREWALL PROTECTIONS
IN PLACE SO THAT

WE'RE NOT ABLE TO LOG IN
OR, I GUESS,

GO TO THE HPMS WEB SITE
WHENEVER WE DO THE UPLOAD.

WE GET AN ERROR MESSAGE.

SO WE ACTUALLY HAVE TO
LOG IN TO HPMS

AND THEN MANUALLY
DO THE PROCESS THERE.

MY CONCERN IS THAT WE MAY NOT
GET THE CONFIRMATION SCREEN

ONCE WE UPLOAD THE PLANS.

IF WE DON'T GET
THAT CONFIRMATION SCREEN,

IS THERE AN ISSUE
WITH THE UPLOAD?

NO. THERE'S
NO ISSUE,

AND YOU SHOULD GET
IT EITHER WAY,

BUT IF YOU DON'T
GET IT,

YOU CAN CONTACT
THE HELP DESK.

THEY HAVE ACCESS TO
ALL OF THE UPLOADS

AND ALL
THE CONFIRMATION NUMBERS.

SO IF YOU END UP
NOT GETTING

THE CONFIRMATION
SCREEN OR IF ANYONE

FORGETS TO WRITE
DOWN THEIR CONFIRMATION NUMBER

WHEN THEY UPLOAD,
IF YOU CONTACT THE HELP DESK,

TELL THEM
WHO YOU ARE AND WHAT PLANS

YOU'RE LOOKING AT,
THEY CAN FIND

THE CONFIRMATION
NUMBERS FOR YOU.

OK.

AND SOMETHING ELSE
I JUST WANTED TO ADD.

WE DO HAVE THOSE REPORTS
ON HPMS.

SO IF ITEMS WERE

SUCCESSFULLY UPLOADED,

YOU CAN ALWAYS CHECK THERE
IF THERE IS AN ISSUE.

THERE ARE SOME PEOPLE--
THERE'S NOTHING WRONG

WITH DOING AN UPLOAD
THE WAY YOU'RE DESCRIBING IT.

WE WERE JUST SHOWING YOU
ONE OF THE OPTIONS

FOR AN UPLOAD WHERE YOU
CAN DO IT THROUGH THE SOFTWARE,

BUT A LOT OF PEOPLE
PREFER TO UPLOAD THE .ZIP FILE THEMSELVES

WHEN THEY'RE
SUBMITTING THE BID,

SO PLEASE DON'T WORRY
ABOUT THAT BEING A PROBLEM

IF YOU HAVE FIREWALL
ISSUES DOING THAT.

Maddox: OK. THE SECOND
QUESTION IS THAT

BASICALLY AROUND
THE AUTHORIZATIONS.

ONCE A BID HAS
BEEN APPROVED,

IF WE IMPLEMENT
A NEW CONTRACT

TO WHERE IT CHANGES OUR
AUTHORIZATION REQUIREMENTS

THAT WE'VE NOTED
IN THE BID,

HOW DO WE GO ABOUT
NOTIFYING CMS,

OR WOULD BE ABLE
TO EVEN IMPLEMENT

THAT TYPE OF CONTRACT

MID-YEAR?

Sara Silver: AND I THINK THIS IS
WHERE WE'RE GONNA NEED

SOME OF THE POLICY PEOPLE
TO COME UP

IF ANYONE IS AVAILABLE
TO TALK ABOUT AUTHORIZATION

OR IF THEY CAN CHANGE
THAT TYPE OF BENEFIT MID-YEAR.

DOES ANYBODY WANT TO
ADDRESS THAT?

I MEAN, THEY MAY NEED
MORE INFORMATION, AS WELL.

Man: RIGHT. CAN YOU--
YEAH. IN GENERAL,

YOU CANNOT CHANGE
ANY BENEFITS MID-YEAR.

WE USED TO ALLOW
MID-YEAR BENEFIT ENHANCEMENTS.

WE CALLED THE MYBE,
AND WHAT HAPPENED WAS NOT

THAT WE BECAME MEAN
OR ANYTHING,

BUT RATHER WHEN
THE MMA WAS PUBLISHED,

RECALL THERE'S SOMETHING
CALLED THE BENCHMARK,

AND THE BENCHMARK
INFLUENCES THE REBATES

THE ENROLLEES GET
AND EVERYTHING ELSE.

THE BENCHMARK IS
NOTHING MORE THAN THE AVERAGE BID.

SO THERE BECAME
A CONCERN THAT IF YOU AVERAGED ALL THE BIDS,

WHICH IS HOW MUCH

EVERYTHING COSTS,

AND THEN CHANGED THINGS
THAT WOULD CHALLENGE

THE INTEGRITY
OF THE BENCHMARK.

SO SINCE 2005
WHEN THE MMA WAS PUBLISHED,

WE WENT IN THE DIRECTION
OF PROHIBITING MYBEs.

IF YOU LOOK AT CHAPTER
4 OF THE "MANAGED CARE MANUAL,"

THERE'S A SECTION
ON NONYEAR BENEFITS.

IT'S ABOUT 5 SENTENCES.

ONE IS ABOUT
MULTIYEAR BENEFITS,

AND ALTHOUGH THEY'RE
ON THEIR WAY OUT,

THEY'RE STILL ALLOWED.

SO YOU CAN OFFER
GLASS FRAMES ONCE EVERY TWO YEARS.

MYBEs ARE OUT,
AND THAT'S BASICALLY

WHAT'S GOING ON
WITH MYBEs.

YOU CANNOT CHANGE
MID-YEAR,

SO THINK CAREFULLY
AT THE BEGINNING OF THE YEAR

WHAT YOU WANT TO OFFER.

Maddox: LET ME JUST ASK THIS.

SAY, THE BENEFIT AMOUNT
IS NOT JUST CHANGING.

IT'S JUST THE AUTHORIZATION
RULES AROUND THOSE BENEFITS.

WOULD THAT BE AN ISSUE?

Silver: MARTY, IF YOU COULD
JUST IDENTIFY YOURSELF.

YES. I'M MARTY ABELN,
AND I WORK ON THE POLICY TEAM.

WELL, YOU CAN'T--
IT DEPENDS WHAT KIND OF PLAN YOU HAVE.

YOU CAN'T HAVE
PRIOR AUTHORIZATION RULES

FOR, FOR EXAMPLE,
A PPO

OR A PRIVATE
FEE-FOR-SERVICE PLAN

WHEN PEOPLE GO
OUT OF NETWORK.

IS THAT WHAT
YOU'RE ASKING?

Maddox: YEAH.
WE ARE A PPO PLAN.

RIGHT.

AND WE ARE CONSIDERING
SINGING A CONTRACT

THAT WOULD BASICALLY CHANGE
THE AUTHORIZATION RULES

AROUND ADVANCED IMAGING.

WOULD WE BE ALLOWED
TO DO THAT MID-YEAR

AFTER THE BID
IS APPROVED?

OH. I SEE WHAT
YOU'RE SAYING.

SO THE AUTHORIZATION
RULES THAT WOULD

APPLY TO
THE PROVIDER

WHEN YOUR
MEMBER GOES?

WOULD THIS BE
IN NETWORK OR OUT OF NETWORK?

IT WOULD BE IN NETWORK.

THAT WOULDN'T
BE A PROBLEM.

I MEAN, THE THING
TO REMEMBER, TOO,

IS WHEN YOUR MEMBER
GOES TO A NETWORK PROVIDER

AND IF THE PROVIDER
GOES AHEAD

AND FURNISHES
SERVICES,

THE MEMBER'S HELD
HARMLESS EVEN IF

THE PROVIDER DOESN'T
FOLLOW THOSE RULES.

THAT IS CORRECT.

BUT, YEAH, THAT
WOULDN'T BE ANY PROBLEM

IF YOU'RE JUST
SORT OF MANAGING

UTILIZATION
IN YOUR NETWORK

AS LONG AS IT
DOESN'T HINDER ACCESS

FOR YOUR ENROLLEES.

GOTCHA. OK. COOL.
THANK YOU.

JUST ONE MORE--
BY THE WAY, I'M RUSSELL HENDEL.

I WORK WITH MARTY
ON THE POLICY TEAM,

AND I'M
THE TECHNICAL LEAD ON CHAPTER 4.

WHENEVER YOU CHANGE
SOMETHING,

WHENEVER YOU'RE
ALLOWED TO CHANGE SOMETHING,

LIKE MARTY SAID
THERE WAS NO PROBLEM,

THERE'S A 30-DAY
REQUIREMENT THAT

YOU NOTIFY
YOUR ENROLLEES 30 DAYS IN ADVANCE.

SO IT'S A BENEFICIARY
PROTECTION

THAT IF YOU CHANGE
SOMETHING

IT'S NOT GONNA TAKE
PLACE TOMORROW.

EVERYONE WILL BE ON
A LEVEL PLAYING FIELD.

THEY'LL KNOW ABOUT IT.

SO YOU SHOULD ALWAYS
PLAN THESE THINGS IN ADVANCE.

GOTCHA. THANK YOU.

HELLO. I'M DEB SOPO
FROM HEALTHPLUS OF MICHIGAN,

AND I HAVE A QUESTION.

WE WOULD LIKE TO
PREPOPULATE OUR PBP

WITH LAST YEAR'S DATA,

AND WHERE WOULD I FIND
PBP2010.MDB?

CAN WE GET THAT
FROM HPMS

IF WE DON'T HAVE
THE 2010 SOFTWARE

DOWNLOADED SOMEWHERE?

THROUGH AN ODD SERIES
OF EVENTS,

WE DON'T--THAT HAS
BEEN LOST,

THE SOFTWARE THAT WE WOULD
NORMALLY PULL IT FROM.

I MEAN, SOMETHING
WORTH NOTING IS

YOU DON'T HAVE TO BE
THE PLAN OWNER FROM 2010

TO HAVE THAT INFORMATION
ACCESSIBLE.

YOU AREN'T GOING TO
BE ABLE TO DOWNLOAD

THAT DATABASE FROM HPMS.

YOU DON'T HAVE--
THE ORGANIZATION

AS A TOTAL,
YOU DON'T HAVE ANY

OF THE 2010
SOFTWARE DOWNLOADED SOMEWHERE ELSE,

EVEN IF YOU WEREN'T
THE PLAN MANAGER?

THAT'S WHAT WE'RE HAVING
AN ISSUE WITH.

WE THINK THAT WAS
ACCIDENTALLY DESTROYED.

OK. YEAH. I THINK
WE'RE KIND OF

IN AN UNFORTUNATE
SITUATION HERE

BECAUSE WE'RE
GONNA NEED-- YOU'RE GONNA NEED

THAT ACCESS DATABASE
TO PREPOPULATE THAT DATA.

WE DON'T HAVE THAT
ACCESSIBLE CURRENTLY IN HPMS.

I GUESS THAT'S
SOMETHING WE COULD

ALWAYS CONSIDER
FOR THE FUTURE,

BUT THAT'S NOT
SOMETHING THAT WE

CURRENTLY HAVE
ACCESSIBLE THROUGH THERE.

YOU CAN CERTAINLY
REACH OUT TO ME.

WE CAN SEE IF
THERE'S ANYTHING WE CAN DO

TO TRY TO HELP YOU,
BUT WITHOUT THAT

DATABASE AVAILABLE
TO YOU,

IT'S GONNA BE HARD
TO PREPOULATE THAT DATA.

NO BACKUP?

WELL, WE ARE
SEARCHING FOR IT,

AND SO FAR,
WE'VE BEEN UNSUCCESSFUL

FOR AN ENTIRE WEEK,
SO THIS IS WHY I WAS ASKING HERE.

YOUR HELP DESK HAS BEEN
VERY HELPFUL,

BUT BOTTOM LINE IS
WE DON'T HAVE IT.

IS THERE ANY WAY
WE CAN RETRIEVE IT,

AND SO I WILL BE
WRITING YOU AN E-MAIL.

THANK YOU.

OK. THANKS.

HI. I'M SHEBA FABER
FROM EXCELLUS BLUE CROSS BLUE SHIELD.

I NOTICED IN THE 2011 PBP
THERE'S SOME NEW QUESTIONS

ASKING IF THERE'S
A SEPARATE OFFICE VISIT

CO-PAYMENT OR CO-INSURANCE
FOR A NUMBER OF CATEGORIES

IN SECTION "B,"
AND THERE'S--

IF YOU INDICATE THAT YOU
HAVE SEPARATE

CO-PAYMENT OR CO-INSURANCE,

IT ASKS FOR A MINIMUM
AND A MAXIMUM.

I JUST WANTED SOME
CLARITY ON WHAT

THAT MINIMUM AND MAXIMUM
WAS REFERRING TO.

FOR EXAMPLE, IS IT, LIKE,
A PCP TO A SPECIALIST CO-PAY,

OR IS IT LIKE AN IN
VERSUS OUT OF NETWORK?

I CAN ANSWER IT,
BUT I'LL LET POLICY ALSO CONFIRM.

THAT'S MY UNDERSTANDING
OF THAT, AS WELL.

I'M NOT SURE.
IT SOUNDS LIKE MAYBE

YOU DID THE PBP
LAST YEAR, AS WELL,

AND AS YOU'LL RECALL,
LAST YEAR, YOU HAD TO

ENTER THAT PCP
MIN AND MAX FIELD IN YOUR--I'M SORRY--

THE OFFICE CO-PAY
MIN/MAX FIELD

IN YOUR PCP CO-PAY FIELD
LAST YEAR.

THIS YEAR, WE'VE
PULLED THAT OUT

SO YOU CAN DO THAT
DATA ENTRY

IN THE APPLICABLE
SERVICE CATEGORY.

SO THE MIN/MAX
REALLY WOULD BE, AS YOU INDICATED,

MINIMUM'S TYPICALLY,
I GUESS, PCP,

WHERE THE MAXIMUM IS
KIND OF LIKE IF YOU'RE GETTING THAT SERVICE

AT A SPECIALIST VISIT.
RIGHT? OK.

Abeln: CONFIRMED.

OK. THINK WE'RE GOOD.

I JUST WANTED TO ASK
WITH THE GAP COVERAGE,

ARE WE REQUIRED
FOR ALL OUR PLANS

TO ENTER GAP COVERAGE
WITH THAT 93% CO-INSURANCE?

93%.

Silver: I THINK THE PART "D"
TEAM IS HERE, AS WELL,

BUT THERE'S NO DATA ENTRY
FOR THAT 93% OR 7%

GENERIC GAP COVERAGE
THIS YEAR,

AND I THINK THAT'S
DESCRIBED IN THAT APRIL 16

PART "D" POLICY MEMO,

BUT THE ONLY GAP COVERAGE
THAT'S GOING TO BE ENTERED

IN THE PBP IS IF YOU ARE
AN ENHANCED ALTERNATIVE PLAN

AND YOU'RE OFFERING
ADDITIONAL GAP COVERAGE

ABOVE AND BEYOND WHAT'S
NOW THE DEFINED STANDARD.

LIKE THE OTHER
PPB DATA ENTRY SCREENS,

IF IT'S PART
OF THE DEFINED BENEFIT,

YOU'RE NOT DOING
THE DATA ENTRY.

SO THAT'S THE WAY WE'VE
SET IT UP THIS YEAR,

WHERE THERE IS NO
DATA ENTRY FOR THAT 7% GENERIC GAP COVERAGE.

YOU WILL SEE SOME
REBENEFIT SENTENCES GENERATE THIS YEAR,

SO YOU MIGHT WANT TO
PAY ATTENTION TO THAT.

WE MAY BE CHANGING
THE WAY THAT WORKS FOR 2012,

BUT FOR 2011, THERE'S NO
GAP COVERAGE DATA ENTRY

EXCEPT FOR THE ADDITIONAL
GAP COVERAGE

IF YOU'RE AN ENHANCED
ALTERNATIVE PLAN.

Part 12

MY NAME IS
CHARRO KNIGHT-LILLY,

AND I'M WITH
ARCADIAN HEALTH PLAN.

AND I HAVE ONE OBSERVATION
AND THEN ONE QUESTION.

SO I'LL START
WITH THE QUESTION.

AND THE QUESTION IS, I KNOW
THAT THE NOTES FIELDS HAVE

BEEN SHORTENED TO
ONLY ALLOW A CERTAIN NUMBER OF CHARACTERS

NOW, IF I REMEMBER
THAT CORRECTLY FROM THE SESSION.

AND FOR US, FOR EXAMPLE,
WE HAVE A SUPPLEMENTAL DENTAL

PRODUCT THAT DOES NOT FIT
IN THE LITTLE CHECK BOXES,

AND THERE IS NO WAY FOR US
TO EXPLAIN IT, AND I DON'T

BELIEVE THE 250
CHARACTERS WILL ALLOW US TO PROPERLY EXPLAIN.

WHAT WOULD BE YOUR
SUGGESTION IN THAT CASE?

WELL, YOU GUYS
CAN GO AHEAD.

WELL, THE 250 ACTUALLY
ONLY APPLIES TO SECTION RX.

OK, OK.

SO I BELIEVE YOU
HAVE 4,000 CHARACTERS?

OK, OK.
THANK YOU FOR THAT.

AND THEN THE OBSERVATION
PIECE, AS I NOTICE THROUGHOUT THE YEARS

THAT SOMETIMES
WHEN THE SENTENCES FOR THE S.B. ARE

GENERATED THROUGH
THE HPMS SUMMARY OF BENEFITS REPORT

COMPARED TO THE HPMS
SUMMARY OF BENEFITS REPORTS, THE LANGUAGE CONFLICTS.

AND THAT'S BEEN A CONSTANT
THROUGHOUT THE YEARS.

AND AS UPDATES OCCUR,
WITHIN THE HPMS REPORT THEY DON'T

SHOW UP ON THE--
ON THE PBP VERSION.

OK. WHAT YOU MAY BE
ALSO REFERRING TO IS,

LIKE, WHEN WE RELEASE THE
PART "B" AMOUNTS OR SOMETHING LIKE THAT--

NO. THE ACTUAL
SENTENCES OF THE SUMMARY OF BENEFITS.

OK. WELL, I THINK--

ANYBODY ELSE HAVE
THAT SAME PROBLEM?

YES.

AND YOU'RE NOT NECESSARILY
JUST TALKING ABOUT WHEN WE

UPDATE THE INFORMATION WITH,
LIKE, THE PART "B" REPORT. OK.

DO WE EVENTUALLY--WILL WE
HAVE THE PATCH WHICH THEY CAN DOWNLOAD IN SEPTEMBER?

DOES THAT INCLUDE
ANY UPDATES WE'VE MADE TO THEM? NO.

I DON'T REMEMBER.

AND SO IT'S VERY
PROBLEMATIC FOR US BECAUSE WHEN WE CREATE

OUR TEMPLATE, WE TURN
IT IN TO CMS FOR REVIEW.

TEMPLATE GETS APPROVED,
AND THEN THE LANGUAGE IS NOT CONSISTENT.

AND THAT HAPPENS
ON A YEARLY BASIS.

YEAH, I'LL DEFINITELY
LOOK INTO THAT MORE.

I KNOW WE HAVE HAD SITUATIONS
WHERE THE SUMMARY OF BENEFITS

SENTENCE ISN'T
GENERATING CORRECTLY.

SO WE'VE UPDATED IT
ON THE BACK END.

SO MAYBE, YOU KNOW, I'LL
WORK ON HOW TO DO BETTER

COMMUNICATION FOR THAT TO
KIND OF KEEP YOU GUYS IN THE KNOW OF WHAT'S IN THERE.

BUT MY UNDERSTANDING FOR THE
SUMMARY OF BENEFITS IS WHAT'S

IN HPMS IS WHAT IS
SUPPOSED TO BE THE FINAL.

IF IT GETS UPDATED, YOU KNOW,
YOU ARE GONNA HAVE TO UPDATE

YOUR SUMMARY OF BENEFITS THAT
GENERATES OUT OF THE PBP.

I UNDERSTAND WHAT YOU'RE
SAYING IS THAT SOMETIMES MAYBE

YOU'RE NOT AWARE OF THE
CHANGES THAT ARE BEING MADE

ON THE SUMMARY OF BENEFITS
IN HPMS, AND I THINK THAT'S

SOMETHING, YOU KNOW, WE CAN
WORK ON TO TRY TO MAKE THAT

COMMUNICATION PIECE A LITTLE
MORE CLEAR, IF WE ARE MAKING

UPDATES, AND WHAT
THOSE UPDATES ARE.

ALL RIGHT. THANK YOU.

HI. I'M MARY FROM
UNITED HEALTH CARE.

AND I JUST HAVE A QUESTION
ABOUT THE ADDITIONAL QUESTION.

THERE'S A NEW QUESTION IN HPMS
THAT WE HAVE TO ANSWER IF WE

HAVE ANY PROVIDER
SPECIFIC PLANS.

WILL CMS BE PROVIDING US
MORE DIRECTION ON WHAT NEEDS

TO BE INCLUDED IN HSD TABLES,
WHEN THAT NEEDS TO HAPPEN?

I'M NOT 100% SURE IF WE HAVE
ALL THE RIGHT PEOPLE HERE.

BUT IF YOU DO A
PROVIDER SPECIFIC SPLIT,

MY UNDERSTANDING OF
THAT IS YOU'RE GONNA HAVE DIFFERENT PROVIDER GROUPS.

AND WE NEED TO MAKE SURE THAT,
YOU KNOW, YOU'RE STILL MEETING

ALL THE NECESSARY ACCESS
STANDARDS FOR THE PLANS.

SO YOU'RE GONNA NEED TO SUBMIT
THOSE HSD TABLES FOR, I GUESS,

THE DIFFERENT PROVIDER GROUPS
THAT YOU'RE SPLITTING AMONGST THE PLANS.

I DON'T KNOW IF ANY
OF THE POLICY TEAM

CAN ADD MORE
TO THAT RIGHT NOW.

MARTY, DID YOU WANT TO?

NO, THAT'S BASICALLY
CORRECT.

I MEAN, THE PROVIDER

SPECIFIC IDEA IS

THAT, TYPICALLY, WHEN THEY
DO THE--WHEN THEY APPROVE

NETWORKS, IT'S AT
THE COUNTY LEVEL.

SO THEY'LL LOOK AT A COUNTY
AND VALIDATE THAT WITHIN

A PARTICULAR COUNTY YOU HAVE
AN ADEQUATE PROVIDER NETWORK.

NOW, IF YOU HAPPEN TO HAVE 2
PLANS OPERATING IN THAT COUNTY

AND ONE OF THE PLANS DOESN'T--
YOU KNOW, HAS SOME SUBSET

OF THAT ENTIRE NETWORK,
THEN THEY NEED TO BE ABLE TO

FLAG THAT SO THEY CAN VALIDATE
THAT THE PLAN THAT HAS

THE SUBSET NETWORK--IN OTHER
WORDS, IS USING LESS THAN

EVERY PROVIDER YOU HAVE UNDER
CONTRACT IN THAT COUNTY--THEN

THAT ALONE MEETS AVAILABILITY
AND ACCESS BECAUSE WE, AGAIN,

WE LOOK AT THE PROVIDER
NETWORKS AT SORT OF A COUNTY

LEVEL, BUT THEY HAVE TO BE
VALIDATED AT A PLAN LEVEL.

SO I THINK THAT'S

ALL THEY'RE TRYING
TO KEEP TRACK OF.

OK. GOOD. THANKS.

I HAD A COUPLE OF
ADDITIONAL QUESTIONS.

FIRST OF ALL, REGARDING THE
ZERO DOLLAR COST SHARING

FOR PREVENTATIVE SERVICES--IS
THAT INCLUSIVE OF BOTH THE

PROFESSIONAL AND FACILITY COST
SHARING IF YOU HAVE SEPARATE

FACILITY AND PROFESSIONAL
COST SHARING?

OR DO YOU ENTER A LIMIT OR
A RANGE, MIN AND MAX, IN THE PBP FOR THOSE BENEFITS?

OR IS IT SUPPOSED TO BE
UNDERSTOOD THAT THE ENTIRE

COST SHARING FOR PREVENTATIVE
SERVICES IS GONNA BE ZERO

ACROSS THE BOARD,
REGARDLESS OF THE FACILITY AND PROFESSIONAL COST SHARING?

I'M GONNA LOOK FOR
OUR PBP POLICY TEAM TO ADDRESS THAT QUESTION.

I MEAN, I NEED TO DOUBLE-
CHECK, BUT I THINK IT'S THE

OFFICE VISIT YOU
COULD HAVE A CHARGE, BUT THE PREVENTATIVE

SERVICE ITSELF YOU
CAN'T HAVE A CHARGE.

BUT I WILL DOUBLE-CHECK
THAT BECAUSE I'M NOT 100% SURE.

DALE, DID YOU HAVE ANY?

IF IT'S AN
INPATIENT, IT WOULD BE JUST COVERED

UNDER "INPATIENT."

AND DALE WAS SAYING,
IF IT'S AN INPATIENT, THEN IT WOULD BE

COVERED UNDER "INPATIENT."

SO, I GUESS THE EXAMPLE
I WOULD HAVE WOULD BE FOR COLORECTAL SCREENINGS.

IF IT'S NOT DONE IN THE
PROVIDER'S OFFICE BUT IT'S

DONE AT AMBULATORY SURGERY
CENTER, WOULD THERE BE

A FACILITY CHARGE FOR THE
A.S.C. AND A SEPARATE

PROFESSIONAL CHARGE OF ZERO?

I THINK WE THINK
IT WOULD BE A ZERO COST SHARE.

OK, AND MY SECOND QUESTION IS,
IF ONE OF YOUR PLANS IS

IDENTIFIED AS A LOW-ENROLLMENT
PLAN, AND IS ASKED TO

NON-RENEW--I UNDERSTAND THE
GUIDANCE IS GONNA BE COMING

OUT IN A COUPLE OF WEEKS AS TO
WHICH PLANS THAT AFFECTS--BUT

IF WE'VE ALREADY
DOWNLOADED AND HAVE STARTED

POPULATING THE PBP,
DO WE NEED TO GO BACK

IN AND RE-UPDATE OUR
PLAN DATA AND NOT INCLUDE THAT PLAN IN THE PBP?

OR JUST SIMPLY NOT
UPLOAD THAT PLAN?

WELL, WHAT YOU
SHOULD DO IS YOU

SHOULD DELETE THAT
PLAN IN HPMS.

SO ONCE YOU'VE DELETED THAT
PLAN, YOU SHOULD DOWNLOAD

A PLAN SPECIFIC UPDATE SO THAT
PLAN'S NO LONGER IN YOUR,

YOU KNOW, PBP SOFTWARE.

AND THEN THAT WAY EVERYTHING'S
CONSISTENT BETWEEN WHAT'S

IN HPMS AND WHAT YOU'RE
DOING IN THE PBP.

JUST ALSO SO YOU AREN'T
ACCIDENTALLY DOING DATA ENTRY

FOR THAT PLAN,
ESPECIALLY SINCE YOU'RE NOT GONNA BE UPLOADING IT.

RIGHT. OK. THANKS.

HEY, I HAVE A COUPLE
OF FOLLOW-UP QUESTIONS.

WE HAVE A FEW NON-NETWORK
FEE-FOR-SERVICE PLANS, AND WE ALSO HAVE PPO PLANS.

NOW, NON-NETWORK
FEE-FOR-SERVICE IS GOING AWAY

IN 2011. SO HOW DO WE HANDLE
THESE PLANS ACCORDING TO

THE CROSSWALK IN HPMS?
WHAT DO WE NEED TO DO?

OK. THE NON-NETWORK, PRIVATE
FEE-FOR-SERVICE PLANS--YOU'RE

ALLOWED TO CROSSWALK THEM PER
THE CROSSWALK GUIDANCE TO MORE

NETWORKED, PRIVATE
FEE-FOR-SERVICE PLANS.

SO SOME ORGANIZATIONS,
I BELIEVE THEY ENDED UP

SUBMITTING APPLICATIONS FOR
A FULL NETWORK PRIVATE FEE-FOR-SERVICE FOR 2011.

AND IN THAT SITUATION, IF
YOU WANT TO CROSSWALK THOSE

MEMBERS IN THE NON-NETWORK TO
THE FULL NETWORK, PRIVATE

FEE-FOR-SERVICE, YOU HAVE TO
REQUEST THAT, AND YOU ACTUALLY

HAVE TO SEND AN E-MAIL TO ME.

I THINK THERE'S A CHART IN
THAT APRIL 16 MEMO TELLING

ORGANIZATIONS WHAT INFORMATION

WE NEED TO COMPLETE THAT

CROSSWALK ON BEHALF
OF THE ORGANIZATION.

NOW, WHAT IT SOUNDS LIKE YOU'RE
ASKING ABOUT IS PRIVATE

FEE-FOR-SERVICE TO PPO.

RIGHT. WE DON'T HAVE
ANY NETWORK PRIVATE FEE-FOR-SERVICE PLANS.

AND PER THE GUIDANCE THAT'S
CURRENTLY OUT THERE, THAT IS

NOT AN ALLOWABLE PLAN
CROSSWALK, BUT IF ANYBODY FROM

THE POLICY TEAM WANTS TO
FURTHER EXPLAIN THAT--

RIGHT. I JUST WANTED TO
CONFIRM WHAT SARAH SAID.

THAT MEMO IS RELEASED IN
THE 16th. I HAVE A COPY OF IT.

THERE IS A CHART.
THE CHART IS DEALT WITH TO DEAL WITH EVERY SITUATION.

THE NON-NETWORK STARTS
ON 7-A AND GOES ON TO 8-A, 8-B, AND 8-C.

AND EVERYTHING IS LISTED
THERE THAT YOU CAN DO, AS SARAH MENTIONED.

AND THE THINGS THAT ARE NOT
LISTED THERE, YOU CAN'T DO.

AND IF YOU HAVE A BURNING
DESIRE TO DO THEM, YOU COULD WRITE TO US.

WE'LL PROBABLY TELL
YOU IT'S NOT THERE.

BUT THE CHART IS VERY
THOROUGH. WE RELEASED THAT.

WE'VE BEEN DISCUSSING THIS
ALL YEAR BECAUSE AFTER WE DID

THINGS LAST YEAR AND WE
PUBLISHED THE GUIDANCE,

WE REALIZED WE LEFT CASES OUT.

SO, THE CHART JUST CAME OUT
AND I'M SURE YOU HAVEN'T READ

IT YET BECAUSE IT'S A
VERY DETAILED DOCUMENT.

BUT THERE'S A DOCUMENT, AND
THEN THERE'S A SUMMARY CHART.

AND YOU SHOULD
READ BOTH OF THEM.

THE SUMMARY CHART
IS VERY NICE.

ALL I DID IS LOOK DOWN THE
FIRST COLUMN FOR PRIVATE

FEE-FOR-SERVICE UNTIL I
FOUND NON-NETWORK. AS I SAID, IT STARTS IN 7-A.

SO IT'S A FRIENDLY CHART.
EVEN I CAN UNDERSTAND IT.

ARE THERE ANY OTHER QUESTIONS?

DOESN'T LOOK LIKE IT. OK.

WELL, I GUESS THAT CONCLUDES
OUR PRESENTATION, THEN.

THANK YOU ALL VERY
MUCH FOR COMING.

IF YOU GUYS DO HAVE QUESTIONS
AFTER YOU DIGEST THIS

INFORMATION FOR A LITTLE BIT,
AND YOU START PLAYING WITH THE

SOFTWARE AND START
ENTERING YOUR, YOU KNOW,

ORGANIZATION-SPECIFIC
BENEFITS, PLEASE FEEL FREE TO REACH OUT TO US.

OUR CONTACT INFORMATION
IS HERE.

AND, YOU KNOW, WE'RE MORE
THAN HAPPY TO HELP YOU GUYS COMPLETE YOUR DATA ENTRY.

ALL RIGHT. THANK YOU.

[APPLAUSE]