

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 1

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Additional Days  
 Non-Medicare-covered Stay  
 Upgrades

Select type of benefit for Additional Days:

Mandatory  
 Optional

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

Indicate number of Additional Days per benefit period:

Select type of benefit for Non-Medicare-covered stay:

Mandatory  
 Optional

Select type of benefit for Upgrades:

Mandatory  
 Optional

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 2

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 2

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

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

Yes  
 No

Indicate the Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

Does this plan's cost sharing vary by hospital(s) in which an enrollee obtains care?

Yes  
 No

How many cost sharing tiers do you offer?

What is your lowest cost tier?

Tier 1  
 Tier 2  
 Tier 3

Is there an enrollee Coinsurance?

Yes  
 No

Medicare-covered Coinsurance Cost Sharing for Tier 1:

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):

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

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 3

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 3

Medicare-covered Coinsurance Cost Sharing for Tier 2:  
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:  
[ ]

Indicate the number of day intervals for the Medicare-covered stay:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
[ ]	[ ]	[ ]
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
[ ]	[ ]	[ ]
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
[ ]	[ ]	[ ]

Medicare-covered Coinsurance Cost Sharing for Tier 3:  
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:  
[ ]

Indicate the number of day intervals for the Medicare-covered stay:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
[ ]	[ ]	[ ]
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
[ ]	[ ]	[ ]
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
[ ]	[ ]	[ ]

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 4

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 4

Medicare-covered Life Time Reserve Days Tier 1

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)

One

Two

Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

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

Medicare-covered Life Time Reserve Days Tier 2

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)

One

Two

Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

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

Medicare-covered Life Time Reserve Days Tier 3

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)

One

Two

Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

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

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 5

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 5

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):

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

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 6

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 6

Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay?

Yes  
 No

Indicate Coinsurance percentage for the Non-Medicare-covered stay:

Indicate the number of day intervals for the Non-Medicare-covered stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.: 1 to 999):

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

Indicate Coinsurance percentage for Upgrades:

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 7

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #1a Inpatient Hospital-Acute - Base 7

Medicare-covered Copayment Cost Sharing for Tier 1:

If you do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D.

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount for Tier 1:

Indicate Deductible Amount for Tier 2:

Indicate Deductible Amount for Tier 3:

Is there an enrollee Copayment?

Yes  
 No

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90). For more information on cost share limitations please view the variable help.

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

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 8

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit [Validate] Exit [No Validate] Go To: #1a Inpatient Hospital-Acute - Base 8

Medicare-covered Copayment Cost Sharing for Tier 2:  
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No  
Indicate Copayment amount for the Medicare-covered stay:  
  
Indicate the number of day intervals for the Medicare-covered stay:  
 Zero (No Copayment per Day)  
 One  
 Two  
 Three  
Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.  
Copayment Amt Interval 1:  Begin Day Interval 1:  End Day Interval 1:   
Copayment Amt Interval 2:  Begin Day Interval 2:  End Day Interval 2:   
Copayment Amt Interval 3:  Begin Day Interval 3:  End Day Interval 3:

Medicare-covered Copayment Cost Sharing for Tier 3:  
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No  
Indicate Copayment amount for the Medicare-covered stay:  
  
Indicate the number of day intervals for the Medicare-covered stay:  
 Zero (No Copayment per Day)  
 One  
 Two  
 Three  
Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.  
Copayment Amt Interval 1:  Begin Day Interval 1:  End Day Interval 1:   
Copayment Amt Interval 2:  Begin Day Interval 2:  End Day Interval 2:   
Copayment Amt Interval 3:  Begin Day Interval 3:  End Day Interval 3:



# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 9

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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Medicare-covered Life Time Reserve Days Tier 1	Medicare-covered Life Time Reserve Days Tier 2	Medicare-covered Life Time Reserve Days Tier 3																																													
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:																																													
<input type="radio"/> Zero (No Copayment per Day) <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three	<input type="radio"/> Zero (No Copayment per Day) <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three	<input type="radio"/> Zero (No Copayment per Day) <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three																																													
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# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 10

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for Additional Days  
(enter '999' if unlimited days are offered; e.g., 91 to 999):

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

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 11

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 11

Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?

Yes  
 No

Indicate Copayment amount for the Non-Medicare-covered stay:

Indicate the number of day intervals for the Non-Medicare-covered stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.: 1 to 999):

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

Indicate Copayment amount for Upgrades per stay:

Indicate Copayment amount for Upgrades per day:

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

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

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute – Base 12

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute - Base 12

Is a referral required for Inpatient Hospital - Acute Services?

Yes

No

Inpatient Hospital - Acute Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute (B Only) – Base 1

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute (B Only) - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer Inpatient Hospital - Acute Services as a benefit?

Yes  
 No

Select type of benefit for Inpatient Hospital - Acute Services:

Mandatory  
 Optional

Does this benefit have unlimited days?

Yes  
 No, indicate number

Indicate number of days per period:

Select the days periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute (B Only) – Base 2

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute (B Only) - Base 2

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

Yes  
 No

Indicate the Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage per stay:

Indicate the number of day intervals for the stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the stay  
(enter "999" if unlimited days are offered; e.g., 1 to 999):

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

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute (B Only) – Base 3

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute (B Only) - Base 3

Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per stay:

Indicate the number of day intervals for the stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Copayment Amt Interval	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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

Is a referral required for Inpatient Hospital - Acute Services?

Yes  
 No

# PBP 2015 Data Entry System Screens

## #1a Inpatient Hospital – Acute (B Only) – Base 4

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1a Inpatient Hospital-Acute (B Only) - Base 4

Inpatient Hospital - Acute Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):



# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 1

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 1

Maximum Plan Benefit Coverage is not applicable for this Service Category

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Additional Days  
 Non-Medicare-covered Stay

Select type of benefit for Additional Days:

Mandatory  
 Optional

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

Indicate number of Additional Days per benefit period:

Select type of benefit for Non-Medicare-covered stay:

Mandatory  
 Optional

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

Yes  
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Inpatient Hospital Services Category 1a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 2

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 2

Does this plan's cost sharing vary by hospital(s) in which an enrollee obtains care?  
 Yes  
 No

How many cost sharing tiers do you offer?  
[ ]

What is your lowest cost tier?  
 Tier 1  
 Tier 2  
 Tier 3

Is there an enrollee Coinsurance?  
 Yes  
 No

Medicare-covered Coinsurance Cost Sharing for Tier 1:

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:  
[ ]

Indicate the number of day intervals for the Medicare-covered stay:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
[ ]	[ ]	[ ]
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
[ ]	[ ]	[ ]
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
[ ]	[ ]	[ ]

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 3

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 3

Medicare-covered Coinsurance Cost Sharing for Tier 2: Medicare-covered Coinsurance Cost Sharing for Tier 3:

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):

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

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):

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

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 4

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 4

Medicare-covered Life Time Reserve Days Tier 1

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

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

Medicare-covered Life Time Reserve Days Tier 2

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

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

Medicare-covered Life Time Reserve Days Tier 3

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

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

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 5

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 5

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):

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

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 6

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 6

Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay?

Yes  
 No

Indicate Coinsurance percentage for the Non-Medicare-covered stay:

Indicate the number of day intervals for the Non-Medicare-covered stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.: 1 to 999):

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

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 7

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #1b Inpatient Hospital Psychiatric - Base 7

If you do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D.

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount for Tier 1:

Indicate Deductible Amount for Tier 2:

Indicate Deductible Amount for Tier 3:

Is there an enrollee Copayment?

Yes  
 No

Medicare-covered Copayment Cost Sharing for Tier 1:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.

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

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 8

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 8

Medicare-covered Copayment Cost Sharing for Tier 2:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90). For more information on cost share limitations please view the variable help.

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

Medicare-covered Copayment Cost Sharing for Tier 3:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90). For more information on cost share limitations please view the variable help.

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



# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 9

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 9

Medicare-covered Life Time Reserve Days Tier 1 Medicare-covered Life Time Reserve Days Tier 2 Medicare-covered Life Time Reserve Days Tier 3

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

Interval Days			Interval Days			Interval Days		
Copay Amount	Begin Day	End Day	Copay Amount	Begin Day	End Day	Copay Amount	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>	Interval 1:	<input type="text"/>	<input type="text"/>	Interval 1:	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>	Interval 2:	<input type="text"/>	<input type="text"/>	Interval 2:	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>	Interval 3:	<input type="text"/>	<input type="text"/>	Interval 3:	<input type="text"/>	<input type="text"/>

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 10

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 10

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., '91 to 999):

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

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 11

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 11

Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?

Yes  
 No

Indicate Copayment amount for the Non-Medicare-covered stay:

Indicate the number of day intervals for the Non-Medicare-covered stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.: 1 to 999).

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

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

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

Is a referral required for Inpatient Psychiatric Hospital Services?

Yes  
 No

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 12

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric - Base 12

Inpatient Psychiatric Hospital Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric (B Only) – Base 1

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer Inpatient Psychiatric Hospital Services as a benefit?

Yes  
 No

Select type of benefit for Inpatient Psychiatric Hospital Services:

Mandatory  
 Optional

Does this benefit have unlimited days?

Yes  
 No, indicate number

Indicate number of days per period:

Select the days periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Select the Maximum Plan Benefit Coverage type:

Covered under Inpatient Hospital Services Category 1a  
 Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric (B Only) – Base 2

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 2

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

Yes  
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under the Inpatient Hospital Services Category 1a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric (B Only) – Base 3

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 3

Indicate the coinsurance percentage and day interval(s) for the stay  
(enter "999" if unlimited days are offered; e.g., 1 to 999):

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage per stay:

Indicate the number of day intervals for the stay:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric (B Only) – Base 4

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 4

Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per stay:

Indicate the number of day intervals for the stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

Is a referral required for Inpatient Psychiatric Hospital Services?

Yes  
 No



# PBP 2015 Data Entry System Screens

## #1b Inpatient Hospital Psychiatric (B Only) – Base 5

PBP Data Entry System - Section B-1, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 5

Inpatient Psychiatric Hospital Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Empty text area for optional notes]

# PBP 2015 Data Entry System Screens

## #2 SNF – Base 1

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Additional days beyond Medicare-covered  
 Non-Medicare-covered stay

Select type of benefit for Additional Days beyond Medicare-covered:

Mandatory  
 Optional

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

Indicate the number of Additional Days beyond Medicare-covered per benefit period:

Select type of benefit for the Non-Medicare-covered stay:

Mandatory  
 Optional

Do you allow less than 3 day inpatient hospital stay prior to SNF admission?

Yes  
 No

Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):

Zero  
 One  
 Two

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

# PBP 2015 Data Entry System Screens

## #2 SNF – Base 2

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #2 SNF - Base 2

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Stay  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for Medicare-covered stay (e.g.: 1 to 20; 21 to 100):

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

# PBP 2015 Data Entry System Screens

## #2 SNF – Base 3

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF - Base 3

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

# PBP 2015 Data Entry System Screens

## #2 SNF – Base 4

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF - Base 4

Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay?

Yes  
 No

Indicate Coinsurance percentage for the Non-Medicare-covered stay:

Indicate the number of day intervals for the Non-Medicare-covered stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

# PBP 2015 Data Entry System Screens

## #2 SNF – Base 5

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Copayment?

Yes  
 No

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

Yes  
 No

Indicate Copayment amount for Medicare-covered stay:

Indicate the number of day intervals for the Medicare-covered stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g., 1 to 20; 21 to 100). For more information on cost share limitations please view the variable help.

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

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

# PBP 2015 Data Entry System Screens

## #2 SNF – Base 6

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF - Base 6

Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?

Yes  
 No

Indicate Copayment amount for Non-Medicare-covered stay:

Indicate the number of day intervals for the Non-Medicare-covered stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.: 1 to 999):

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

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

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

Is a referral required for SNF Services?

Yes  
 No

# PBP 2015 Data Entry System Screens

## #2 SNF – Base 7

The screenshot shows a software window titled "PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000". The window has a menu bar with "File" and "Help". Below the menu bar is a navigation bar with buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". To the right of these buttons is a "Go To:" label followed by a dropdown menu currently displaying "#2 SNF - Base 7".

Below the navigation bar, the text "SNF Notes" is displayed. A note is provided: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." Below this note, the text "Notes (Optional):" is shown above a large, empty text area with a vertical scrollbar on the right side.



# PBP 2015 Data Entry System Screens

## #2 SNF (B Only) – Base 1

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF (B Only) - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer SNF Care as a benefit?

Yes  
 No

Select type of benefit for SNF Care:

Mandatory  
 Optional

Does this benefit have unlimited days?

Yes  
 No, indicate number

Indicate number of days per period:

Select the days periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Stay  
 Other, Describe

Is a hospital stay required before admission to a SNF?

Yes  
 No

Indicate number of days required for hospital stay:

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Stay  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #2 SNF (B Only) – Base 2

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #2 SNF (B Only) - Base 2

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

Yes  
 No

Indicate amount for Maximum Enrollee Out-of-Pocket Cost:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Stay  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage:

Indicate the number of day intervals for the stay:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the stay  
(enter "999" if unlimited days are offered; e.g.: 1 to 999):

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

# PBP 2015 Data Entry System Screens

## #2 SNF (B Only) – Base 3

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #2 SNF (B Only) - Base 3

Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per Stay:

Indicate the number of day intervals for the stay:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

# PBP 2015 Data Entry System Screens

## #2 SNF (B Only) – Base 4

PBP Data Entry System - Section B-2, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #2 SNF (B Only) - Base 4

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

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

Is a referral required for SNF Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #3 Cardiac and Pulmonary Rehabilitation Services – Base 1

PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Additional Cardiac Rehabilitation Services  
 Additional Intensive Cardiac Rehabilitation Services  
 Additional Pulmonary Rehabilitation Services

Select type of benefit for Additional Cardiac Rehabilitation Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Cardiac Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Cardiac Rehabilitation Services:

Select the Additional Cardiac Rehabilitation Services periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select type of benefit for Additional Intensive Cardiac Rehabilitation Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Intensive Cardiac Rehabilitation Services:

Select the Additional Intensive Cardiac Rehabilitation Services periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select type of benefit for Additional Pulmonary Rehabilitation Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Pulmonary Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Pulmonary Rehabilitation Services:

Select the Additional Pulmonary Rehabilitation Services periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #3 Cardiac and Pulmonary Rehabilitation Services – Base 2

PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 2

Maximum Plan Benefit Coverage is not applicable for this Service Category

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Select which Cardiac and Pulmonary Rehabilitation Services have a Coinsurance (Select all that apply):

Medicare-covered Cardiac Rehabilitation Services  
 Medicare-covered Intensive Cardiac Rehabilitation Services  
 Medicare-covered Pulmonary Rehabilitation Services  
 Additional Cardiac Rehabilitation Services  
 Additional Intensive Cardiac Rehabilitation Services  
 Additional Pulmonary Rehabilitation Services

	Minimum Coinsurance	Maximum Coinsurance
Indicate Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Additional Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Additional Pulmonary Rehabilitation Services:	<input type="text"/>	<input type="text"/>

# PBP 2015 Data Entry System Screens

## #3 Cardiac and Pulmonary Rehabilitation Services – Base 3

PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 3

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):  
 Medicare-covered Cardiac Rehabilitation Services  
 Medicare-covered Intensive Cardiac Rehabilitation Services  
 Medicare-covered Pulmonary Rehabilitation Services  
 Additional Cardiac Rehabilitation Services  
 Additional Intensive Cardiac Rehabilitation Services  
 Additional Pulmonary Rehabilitation Services

	Minimum Copayment	Maximum Copayment
Indicate Copayment amount for Medicare-covered Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Copayment amount for Medicare-covered Intensive Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Copayment amount for Additional Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Copayment amount for Additional Intensive Cardiac Rehabilitation Services:	<input type="text"/>	<input type="text"/>
Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:	<input type="text"/>	<input type="text"/>

# PBP 2015 Data Entry System Screens

## #3 Cardiac and Pulmonary Rehabilitation Services – Base 4

PBP Data Entry System - Section B-3, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 4

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

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

Cardiac and Pulmonary Rehabilitation Programs Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):



# PBP 2015 Data Entry System Screens

## #4a Emergency Care – Base 1

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4a Emergency Care - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?

Yes  
 No

Select either Days or Hours within which admission must occur for waiver:

Days  
 Hours

Enter number of Days or Hours:

# PBP 2015 Data Entry System Screens

## #4a Emergency Care – Base 2

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #4a Emergency Care - Base 2

Authorization is not applicable for this Service Category.

Referral is not applicable for this Service Category.

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?

Yes  
 No

Select either Days or Hours within which admission must occur for waiver:

Days  
 Hours

Enter number of Days or Hours:

# PBP 2015 Data Entry System Screens

## #4b Urgently Needed Care – Base 1

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Yes  
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Emergency Care Service Category 4a  
 Plan-specified amount per period

Go To: #4b Urgently Needed Care - Base 1

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits

Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?

Yes  
 No

Select either Days or Hours within which admission must occur for waiver:

Days  
 Hours

Enter number of Days or Hours:

# PBP 2015 Data Entry System Screens

## #4b Urgently Needed Care – Base 2

**PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous   Next>>   Exit (Validate)   Exit (No Validate)   **Go To:** #4b Urgently Needed Care - Base 2

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Is the Copayment for Medicare-covered Benefits waived if admitted to hospital?  
 Yes  
 No

Select either Days or Hours within which admission must occur for waiver:  
 Days  
 Hours

Enter number of Days or Hours:

# PBP 2015 Data Entry System Screens

## #4b Urgently Needed Care – Base 3

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4b Urgently Needed Care - Base 3

Authorization is not applicable for this Service Category.

Referral is not applicable for this Service Category.

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

If you have entered a range of cost sharing, you must describe the reason for this range.

Notes (Optional):

[Empty text area for notes]

# PBP 2015 Data Entry System Screens

## #4c Worldwide Emergency Coverage – Base 1

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4c Worldwide Emergency Coverage - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Worldwide Emergency Coverage as a supplemental benefit under Part C?

Yes  
 No

Select type of benefit for Worldwide Emergency Coverage:

Mandatory  
 Optional

Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency Coverage?

Yes  
 No

Is the service-specific Maximum Plan Benefit Coverage amount unlimited?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #4c Worldwide Emergency Coverage – Base 2

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4c Worldwide Coverage - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage for Worldwide Coverage:

Is this Coinsurance waived for Worldwide Coverage if admitted to hospital?

Yes  
 No

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount for Worldwide Coverage:

Is this Copayment waived for Worldwide Coverage if admitted to hospital?

Yes  
 No

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

# PBP 2015 Data Entry System Screens

## #4c Worldwide Emergency Coverage – Base 3

PBP Data Entry System - Section B-4, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #4c Worldwide Coverage - Base 3

Authorization is not applicable for this Service Category.

Referral is not applicable for this Service Category.

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Empty text area]



# PBP 2015 Data Entry System Screens

## #5 Partial Hospitalization – Base 1

PBP Data Entry System - Section B-5, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #5 Partial Hospitalization - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

# PBP 2015 Data Entry System Screens

## #5 Partial Hospitalization – Base 2

PBP Data Entry System - Section B-5, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount for Medicare-covered Benefits per day:

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

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

Is a referral required for Partial Hospitalization?

Yes  
 No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #6 Home Health Services – Base 1

PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

Is there an enrollee Coinsurance?

Yes

No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

# PBP 2015 Data Entry System Screens

## #6 Home Health Services – Base 2

PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #6 Home Health Services - Base 2

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# PBP 2015 Data Entry System Screens

## #6 Home Health Services – Base 3

The screenshot shows a software window titled "PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with buttons for "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "#6 Home Health Services - Base 3".

Below the toolbar, there is a section titled "Enrollee must receive Authorization from one or more of the following:" with five checkboxes:

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

Below this is a question: "Is a referral required for Home Health Services?" with two radio button options: "Yes" and "No".

A note below the radio buttons reads: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."

At the bottom, there is a text area labeled "Notes (Optional):" which is currently empty.

# PBP 2015 Data Entry System Screens

## #6 Home Health Services – MMP – Base 1

PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare Home Health Services?

Yes  
 No

Select Non-Medicare Home Health Services:

Additional Hours of Care  
 Personal Care Services  
 Other 1  
 Other 2

Enter name of Other 1 Service:  
[Text Box]

Enter name of Other 2 Service:  
[Text Box]

Is there a service-specific Maximum Plan Benefit Coverage Amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:  
[Text Box]

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a limit on the services provided?

Yes  
 No

Select Non-Medicare Home Health Services where limit applies:

Additional Hours of Care  
 Personal Care Services  
 Other 1  
 Other 2

Indicate units a limit will be provided in for Additional Hours of Care:

Sessions  
 Visits  
 Hours  
 Points  
 Meals

Indicate numerical limit on the services provided for Additional Hours of Care:  
[Text Box]

Select limit on services periodicity for Additional Hours of Care:

Every day  
 Every week  
 Every month  
 Every year  
 Other, Describe

Indicate units a limit will be provided in for Personal Care Services:

Sessions  
 Visits  
 Hours  
 Points  
 Meals

Indicate numerical limit on the services provided for Personal Care Services:  
[Text Box]

Select limit on services periodicity for Personal Care Services:

Every day  
 Every week  
 Every month  
 Every year  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #6 Home Health Services – MMP – Base 2

PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #6 Home Health Services - MMP - Base 2

Indicate units a limit will be provided in for Other 1:

Sessions  
 Visits  
 Hours  
 Points  
 Meals

Indicate numerical limit on the services provided for Other 1:

Select limit on services periodicity for Other 1:

Every day  
 Every week  
 Every month  
 Every year  
 Other, Describe

Indicate units a limit will be provided in for Other 2:

Sessions  
 Visits  
 Hours  
 Points  
 Meals

Indicate numerical limit on the services provided for Other 2:

Select limit on services periodicity for Other 2:

Every day  
 Every week  
 Every month  
 Every year  
 Other, Describe

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Non-Medicare Home Health Services have a Coinsurance (select all that apply):  
 Additional Hours of Care  
 Personal Care Services  
 Other 1  
 Other 2

Indicate coinsurance percentage for one or more of the following services:

	Minimum Coinsurance	Maximum Coinsurance
Additional Hours of Care:	<input type="text"/>	<input type="text"/>
Personal Care Services:	<input type="text"/>	<input type="text"/>
Other 1:	<input type="text"/>	<input type="text"/>
Other 2:	<input type="text"/>	<input type="text"/>

# PBP 2015 Data Entry System Screens

## #6 Home Health Services – MMP – Base 3

**PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #6 Home Health Services - MMP - Base 3

Is there an enrollee Copayment?  
 Yes  
 No

Does any service require qualification for and enrollment in a state-operated waiver program?  
 Yes  
 No

Select which Non-Medicare Home Health Services have a Copayment (select all that apply):  
 Additional Hours of Care  
 Personal Care Services  
 Other 1  
 Other 2

Select which service requires qualification for an denrollment in a state-operated waiver program.  
 Additional Hours of Care  
 Personal Care Services  
 Other 1  
 Other 2

Indicate copayment percentage for one or more of the following services:

	Minimum Copayment	Maximum Copayment
Additional Hours of Care:	<input type="text"/>	<input type="text"/>
Personal Care Services:	<input type="text"/>	<input type="text"/>
Other 1:	<input type="text"/>	<input type="text"/>
Other 2:	<input type="text"/>	<input type="text"/>

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Services?  
 Yes  
 No

Notes (Optional):



# PBP 2015 Data Entry System Screens

## #7a Primary Care Physician Services – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) **Go To:** #7a Primary Care Physician Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

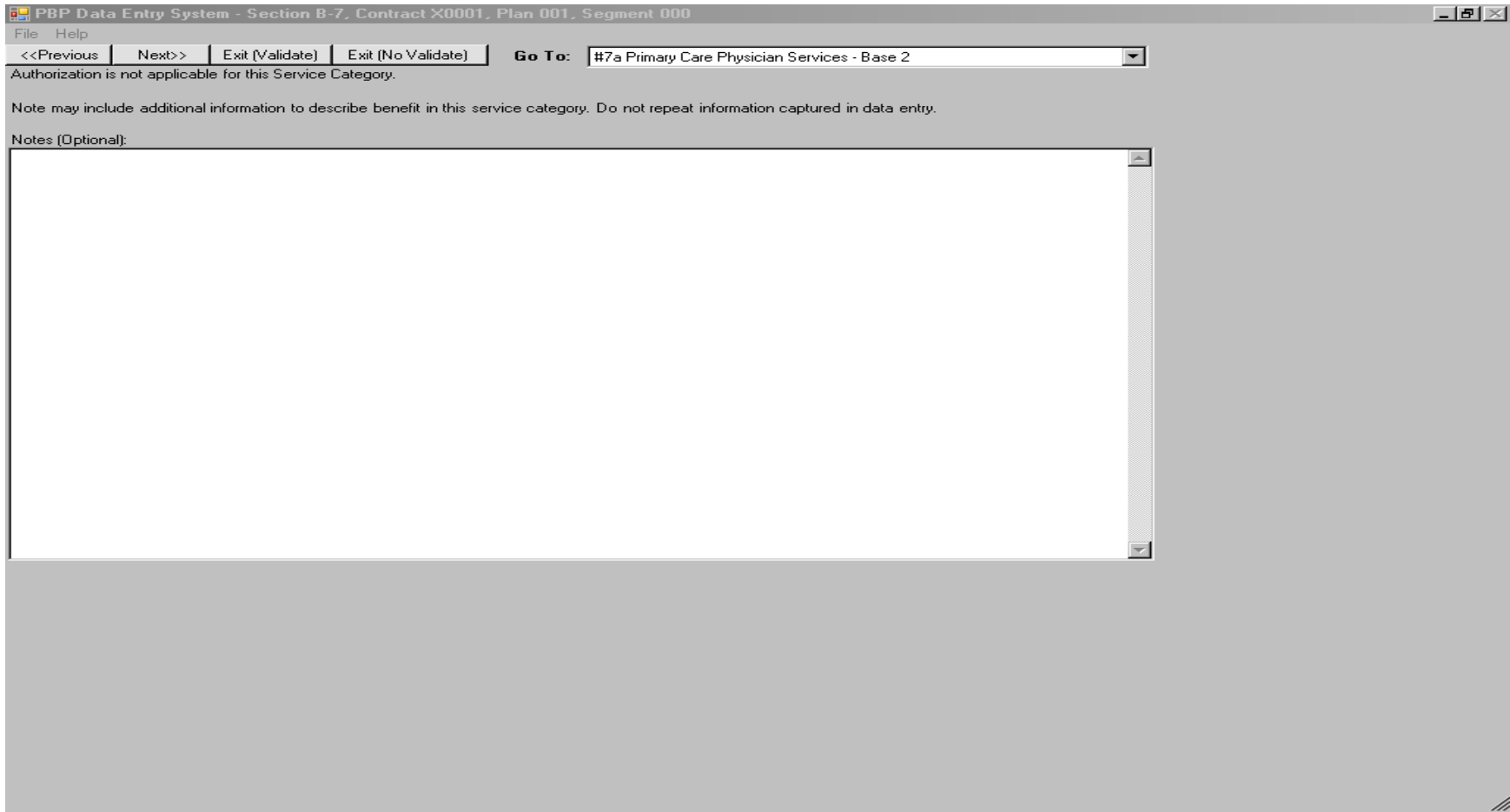
Yes  
 No

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

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

# PBP 2015 Data Entry System Screens

## #7a Primary Care Physician Services – Base 2



PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7a Primary Care Physician Services - Base 2

Authorization is not applicable for this Service Category.

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #7b Chiropractic Services – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7b Chiropractic Services - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:  
 Routine Care

Select type of benefit for Routine Care:  
 Mandatory  
 Optional

Is this benefit unlimited for Routine Care?  
 Yes  
 No, indicate number

Indicate number of visits for Routine Care:

Select Routine Care periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a service-specific Maximum Plan Benefit Coverage amount?  
 Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  
 Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #7b Chiropractic Services – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7b Chiropractic Services - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

Select which Chiropractic Services have a Coinsurance (Select all that apply):

Medicare-covered Chiropractic Services  
 Routine Care

Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:

Indicate the Minimum Coinsurance percentage per visit for Routine Care:

Indicate the Maximum Coinsurance percentage per visit for Routine Care:

# PBP 2015 Data Entry System Screens

## #7b Chiropractic Services – Base 3

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Select which Chiropractic Services have a Copayment (Select all that apply):  
 Medicare-covered Chiropractic Services  
 Routine Care

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount per visit for Routine Care:

Indicate Maximum Copayment amount per visit for Routine Care:

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Chiropractic Services?  
 Yes  
 No

# PBP 2015 Data Entry System Screens

## #7b Chiropractic Services – Base 4

The screenshot shows a software window titled "PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with buttons for "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "#7b Chiropractic Services - Base 4". Below the toolbar, the text "Chiropractic Services Notes" is displayed, followed by a note: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." A large, empty text area labeled "Notes (Optional):" is provided for data entry.

# PBP 2015 Data Entry System Screens

## #7c Occupational Therapy Services – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7c Occupational Therapy Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category, except for MMPs.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# PBP 2015 Data Entry System Screens

## #7c Occupational Therapy Services – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7c Occupational Therapy Services - Base 2

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

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

Is a referral required for Occupational Therapy Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Empty text area]



# PBP 2015 Data Entry System Screens

## #7c Occupational Therapy Services – MMP – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7c Occupational Therapy Services - MMP - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare Occupational Therapy Services?

Yes  
 No

Enter name of Non-Medicare Occupational Therapy Service:

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage:

Indicate Maximum Coinsurance percentage:

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount:

Indicate Maximum Copayment amount:

# PBP 2015 Data Entry System Screens

## #7c Occupational Therapy Services – MMP – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7c Occupational Therapy Services - MMP - Base 2

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

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

Is a referral required for Services?

Yes

No

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #7d Physician Specialist Services – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7d Physician Specialist Services - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# PBP 2015 Data Entry System Screens

## #7d Physician Specialist Services – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7d Physician Specialist Services - Base 2

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

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

Is a referral required for Physician Specialist Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #7e Mental Health Specialty Services – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7e Mental Health Specialty Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

# PBP 2015 Data Entry System Screens

## #7e Mental Health Specialty Services – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7e Mental Health Specialty Services - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Mental Health Specialty Services have a Coinsurance (Select all that apply):  
 Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate minimum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:

Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:

Is there an enrollee Copayment?  
 Yes  
 No

Select which Mental Health Specialty Services have a Copayment (Select all that apply):  
 Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate maximum Copayment Amount for Medicare-covered Individual Sessions:

Indicate minimum Copayment amount for Medicare-covered Group Sessions:

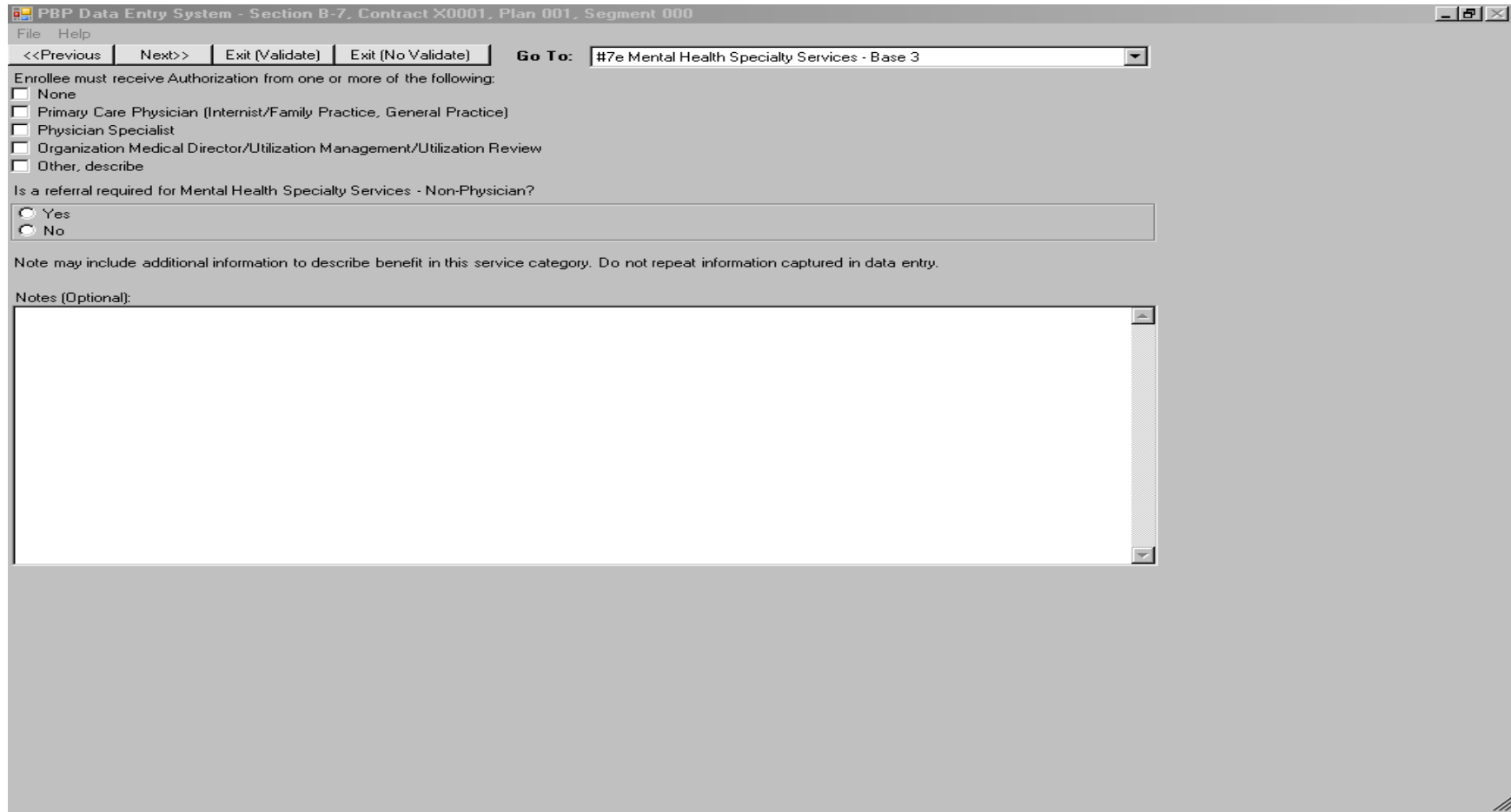
Indicate maximum Copayment amount for Medicare-covered Group Sessions:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

# PBP 2015 Data Entry System Screens

## #7e Mental Health Specialty Services – Base 3



PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7e Mental Health Specialty Services - Base 3

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

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

Is a referral required for Mental Health Specialty Services - Non-Physician?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #7f Podiatry Services – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7f Podiatry Services - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Does the plan provide Podiatry Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Routine Footcare

Select type of benefit for Routine Footcare:

Mandatory  
 Optional

Is this benefit unlimited for Routine Footcare?

Yes  
 No

Indicate number of Routine Footcare visits:

Select the Routine Footcare periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe



# PBP 2015 Data Entry System Screens

## #7f Podiatry Services – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7f Podiatry Services - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

Select which Podiatry Services have a Coinsurance (Select all that apply):

Medicare-covered Podiatry Services  
 Routine Footcare

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Footcare:

Indicate Maximum Coinsurance percentage for Routine Footcare:

Is there an enrollee Copayment?

Yes  
 No

Select which Podiatry Services have a Copayment (Select all that apply):

Medicare-covered Podiatry Services  
 Routine Footcare

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

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

Indicate Minimum Copayment amount per visit for Routine Footcare:

Indicate Maximum Copayment amount per visit for Routine Footcare:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

# PBP 2015 Data Entry System Screens

## #7f Podiatry Services – Base 3

The screenshot shows a software window titled "PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with buttons for "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "#7f Podiatry Services - Base 3".

Below the toolbar, there is a section for authorization requirements: "Enrollee must receive Authorization from one or more of the following:" followed by a list of checkboxes: "None", "Primary Care Physician (Internist/Family Practice, General Practice)", "Physician Specialist", "Organization Medical Director/Utilization Management/Utilization Review", and "Other, describe".

Next is a question: "Is a referral required for Podiatrist Services?" with radio buttons for "Yes" and "No".

A note field is present: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." Below this is a "Notes (Optional):" section with a large, empty text area.

# PBP 2015 Data Entry System Screens

## #7g Other Health Care Professional – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7g Other Health Care Professional - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

\_\_\_\_\_

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

\_\_\_\_\_

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

\_\_\_\_\_

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

\_\_\_\_\_

Is there an enrollee Copayment?

Yes  
 No

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

\_\_\_\_\_

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

\_\_\_\_\_

# PBP 2015 Data Entry System Screens

## #7g Other Health Care Professional – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7g Other Health Care Professional - Base 2

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

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

Is a referral required for Other Health Care Professional Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #7h Psychiatric Services – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7h Psychiatric Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

# PBP 2015 Data Entry System Screens

## #7h Psychiatric Services – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7h Psychiatric Services - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

Select which Psychiatric Services have a Coinsurance (Select all that apply):

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate minimum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:

Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:

Is there an enrollee Copayment?

Yes  
 No

Select which Psychiatric Services have a Copayment (Select all that apply):

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate maximum Copayment amount for Medicare-covered Individual Sessions:

Indicate minimum Copayment amount for Medicare-covered Group Sessions:

Indicate maximum Copayment amount for Medicare-covered Group Sessions:

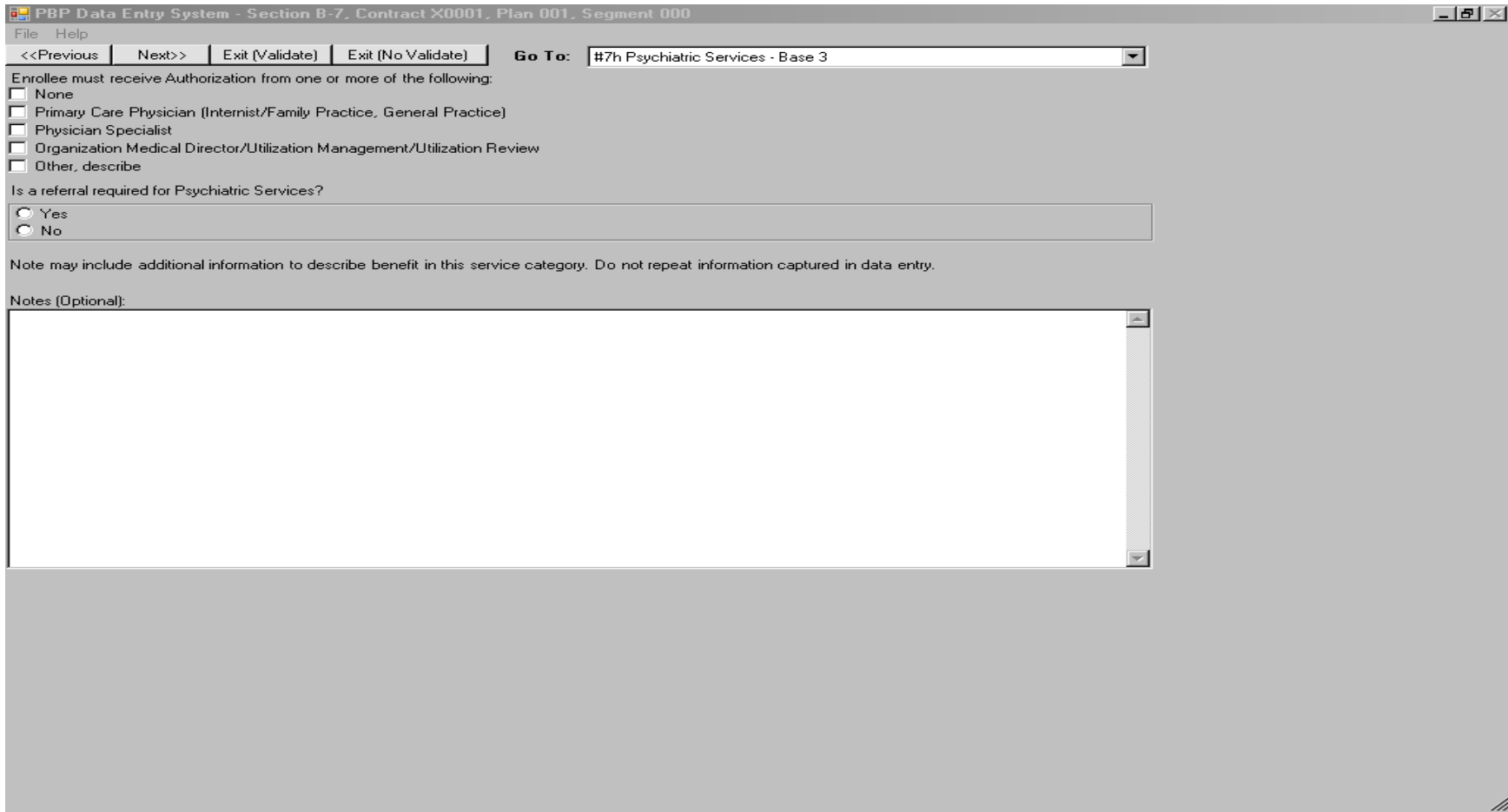
Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

# PBP 2015 Data Entry System Screens

## #7h Psychiatric Services – Base 3



PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

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

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

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

Is a referral required for Psychiatric Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #7i PT and SP Services – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7i PT and SP Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category, except for MMPs.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

You must include total cost sharing to the beneficiary, including any facility cost sharing.

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

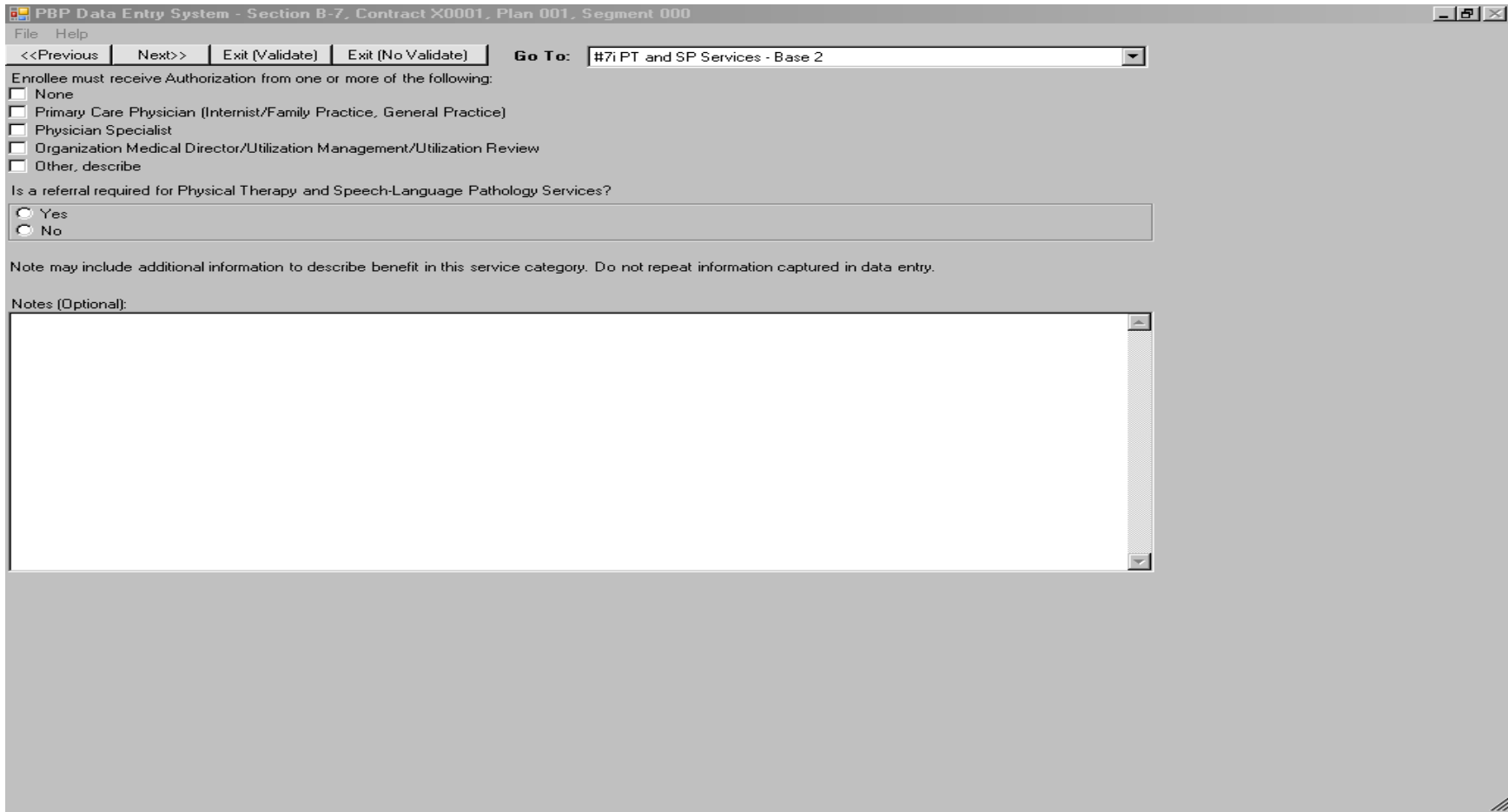
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:

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



# PBP 2015 Data Entry System Screens

## #7i PT and SP Services – Base 2



PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7i PT and SP Services - Base 2

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

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

Is a referral required for Physical Therapy and Speech-Language Pathology Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

#7i PT and ST – MMP – Base 1

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #7i PT and ST - MMP - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare Physical and/or Speech Therapy services?

Yes  
 No

Select Non-Medicare Physical and/or Speech Therapy Services:

Other 1  
 Other 2

Enter name of Other 1 Service:  
\_\_\_\_\_  
Enter name of Other 2 Service:  
\_\_\_\_\_

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:  
\_\_\_\_\_

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Select which Non-Medicare Physical and/or Speech Therapy services have a Coinsurance (select all that apply):

Other 1  
 Other 2

Indicate coinsurance percentage for one or more of the following services:	Minimum Coinsurance	Maximum Coinsurance
Other 1:	_____	_____
Other 2:	_____	_____

# PBP 2015 Data Entry System Screens

#71 PT and ST – MMP – Base 2

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #71 PT and ST - MMP - Base 2

Is there an enrollee Copayment?

Yes  
 No

Select which Non-Medicare Physical and/or Speech Therapy services have a Copayment (select all that apply):

Other 1  
 Other 2

Indicate copayment percentage for one or more of the following services:	Minimum Copayment	Maximum Copayment
Other 1:	<input type="text"/>	<input type="text"/>
Other 2:	<input type="text"/>	<input type="text"/>

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

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

Is a referral required for Services?

Yes  
 No

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #8a Outpatient Diag Procs/Tests/Lab Services – Base 1

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

# PBP 2015 Data Entry System Screens

## #8a Outpatient Diag Procs/Tests/Lab Services – Base 2

PBP Data Entry System - Section B-B, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 2

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Indicate Minimum Coinsurance percentage for Medicare-covered Lab Services

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Maximum Coinsurance percentage for Medicare-covered Lab Services

Select which Outpatient Diag Procs/Tests/Lab Services have a Coinsurance (Select all that apply):  
 Medicare-covered Diagnostic Procedures/Tests  
 Medicare-covered Lab Services

Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests:

Indicate Maximum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests:

# PBP 2015 Data Entry System Screens

## #8a Outpatient Diag Procs/Tests/Lab Services – Base 3

PBP Data Entry System - Section B-B, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 3

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):  
 Medicare-covered Diagnostic Procedures/Tests  
 Medicare-covered Lab Services

Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Minimum Copayment amount for Medicare-covered Lab Services:

Indicate Maximum Copayment amount for Medicare-covered Lab Services:

Indicate whether a separate physician/professional service cost share applies:  
 Sometimes, describe  
 No

Is there an enrollee Coinsurance for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:

Indicate Maximum Coinsurance percentage for a separate physician/professional service:

Is there an enrollee Copayment for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:

Indicate Maximum Copayment amount for a separate physician/professional service:

# PBP 2015 Data Entry System Screens

## #8a Outpatient Diag Procs/Tests/Lab Services – Base 4

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 4

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

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

Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Enter Notes for Medicare-covered Diagnostic Procedures/Tests (Optional):

Enter Notes for Medicare-covered Lab Services (Optional):

# PBP 2015 Data Entry System Screens

## #8b Outpatient Diag/Therapeutic Rad Services – Base 1

PBP Data Entry System - Section B-B, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Select which Outpatient Diag/Therapeutic Rad Services have a Coinsurance (Select all that apply):

Medicare-covered X-Ray Services  
 Medicare-covered Diagnostic Radiological Services  
 Medicare-covered Therapeutic Radiological Services

Indicate Minimum Coinsurance percentage for Medicare-covered X-Ray Services:

Indicate Maximum Coinsurance percentage for Medicare-covered X-Ray Services:

Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):

Indicate Maximum Coinsurance percentage for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):

Indicate Minimum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services:

Indicate Maximum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services:



# PBP 2015 Data Entry System Screens

## #8b Outpatient Diag/Therapeutic Rad Services – Base 2

PBP Data Entry System - Section B-B, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 2

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

Select which Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):  
 Medicare-covered X-Ray Services  
 Medicare-covered Diagnostic Radiological Services  
 Medicare-covered Therapeutic Radiological Services

Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:  
[ ]

Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:  
[ ]

Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):  
[ ]

Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):  
[ ]

Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:  
[ ]

Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:  
[ ]

Indicate whether a separate physician/professional service cost share applies:  
 Sometimes, describe  
 No

Is there an enrollee Coinsurance for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:  
[ ]

Indicate Maximum Coinsurance percentage for a separate physician/professional service:  
[ ]

Is there an enrollee Copayment for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:  
[ ]

Indicate Maximum Copayment amount for a separate physician/professional service:  
[ ]

# PBP 2015 Data Entry System Screens

## #8b Outpatient Diag/Therapeutic Rad Services – Base 3

PBP Data Entry System - Section B-8, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 3

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

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

Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?

Yes

No

Outpatient Diagnostic and Therapeutic Radiological Services Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Enter Notes for Medicare-covered X-Ray Services (Optional):

Enter Notes for Medicare-covered Diagnostic Radiological Services (Optional):

Enter Notes for Medicare-covered Therapeutic Radiological Services (Optional):

# PBP 2015 Data Entry System Screens

## #9a Outpatient Hospital Services – Base 1

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9a Outpatient Hospital Services - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

# PBP 2015 Data Entry System Screens

## #9a Outpatient Hospital Services – Base 2

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9a Outpatient Hospital Services - Base 2

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

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

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

Is a referral required for Outpatient Hospital Services?

Yes  
 No

# PBP 2015 Data Entry System Screens

## #9a Outpatient Hospital Services – Base 3

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9a Outpatient Hospital Services - Base 3

Outpatient Hospital Services Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #9b ASC Services – Base 1

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9b ASC Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Outpatient Hospital Services Category 9a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

# PBP 2015 Data Entry System Screens

## #9b ASC Services – Base 2

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9b ASC Services - Base 2

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

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

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

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

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

Is a referral required for Ambulatory Surgical Center Services?  
 Yes  
 No

# PBP 2015 Data Entry System Screens

## #9b ASC Services – Base 3

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9b ASC Services - Base 3

ASC Services Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):



# PBP 2015 Data Entry System Screens

## #9c Outpatient Substance Abuse – Base 1

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9c Outpatient Substance Abuse - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Outpatient Hospital Services Category 9a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #9c Outpatient Substance Abuse – Base 2

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9c Outpatient Substance Abuse - Base 2

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Select which Outpatient Substance Abuse Services have a Coinsurance (Select all that apply):

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate minimum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate maximum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate minimum Coinsurance percentage for Medicare-covered Group Sessions:

Indicate maximum Coinsurance percentage for Medicare-covered Group Sessions:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Select which Outpatient Substance Abuse Services have a Copayment (Select all that apply):

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate maximum Copayment amount for Medicare-covered Individual Sessions:

Indicate minimum Copayment amount for Medicare-covered Group Sessions:

Indicate maximum Copayment amount for Medicare-covered Group Sessions:

# PBP 2015 Data Entry System Screens

## #9c Outpatient Substance Abuse – Base 3

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9c Outpatient Substance Abuse - Base 3

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

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

Is a referral required for Outpatient Substance Abuse Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #9d Outpatient Blood Services – Base 1

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9d Outpatient Blood Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

If blood is given as a part of an inpatient hospital stay, the cost sharing for the blood should be included in the inpatient hospital cost sharing.

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:  
 Three (3) pint deductible waived

Select type of benefit for Three (3) Pint Deductible Waived:  
 Mandatory  
 Optional

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage per unit for Medicare-covered Benefits:

# PBP 2015 Data Entry System Screens

## #9d Outpatient Blood Services – Base 2

PBP Data Entry System - Section B-9, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #9d Outpatient Blood Services - Base 2

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount per unit for Medicare-covered Benefits:

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Outpatient Blood Services?  
 Yes  
 No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #10a Ambulance Services – Base 1

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #10a Ambulance Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Is this Coinsurance waived if admitted to hospital?

Yes  
 No

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate the Minimum Copayment amount for Medicare-covered Benefits:

Indicate the Maximum Copayment amount for Medicare-covered Benefits:

Is this Copayment waived if admitted to hospital?

Yes  
 No

# PBP 2015 Data Entry System Screens

## #10a Ambulance Services – Base 2

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #10a Ambulance Services - Base 2

Enrollee must receive Authorization for non-emergency Medicare services from one or more of the following:

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

Referral is not applicable for this Service Category.  
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #10b Transportation Services – Base 1

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #10b Transportation Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Transportation Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Plan-approved Location  
 Any Location

Select type of benefit for Plan-approved Location:

Mandatory  
 Optional

Is this benefit unlimited for number of trips for Plan-approved Location?

Yes  
 No

Indicate number of trips for Plan-approved Location:

Select Plan-approved Location Trips periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select Type of Transportation for Plan-approved Location:

One-way  
 Round Trip  
 Days  
 Other, describe

Indicate number of days for Plan-approved Location:

Select Mode of Transportation for Plan-approved Location:

Taxi  
 Bus/Subway  
 Van  
 Medical Transport  
 Other, describe

Select type of benefit for Any Location:

Mandatory  
 Optional

Is this benefit unlimited for number of trips for Any Location?

Yes  
 No

Select Any Location Trips periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select Type of Transportation for Any Location:

One-way  
 Round Trip  
 Days  
 Other, describe

Indicate number of days for Any Location:

Select Mode of Transportation for Any Location:

Taxi  
 Bus/Subway  
 Van  
 Medical Transport  
 Other, describe



# PBP 2015 Data Entry System Screens

## #10b Transportation Services – Base 2

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #10b Transportation Services - Base 2

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Plan Benefit Coverage amount:</p> <input type="text"/>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <input type="text"/>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Coinsurance percentage:</p> <input type="text"/>
<p>Select Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Deductible Amount:</p> <input type="text"/>

# PBP 2015 Data Entry System Screens

## #10b Transportation Services – Base 3

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #10b Transportation Services - Base 3

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount per trip:

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

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

Is a referral required for Transportation Services?

Yes  
 No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #11a DME – Base 1

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11a DME - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# PBP 2015 Data Entry System Screens

## #11a DME – Base 2

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11a DME - Base 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

Yes  
 No

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

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

Notes (Optional):

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Referral is not applicable for this Service Category.

# PBP 2015 Data Entry System Screens

## #11a DME – MMP - Base 1

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11a DME - MMP - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare Durable Medical Equipment?

Yes  
 No

Select Non-Medicare Durable Medical Equipment:

Durable Medical Equipment for use outside the home  
 Other 1  
 Other 2

Enter name of Other 1 Service:  
[Text Box]

Enter name of Other 2 Service:  
[Text Box]

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:  
[Text Box]

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Select which Non-Medicare Durable Medical Equipment(s) (select all that apply):

Durable Medical Equipment for use outside the home  
 Other 1  
 Other 2

Indicate coinsurance percentage for one or more of the following services:

	Minimum Coinsurance	Maximum Coinsurance
Durable Medical Equipment for use outside the home:	[Text Box]	[Text Box]
Other 1:	[Text Box]	[Text Box]
Other 2:	[Text Box]	[Text Box]

# PBP 2015 Data Entry System Screens

#11a DME – MMP - Base 2

**PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11a DME - MMP - Base 2

Is there an enrollee Copayment?  
 Yes  
 No

Select which Non-Medicare Durable Medical Equipment(s) have a Copayment (select all that apply):  
 Durable Medical Equipment for use outside the home  
 Other 1  
 Other 2

Indicate copayment amount for one or more of the following services:

	Minimum Copayment	Maximum Copayment
Durable Medical Equipment for use outside the home:	<input type="text"/>	<input type="text"/>
Other 1:	<input type="text"/>	<input type="text"/>
Other 2:	<input type="text"/>	<input type="text"/>

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Services?  
 Yes  
 No

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #11b Prosthetic/Medical Supplies – Base 1

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11b Prosthetics/Medical Supplies - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Select Maximum Enrollee Out-of-Pocket Cost type:

Covered under DME Category 11a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):

Medicare-covered Prosthetic Devices  
 Medicare-covered Medical Supplies

Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:

# PBP 2015 Data Entry System Screens

## #11b Prosthetic/Medical Supplies – Base 2

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11b Prosthetics/Medical Supplies - Base 2

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):

Medicare-covered Prosthetic Devices  
 Medicare-covered Medical Supplies

Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:

Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:

Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:

Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:



# PBP 2015 Data Entry System Screens

## #11b Prosthetic/Medical Supplies – Base 3

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11b Prosthetics/Medical Supplies - Base 3

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

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

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

Referral is not applicable for this Service Category.

# PBP 2015 Data Entry System Screens

## #11b Prosthetic/Medical Supplies – MMP - Base 1

**PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11b Prosthetics/Medical Supplies - MMP - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare Prosthetics/Medical Supplies?

Yes  
 No

Enter name of Non-Medicare Service:

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance Percentage:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment Amount:

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

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

Is a referral required for Services?

Yes  
 No

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #11c Diabetic Supplies and Services – Base 1

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11c Diabetic Supplies and Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Select Maximum Enrollee Out-of-Pocket Cost type:

Covered under DME Category 11a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Select which Diabetic Supplies and Services have a Coinsurance (Select all that apply):

Medicare-covered Diabetic Supplies  
 Medicare-covered Diabetic Therapeutic Shoes or Inserts

Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Supplies:

Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Supplies:

Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

# PBP 2015 Data Entry System Screens

## #11c Diabetic Supplies and Services – Base 2

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #11c Diabetic Supplies and Services - Base 2

Is there an enrollee Copayment?

Yes  
 No

Select which Diabetic Supplies and Services have a Copayment (Select all that apply):

Medicare-covered Diabetes Supplies  
 Medicare-covered Diabetic Therapeutic Shoes or Inserts

Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:

Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:

Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Do you limit Diabetic Supplies and Services to those from specified manufacturers?

Yes  
 No

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

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

Referral is not applicable for this Service Category.

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #12 End Stage Renal Disease – Base 1

PBP Data Entry System - Section B-12, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #12 End-Stage Renal Disease - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# PBP 2015 Data Entry System Screens

## #12 End Stage Renal Disease – Base 2

PBP Data Entry System - Section B-12, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #12 End-Stage Renal Disease - Base 2

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

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

Is a referral required for End-Stage Renal Disease services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #13a Acupuncture and Other Alternative Therapies – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13a Acupuncture and Other Alternative Therapies - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Acupuncture and Other Alternative Therapies as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Number of Treatments

Select type of benefit for Number of Treatments:

Mandatory  
 Optional

Is this benefit unlimited for Number of Treatments?

Yes  
 No

Indicate limit for Number of Treatments:

Indicate Number of Treatments periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #13a Acupuncture and Other Alternative Therapies – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13a Acupuncture and Other Alternative Therapies - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount per treatment:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Acupuncture and Other Alternative Therapies?  
 Yes  
 No



# PBP 2015 Data Entry System Screens

## #13a Acupuncture and Other Alternative Therapies – Base 3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13a Acupuncture and Other Alternative Therapies - Base 3

Acupuncture and Other Alternative Therapies Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #13b OTC Items – Base 1

**PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13b OTC Items - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Medicare-Medicaid plans may not use this section to provide benefit information about any OTC drugs or items that are submitted under the integrated formulary. Information about those benefits will be entered in the Rx section of the PBP. This section should only be used to provide benefit information about OTC drugs and items that are covered as a supplemental benefit.

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

Yes  
 No

Select type of benefit for OTC Items:

Mandatory  
 Optional

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every month

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every month

# PBP 2015 Data Entry System Screens

## #13b OTC Items – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13b OTC Items - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount:

Does this cover all of the OTC List which may be found in Chapter 4 of the Medicare Managed Care Manual?  
 Yes  
 No

Authorization is not applicable for this service category.

Referral is not applicable for this service category.

# PBP 2015 Data Entry System Screens

## #13b OTC Items – Base 3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #13b OTC Items - Base 3

OTC Items Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Empty text area for optional notes]

# PBP 2015 Data Entry System Screens

## #13c Meal Benefit – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13c Meal Benefit - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide a Meal Benefit as a supplemental benefit under Part C?

Yes  
 No

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

Yes  
 No

Select type of benefit:

Mandatory  
 Optional

How many weeks does your Meal Benefit last?

What is the maximum number of meals the benefit provides?

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #13c Meal Benefit – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #13c Meal Benefit - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Copayment amount:

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

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

Is a referral required for the Meal Benefit?

Yes  
 No

# PBP 2015 Data Entry System Screens

## #13c Meal Benefit – Base 3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13c Meal Benefit - Base 3

Meal Benefit Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Empty text area for notes]

# PBP 2015 Data Entry System Screens

## #13d Other 1 – Base1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13d Other 1 - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Note: After completing your data entry in this category, if you delete ALL text in the "Enter name of Service (Optional)" field you will lose all previously entered data.

You may edit the name of the service text partially without losing all previously entered data.

Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, transportation, medical devices etc).

Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-T3C.

If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.

Enter name of Service (Optional):

Select type of benefit:

Mandatory

Optional

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes

No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe



# PBP 2015 Data Entry System Screens

#13d Other 1 – Base2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13d Other 1 - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

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

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

Is a referral required for Other Services?  
 Yes  
 No

# PBP 2015 Data Entry System Screens

#13d Other 1 – Base3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13d Other 1 - Base 3

Other Services Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #13e Other 2 – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13e Other 2 - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional):' field you will lose all previously entered data.

You may edit the name of the service text partially without losing all previously entered data.

Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, transportation, medical devices etc).

Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13B.

If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.

Enter name of Service (Optional):

Select type of benefit:

Mandatory  
 Optional

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #13e Other 2 – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13e Other 2 - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

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

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

Is a referral required for Other Services?  
 Yes  
 No

# PBP 2015 Data Entry System Screens

#13e Other 2 – Base 3

The screenshot displays a software window titled "PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a set of navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" field contains the text "#13e Other 2 - Base 3". Below this is the "Other Services Notes" section, which contains a text area with the instruction: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." The text area is currently empty and has a vertical scrollbar on the right side.

# PBP 2015 Data Entry System Screens

## #13f Other 3 – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13f Other 3 - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional):' field you will lose all previously entered data.

You may edit the name of the service text partially without losing all previously entered data.

Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, transportation, medical devices etc).

Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13B.

If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.

Enter name of Service (Optional):

Select type of benefit:

Mandatory  
 Optional

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

#13f Other 3 – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13f Other 3 - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Other Services?  
 Yes  
 No

# PBP 2015 Data Entry System Screens

#13f Other 3 – Base 3

The screenshot displays a software window titled "PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000". The window includes a menu bar with "File" and "Help", and a toolbar with buttons for "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" field contains the text "#13f Other 3 - Base 3". Below the toolbar, the text "Other Services Notes" is followed by a note: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." A large, empty text area labeled "Notes (Optional):" is provided for user input.



# PBP 2015 Data Entry System Screens

## #13g Dual Eligible SNPs with Highly Integrated Services – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Plans only fill out this section if they have received written notification from CMS that they qualify for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services.

Dual Eligible SNPs with Highly Integrated Services Benefit Attestation

I attest that I have received written notification from CMS that this individual SNP plan qualifies for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services for CY 2015. I further attest that the additional supplemental benefit(s) that the SNP describes in this section of the PBP do not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside.

You may edit the name of the service text partially without losing all previously entered data.

If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.

Enter name of Service (Optional):

Select type of benefit:

Mandatory

Optional

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes

No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

# PBP 2015 Data Entry System Screens

## #13g Dual Eligible SNPs with Highly Integrated Services – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Minimum Coinsurance percentage:

Indicate Maximum Coinsurance percentage:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Minimum Copayment amount:

Indicate Maximum Copayment amount:

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

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

Is a referral required for Other Services?  
 Yes  
 No

# PBP 2015 Data Entry System Screens

## #13g Dual Eligible SNPs with Highly Integrated Services – Base 3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 3

Dual Eligible SNPs with Highly Integrated Services Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Empty text area for notes]

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Additional Services?

Yes  
 No

Select Additional Services (select all that apply):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18

Enter name of Other 1 Service:

Enter name of Other 2 Service:

Enter name of Other 3 Service:

Enter name of Other 4 Service:

Enter name of Other 5 Service:

Enter name of Other 6 Service:

Enter name of Other 7 Service:

Enter name of Other 8 Service:

Enter name of Other 9 Service:

Enter name of Other 10 Service:

Enter name of Other 11 Service:

Enter name of Other 12 Service:

Enter name of Other 13 Service:

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 2

Enter name of Other 14 Service:  
Enter name of Other 15 Service:  
Enter name of Other 16 Service:  
Enter name of Other 17 Service:  
Enter name of Other 18 Service:

Is there a limit on the Additional Services provided?  
 Yes  
 No

Select Additional Services where limit applies:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 3

**PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 3

Indicate units a limit will be provided in for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:

Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Tobacco Cessation Counseling for Pregnant Women:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Tobacco Cessation Counseling for Pregnant Women:

Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Freestanding Birth Center Services:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Freestanding Birth Center Services:

Select limit on services periodicity for Freestanding Birth Center Services:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Respiratory Care Services:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Respiratory Care Services:

Select limit on services periodicity for Respiratory Care Services:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 4

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 4

Indicate units a limit will be provided in for Family Planning Services:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Family Planning Services:

Select limit on services periodicity for Family Planning Services:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Nursing Home Services:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Nursing Home Services:

Select limit on services periodicity for Nursing Home Services:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Home and Community Based Services:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Home and Community Based Services:

Select limit on services periodicity for Home and Community Based Services:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Personal Care Services:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Personal Care Services:

Select limit on services periodicity for Personal Care Services:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 5

**PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous   Next>>   Exit (Validate)   Exit (No Validate)   Go To: #13h Additional Services - Base 5

<p>Indicate units a limit will be provided in for Self-Directed Personal Assistance Services:</p> <p><input type="radio"/> Sessions <input type="radio"/> Visits <input type="radio"/> Hours <input type="radio"/> Points <input type="radio"/> Meals</p>	<p>Indicate units a limit will be provided in for Case Management (Long Term Care):</p> <p><input type="radio"/> Sessions <input type="radio"/> Visits <input type="radio"/> Hours <input type="radio"/> Points <input type="radio"/> Meals</p>
<p>Indicate numerical limit on the services provided for Self-Directed Personal Assistance Services:</p> <input type="text"/>	<p>Indicate numerical limit on the services provided for Case Management (Long Term Care):</p> <input type="text"/>
<p>Select limit on services periodicity for Self-Directed Personal Assistance Services:</p> <p><input type="radio"/> Every day <input type="radio"/> Every week <input type="radio"/> Every month <input type="radio"/> Every year <input type="radio"/> Other, Describe</p>	<p>Select limit on services periodicity for Case Management (Long Term Care):</p> <p><input type="radio"/> Every day <input type="radio"/> Every week <input type="radio"/> Every month <input type="radio"/> Every year <input type="radio"/> Other, Describe</p>
<p>Indicate units a limit will be provided in for Private Duty Nursing Services:</p> <p><input type="radio"/> Sessions <input type="radio"/> Visits <input type="radio"/> Hours <input type="radio"/> Points <input type="radio"/> Meals</p>	<p>Indicate units a limit will be provided in for Institution for Mental Disease Services for Individuals 65 or Older:</p> <p><input type="radio"/> Sessions <input type="radio"/> Visits <input type="radio"/> Hours <input type="radio"/> Points <input type="radio"/> Meals</p>
<p>Indicate numerical limit on the services provided for Private Duty Nursing Services:</p> <input type="text"/>	<p>Indicate numerical limit on the services provided for Institution for Mental Disease Services for Individuals 65 or Older:</p> <input type="text"/>
<p>Select limit on services periodicity for Private Duty Nursing Services:</p> <p><input type="radio"/> Every day <input type="radio"/> Every week <input type="radio"/> Every month <input type="radio"/> Every year <input type="radio"/> Other, Describe</p>	<p>Select limit on services periodicity for Institution for Mental Disease Services for Individuals 65 or Older:</p> <p><input type="radio"/> Every day <input type="radio"/> Every week <input type="radio"/> Every month <input type="radio"/> Every year <input type="radio"/> Other, Describe</p>



# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 6

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 6

Indicate units a limit will be provided in for Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities:

Select limit on services periodicity for Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Case Management:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Case Management:

Select limit on services periodicity for Case Management:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 1:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 1:

Select limit on services periodicity for Other 1:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 2:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 2:

Select limit on services periodicity for Other 2:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 7

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 7

Indicate units a limit will be provided in for Other 3:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 3:

Select limit on services periodicity for Other 3:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 4:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 4:

Select limit on services periodicity for Other 4:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 5:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 5:

Select limit on services periodicity for Other 5:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 6:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 6:

Select limit on services periodicity for Other 6:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 8

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 8

Indicate units a limit will be provided in for Other 7:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 7:

Select limit on services periodicity for Other 7:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 8:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 8:

Select limit on services periodicity for Other 8:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 9:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 9:

Select limit on services periodicity for Other 9:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 10:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 10:

Select limit on services periodicity for Other 10:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 9

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

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<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 9

Indicate units a limit will be provided in for Other 11:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 11:

Select limit on services periodicity for Other 11:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 12:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 12:

Select limit on services periodicity for Other 12:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 13:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 13:

Select limit on services periodicity for Other 13:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 14:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 14:

Select limit on services periodicity for Other 14:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 10

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

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Indicate units a limit will be provided in for Other 15:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 15:

Select limit on services periodicity for Other 15:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 17:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 17:

Select limit on services periodicity for Other 17:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 16:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 16:

Select limit on services periodicity for Other 16:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

Indicate units a limit will be provided in for Other 18:

- Sessions
- Visits
- Hours
- Points
- Meals

Indicate numerical limit on the services provided for Other 18:

Select limit on services periodicity for Other 18:

- Every day
- Every week
- Every month
- Every year
- Other, Describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 11

**PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 11

Is there a Maximum Plan Benefit Amount for Additional Services?  
 Yes  
 No

Select which Additional Services have a Maximum Plan Benefit Coverage Amount (Select all that apply):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18

<p>Indicate Maximum Plan Benefit Amount for EPSDT:</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Amount for RCS:</p> <input type="text"/>
<p>Indicate Maximum Plan Benefit Coverage Periodicity EPSDT</p> <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	<p>Indicate Maximum Plan Benefit Coverage Periodicity RCS</p> <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe
<p>Indicate Maximum Plan Benefit Amount for TCCPW:</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Amount for FPS:</p> <input type="text"/>
<p>Indicate Maximum Plan Benefit Coverage Periodicity TCCPW</p> <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	<p>Indicate Maximum Plan Benefit Coverage Periodicity FPS</p> <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe
<p>Indicate Maximum Plan Benefit Amount for FBC:</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Amount for NHS:</p> <input type="text"/>
<p>Indicate Maximum Plan Benefit Coverage Periodicity FBCS</p> <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	<p>Indicate Maximum Plan Benefit Coverage Periodicity NHS</p> <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 12

**PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 12

Indicate Maximum Plan Benefit Amount for HCBS: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity HCBS <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Amount for PDNS: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity PDNS <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Amount for ICFMRS: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity ICFMRS <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Amount for OTHER2: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity OTHER2 <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe
Indicate Maximum Plan Benefit Amount for PCS: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity PCS <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Amount for CM_LTC: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity CM_LTC <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Amount for CM: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity CM <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Amount for OTHER3: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity OTHER3 <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe
Indicate Maximum Plan Benefit Amount for SDPAS: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity SDPAS <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Amount for IMDS: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity IMDS <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Amount for OTHER1: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity OTHER1 <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Amount for OTHER4: <input type="text"/> Indicate Maximum Plan Benefit Coverage Periodicity OTHER4 <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 13

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 13

Indicate Maximum Plan Benefit Amount for OTHER5: <input type="text"/>	Indicate Maximum Plan Benefit Amount for OTHER8: <input type="text"/>	Indicate Maximum Plan Benefit Amount for OTHER11: <input type="text"/>
Indicate Maximum Plan Benefit Coverage Periodicity OTHER5: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Coverage Periodicity OTHER8: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Coverage Periodicity OTHER11: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe
Indicate Maximum Plan Benefit Amount for OTHER6: <input type="text"/>	Indicate Maximum Plan Benefit Amount for OTHER9: <input type="text"/>	Indicate Maximum Plan Benefit Amount for OTHER12: <input type="text"/>
Indicate Maximum Plan Benefit Coverage Periodicity OTHER6: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Coverage Periodicity OTHER9: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Coverage Periodicity OTHER12: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe
Indicate Maximum Plan Benefit Amount for OTHER7: <input type="text"/>	Indicate Maximum Plan Benefit Amount for OTHER10: <input type="text"/>	Indicate Maximum Plan Benefit Amount for OTHER13: <input type="text"/>
Indicate Maximum Plan Benefit Coverage Periodicity OTHER7: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Coverage Periodicity OTHER10: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Indicate Maximum Plan Benefit Coverage Periodicity OTHER13: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe



# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 14

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 14

Indicate Maximum Plan Benefit Amount for OTHER14:  
[Text Field]

Indicate Maximum Plan Benefit Coverage Periodicity OTHER14

- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER17:  
[Text Field]

Indicate Maximum Plan Benefit Coverage Periodicity OTHER17

- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER15:  
[Text Field]

Indicate Maximum Plan Benefit Coverage Periodicity OTHER15

- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER18:  
[Text Field]

Indicate Maximum Plan Benefit Coverage Periodicity OTHER18

- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER16:  
[Text Field]

Indicate Maximum Plan Benefit Coverage Periodicity OTHER16

- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 15

**PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 15

Does any service require qualification for and enrollment in a state-operated waiver program?

Yes  
 No

Select services that require qualification for and enrollment in a state-operated waiver program:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18

Is a beneficiary receiving any benefit subject to a state-required monthly payment amount that is based on his or her financial resources (for example: a "patient pay amount")?

Yes  
 No

Select benefits subject to a state-required monthly payment amount that is based on his or her financial resources (for example: a "patient pay amount"):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 16

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 16

	Minimum Patient Pay Amount	Maximum Patient Pay Amount		Minimum Patient Pay Amount	Maximum Patient Pay Amount
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	<input type="text"/>	<input type="text"/>	Other 3	<input type="text"/>	<input type="text"/>
Tobacco Cessation Counseling for Pregnant Women	<input type="text"/>	<input type="text"/>	Other 4	<input type="text"/>	<input type="text"/>
Freestanding Birth Center Services	<input type="text"/>	<input type="text"/>	Other 5	<input type="text"/>	<input type="text"/>
Respiratory Care Services	<input type="text"/>	<input type="text"/>	Other 6	<input type="text"/>	<input type="text"/>
Family Planning Services	<input type="text"/>	<input type="text"/>	Other 7	<input type="text"/>	<input type="text"/>
Nursing Home Services	<input type="text"/>	<input type="text"/>	Other 8	<input type="text"/>	<input type="text"/>
Home and Community Based Services	<input type="text"/>	<input type="text"/>	Other 9	<input type="text"/>	<input type="text"/>
Personal Care Services	<input type="text"/>	<input type="text"/>	Other 10	<input type="text"/>	<input type="text"/>
Self-Directed Personal Assistance Services	<input type="text"/>	<input type="text"/>	Other 11	<input type="text"/>	<input type="text"/>
Private Duty Nursing Services	<input type="text"/>	<input type="text"/>	Other 12	<input type="text"/>	<input type="text"/>
Case Management (Long Term Care)	<input type="text"/>	<input type="text"/>	Other 13	<input type="text"/>	<input type="text"/>
Institution for Mental Disease Services for Individuals 65 or Older	<input type="text"/>	<input type="text"/>	Other 14	<input type="text"/>	<input type="text"/>
Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities	<input type="text"/>	<input type="text"/>	Other 15	<input type="text"/>	<input type="text"/>
Case Management	<input type="text"/>	<input type="text"/>	Other 16	<input type="text"/>	<input type="text"/>
Other 1	<input type="text"/>	<input type="text"/>	Other 17	<input type="text"/>	<input type="text"/>
Other 2	<input type="text"/>	<input type="text"/>	Other 18	<input type="text"/>	<input type="text"/>

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 17

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 17

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Select which Additional Services have a Coinsurance (Select all that apply):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18

Indicate Coinsurance for one or more of the following services.	Minimum Coinsurance	Maximum Coinsurance
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	<input type="text"/>	<input type="text"/>
Tobacco Cessation Counseling for Pregnant Women	<input type="text"/>	<input type="text"/>
Freestanding Birth Center Services	<input type="text"/>	<input type="text"/>
Respiratory Care Services	<input type="text"/>	<input type="text"/>
Family Planning Services	<input type="text"/>	<input type="text"/>
Nursing Home Services	<input type="text"/>	<input type="text"/>
Home and Community Based Services	<input type="text"/>	<input type="text"/>
Personal Care Services	<input type="text"/>	<input type="text"/>
Self-Directed Personal Assistance Services	<input type="text"/>	<input type="text"/>
Private Duty Nursing Services	<input type="text"/>	<input type="text"/>
Case Management (Long Term Care)	<input type="text"/>	<input type="text"/>
Institution for Mental Disease Services for Individuals 65 or Older	<input type="text"/>	<input type="text"/>
Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities	<input type="text"/>	<input type="text"/>
Case Management	<input type="text"/>	<input type="text"/>
Other 1	<input type="text"/>	<input type="text"/>
Other 2	<input type="text"/>	<input type="text"/>
Other 3	<input type="text"/>	<input type="text"/>

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 18

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 18

Indicate Copayment for one or more of the following services.

	Minimum Copayment	Maximum Copayment
Other 4	<input type="text"/>	<input type="text"/>
Other 5	<input type="text"/>	<input type="text"/>
Other 6	<input type="text"/>	<input type="text"/>
Other 7	<input type="text"/>	<input type="text"/>
Other 8	<input type="text"/>	<input type="text"/>
Other 9	<input type="text"/>	<input type="text"/>
Other 10	<input type="text"/>	<input type="text"/>
Other 11	<input type="text"/>	<input type="text"/>
Other 12	<input type="text"/>	<input type="text"/>
Other 13	<input type="text"/>	<input type="text"/>
Other 14	<input type="text"/>	<input type="text"/>
Other 15	<input type="text"/>	<input type="text"/>
Other 16	<input type="text"/>	<input type="text"/>
Other 17	<input type="text"/>	<input type="text"/>
Other 18	<input type="text"/>	<input type="text"/>

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 19

**PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 19

Is there an enrollee Copayment?  
 Yes  
 No

Select which Additional Services have a Copayment (Select all that apply):

Indicate Copayment for one or more of the following services.	Minimum Copayment	Maximum Copayment
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	<input type="text"/>	<input type="text"/>
Tobacco Cessation Counseling for Pregnant Women	<input type="text"/>	<input type="text"/>
Freestanding Birth Center Services	<input type="text"/>	<input type="text"/>
Respiratory Care Services	<input type="text"/>	<input type="text"/>
Family Planning Services	<input type="text"/>	<input type="text"/>
Nursing Home Services	<input type="text"/>	<input type="text"/>
Home and Community Based Services	<input type="text"/>	<input type="text"/>
Personal Care Services	<input type="text"/>	<input type="text"/>
Self-Directed Personal Assistance Services	<input type="text"/>	<input type="text"/>
Private Duty Nursing Services	<input type="text"/>	<input type="text"/>
Case Management (Long Term Care)	<input type="text"/>	<input type="text"/>
Institution for Mental Disease Services for Individuals 65 or Older	<input type="text"/>	<input type="text"/>
Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities	<input type="text"/>	<input type="text"/>
Case Management	<input type="text"/>	<input type="text"/>
Other 1	<input type="text"/>	<input type="text"/>
Other 2	<input type="text"/>	<input type="text"/>
Other 3	<input type="text"/>	<input type="text"/>

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services  
 Tobacco Cessation Counseling for Pregnant Women  
 Freestanding Birth Center Services  
 Respiratory Care Services  
 Family Planning Services  
 Nursing Home Services  
 Home and Community Based Services  
 Personal Care Services  
 Self-Directed Personal Assistance Services  
 Private Duty Nursing Services  
 Case Management (Long Term Care)  
 Institution for Mental Disease Services for Individuals 65 or Older  
 Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities  
 Case Management  
 Other 1  
 Other 2  
 Other 3  
 Other 4  
 Other 5  
 Other 6  
 Other 7  
 Other 8  
 Other 9  
 Other 10  
 Other 11  
 Other 12  
 Other 13  
 Other 14  
 Other 15  
 Other 16  
 Other 17  
 Other 18

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 20

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 20

Indicate Copayment for one or more of the following services.

	Minimum Copayment	Maximum Copayment
Other 4	<input type="text"/>	<input type="text"/>
Other 5	<input type="text"/>	<input type="text"/>
Other 6	<input type="text"/>	<input type="text"/>
Other 7	<input type="text"/>	<input type="text"/>
Other 8	<input type="text"/>	<input type="text"/>
Other 9	<input type="text"/>	<input type="text"/>
Other 10	<input type="text"/>	<input type="text"/>
Other 11	<input type="text"/>	<input type="text"/>
Other 12	<input type="text"/>	<input type="text"/>
Other 13	<input type="text"/>	<input type="text"/>
Other 14	<input type="text"/>	<input type="text"/>
Other 15	<input type="text"/>	<input type="text"/>
Other 16	<input type="text"/>	<input type="text"/>
Other 17	<input type="text"/>	<input type="text"/>
Other 18	<input type="text"/>	<input type="text"/>

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 21

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 21

Is Authorization required for any Additional Services:

Yes  
 No

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

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

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

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

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

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

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

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

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

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

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

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



# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 22

The screenshot displays a software window titled "PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000". The window includes a menu bar with "File" and "Help", and a navigation bar with buttons for "<<Previous", "Next>>", "Exit (Validate)", "Exit (No Validate)", and a "Go To:" dropdown menu currently set to "#13h Additional Services - Base 22".

The main content area is divided into two columns of authorization requirements, each with a list of checkboxes:

- HCBS:** Enrollee must receive Authorization from one or more of the following for HCBS:
  - None
  - Primary Care Physician (Internist/Family Practice, General Practice)
  - Physician Specialist
  - Organization Medical Director/Utilization Management/Utilization Review
  - Other, describe
- CM\_LTC:** Enrollee must receive Authorization from one or more of the following for CM\_LTC:
  - None
  - Primary Care Physician (Internist/Family Practice, General Practice)
  - Physician Specialist
  - Organization Medical Director/Utilization Management/Utilization Review
  - Other, describe
- PCS:** Enrollee must receive Authorization from one or more of the following for PCS:
  - None
  - Primary Care Physician (Internist/Family Practice, General Practice)
  - Physician Specialist
  - Organization Medical Director/Utilization Management/Utilization Review
  - Other, describe
- IMDS:** Enrollee must receive Authorization from one or more of the following for IMDS:
  - None
  - Primary Care Physician (Internist/Family Practice, General Practice)
  - Physician Specialist
  - Organization Medical Director/Utilization Management/Utilization Review
  - Other, describe
- SDPAS:** Enrollee must receive Authorization from one or more of the following for SDPAS:
  - None
  - Primary Care Physician (Internist/Family Practice, General Practice)
  - Physician Specialist
  - Organization Medical Director/Utilization Management/Utilization Review
  - Other, describe
- ICFMRS:** Enrollee must receive Authorization from one or more of the following for ICFMRS:
  - None
  - Primary Care Physician (Internist/Family Practice, General Practice)
  - Physician Specialist
  - Organization Medical Director/Utilization Management/Utilization Review
  - Other, describe
- PDNS:** Enrollee must receive Authorization from one or more of the following for PDNS:
  - None
  - Primary Care Physician (Internist/Family Practice, General Practice)
  - Physician Specialist
  - Organization Medical Director/Utilization Management/Utilization Review
  - Other, describe
- CM:** Enrollee must receive Authorization from one or more of the following for CM:
  - None
  - Primary Care Physician (Internist/Family Practice, General Practice)
  - Physician Specialist
  - Organization Medical Director/Utilization Management/Utilization Review
  - Other, describe

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 23

**PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 23

Enrollee must receive Authorization from one or more of the following for OTHER1:

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

Enrollee must receive Authorization from one or more of the following for OTHER2:

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

Enrollee must receive Authorization from one or more of the following for OTHER3:

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

Enrollee must receive Authorization from one or more of the following for OTHER4:

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

Enrollee must receive Authorization from one or more of the following for OTHER5:

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

Enrollee must receive Authorization from one or more of the following for OTHER6:

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

Enrollee must receive Authorization from one or more of the following for OTHER7:

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

Enrollee must receive Authorization from one or more of the following for OTHER8:

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

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 24

**PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 24

Enrollee must receive Authorization from one or more of the following for OTHER9:

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

Enrollee must receive Authorization from one or more of the following for OTHER10:

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

Enrollee must receive Authorization from one or more of the following for OTHER11:

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

Enrollee must receive Authorization from one or more of the following for OTHER12:

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

Enrollee must receive Authorization from one or more of the following for OTHER13:

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

Enrollee must receive Authorization from one or more of the following for OTHER14:

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

Enrollee must receive Authorization from one or more of the following for OTHER15:

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

Enrollee must receive Authorization from one or more of the following for OTHER16:

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

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 25

**PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #13h Additional Services - Base 25

Enrollee must receive Authorization from one or more of the following for OTHER17:

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

Enrollee must receive Authorization from one or more of the following for OTHER18:

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

# PBP 2015 Data Entry System Screens

## #13h Additional Services – Base 26

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 26

Is a referral required for one or more Additional Services?

Yes  
 No

Select which Additional Services need a Referral (Select all that apply):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18

Additional Services Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

Additional Notes (Optional):

# PBP 2015 Data Entry System Screens

## #14a Medicare-covered Preventive Services

The screenshot shows a web-based data entry application. The title bar reads "PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a set of navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "#14a Medicare-covered Preventive Services".

Below the navigation is a button labeled "CLICK FOR DESCRIPTION OF BENEFIT". The main content area is divided into two columns. The left column contains the following text and form elements:

- Medicare-covered Preventive Services Attestation**
- I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
- Note: Plan may not require an authorization or referral for certain \$0 cost sharing preventive services, for example, screening mammograms.
- Enrollee must receive Authorization from one or more of the following:
  - None
  - Primary Care Physician (Internist/Family Practice, General Practice)
  - Physician Specialist
  - Organization Medical Director/Utilization Management/Utilization Review
  - Other, describe
- Is a referral required?
  - Yes
  - No

The right column contains:

- Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
- Notes (Optional):
- A large, empty text area for entering notes.

# PBP 2015 Data Entry System Screens

## #14b Annual Physical Exam – Base 1

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14b Annual Physical Exam - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Enter Medicare-covered preventive services at \$0 cost sharing in PBP service category 14a.

You should only use these supplemental benefits for Annual Physical Exams not covered by Original Medicare. You may charge copays for these Annual Physical Exams. NOTE: Medicare-covered preventive services are always plan covered, and consequently they are not appropriate as a supplemental benefit.

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

Yes  
 No

Select type of benefit for the Annual Physical Exam:

Mandatory  
 Optional

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

\_\_\_\_\_

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

\_\_\_\_\_

# PBP 2015 Data Entry System Screens

## #14b Annual Physical Exam – Base 2

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14b Annual Physical Exam - Base 2

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage for each Annual Physical Exam:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount for each Annual Physical Exam:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:



# PBP 2015 Data Entry System Screens

## #14b Annual Physical Exam – Base 3

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14b Annual Physical Exam - Base 3

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

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

Is a referral required for the Annual Physical Exam?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes:

# PBP 2015 Data Entry System Screens

## #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 1

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Eligible Supplemental Benefits as Defined in Chapter 4 as a benefit under Part C?

Yes  
 No

Select enhanced benefit (Select all that apply):

- Health Education
- Nutritional Benefit
- Additional Smoking and Tobacco Use Cessation
- Membership in Health Club/Fitness classes
- Nursing Hotline
- Enhanced Disease Management
- Tele-Monitoring
- Web/Phone-Based Technology
- Bathroom Safety Devices
- Counseling Services
- In-Home Safety Assessment
- Personal Emergency Response System (PERS)
- Additional sessions of Medical Nutrition Therapy (MNT)
- Post discharge In-home Medication Reconciliation
- Re-admission Prevention
- Wigs for Hair Loss Related to Chemotherapy

Select type of benefit for Health Education:	Select type of benefit for Nursing Hotline:
<input type="radio"/> Mandatory <input type="radio"/> Optional	<input type="radio"/> Mandatory <input type="radio"/> Optional
Select type of benefit for Nutritional Benefit:	Select type of benefit for Enhanced Disease Management:
<input type="radio"/> Mandatory <input type="radio"/> Optional	<input type="radio"/> Mandatory <input type="radio"/> Optional
Select type of benefit for Additional Smoking and Tobacco Use Cessation:	Select type of benefit for Tele-Monitoring:
<input type="radio"/> Mandatory <input type="radio"/> Optional	<input type="radio"/> Mandatory <input type="radio"/> Optional
Select type of benefit for Membership in Health Club/Fitness Classes:	Select type of benefit for Web/Phone-Based Technology:
<input type="radio"/> Mandatory <input type="radio"/> Optional	<input type="radio"/> Mandatory <input type="radio"/> Optional
Select type of benefit for Bathroom Safety Devices:	Select type of benefit for Counseling Services:
<input type="radio"/> Mandatory <input type="radio"/> Optional	<input type="radio"/> Mandatory <input type="radio"/> Optional
Select type of benefit for In-Home Safety Assessment:	Select type of benefit for Personal Emergency Response System (PERS):
<input type="radio"/> Mandatory <input type="radio"/> Optional	<input type="radio"/> Mandatory <input type="radio"/> Optional
Select type of benefit for Additional sessions of Medical Nutrition Therapy (MNT):	Select type of benefit for Post discharge In-home Medication Reconciliation:
<input type="radio"/> Mandatory <input type="radio"/> Optional	<input type="radio"/> Mandatory <input type="radio"/> Optional
Select type of benefit for Re-admission Prevention:	Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:
<input type="radio"/> Mandatory <input type="radio"/> Optional	<input type="radio"/> Mandatory <input type="radio"/> Optional

# PBP 2015 Data Entry System Screens

## #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 2

**PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 2

Is there a service-specific Maximum Plan Benefit Coverage amount for Eligible Supplemental Benefits as Defined in Chapter 4?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Eligible Supplemental Benefits as Defined in Chapter 4?

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 3

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 3

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Eligible Supplemental Benefits as Defined in Chapter 4 have a Coinsurance (Select all that apply):

- Health Education
- Nutritional Benefit
- Additional Smoking and Tobacco Use Cessation
- Membership in Health Club/Fitness classes
- Nursing Hotline
- Enhanced Disease Management
- Tele-Monitoring
- Web/Phone-Based Technology
- Bathroom Safety Devices
- Counseling Services

Indicate Minimum Coinsurance percentage for Health Education:

Indicate Maximum Coinsurance percentage for Health Education:

Indicate Coinsurance percentage for Nutritional Benefit:

Indicate Coinsurance percentage for Additional Smoking and Tobacco Use Cessation:

Indicate Minimum Coinsurance percentage for Membership in Health Club/Fitness Classes:

Indicate Maximum Coinsurance percentage for Membership in Health Club/Fitness Classes:

Indicate Coinsurance percentage for Nursing Hotline:

Indicate Minimum Coinsurance percentage for Enhanced Disease Management:

Indicate Maximum Coinsurance percentage for Enhanced Disease Management:

Indicate Coinsurance percentage for Tele-Monitoring:

Indicate Minimum Coinsurance percentage for Web/Phone-Based Technology:

Indicate Maximum Coinsurance percentage for Web/Phone-Based Technology:

Indicate Minimum Coinsurance percentage for Bathroom Safety Devices:

Indicate Maximum Coinsurance percentage for Bathroom Safety Devices:

Indicate Minimum Coinsurance percentage for Counseling Services:

Indicate Maximum Coinsurance percentage for Counseling Services:

Indicate Minimum Coinsurance percentage for In-Home Safety Assessment:

Indicate Maximum Coinsurance percentage for In-Home Safety Assessment:

Indicate Minimum Coinsurance percentage for Personal Emergency Response System (PERS):

Indicate Maximum Coinsurance percentage for Personal Emergency Response System (PERS):

Indicate Minimum Coinsurance percentage for Additional sessions of Medical Nutrition Therapy (MNT):

Indicate Maximum Coinsurance percentage for Additional sessions of Medical Nutrition Therapy (MNT):

Indicate Minimum Coinsurance percentage for Post discharge In-home Medication Reconciliation:

Indicate Maximum Coinsurance percentage for Post discharge In-home Medication Reconciliation:

Indicate Minimum Coinsurance percentage for Re-admission Prevention:

Indicate Maximum Coinsurance percentage for Re-admission Prevention:

Indicate Minimum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy:

Indicate Maximum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

# PBP 2015 Data Entry System Screens

## #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 4

**PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000**

File Help

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

Go To: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 4

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Select which Eligible Supplemental Benefits as Defined in Chapter 4 have a Copayment (Select all that apply):

- Health Education
- Nutritional Benefit
- Additional Smoking and Tobacco Use Cessation
- Membership in Health Club/Fitness classes
- Nursing Hotline
- Enhanced Disease Management
- Tele-Monitoring
- Web/Phone-Based Technology
- Bathroom Safety Devices
- Counseling Services
- In-Home Safety Assessment

Indicate Copayment amount for Health Education:

Indicate Copayment amount for Nutritional Benefit:

Indicate Copayment amount for Additional Smoking and Tobacco Use Cessation:

Indicate Minimum Copayment amount for Membership in Health Club/Fitness Classes:

Indicate Maximum Copayment amount for Membership in Health Club/Fitness Classes:

Indicate Copayment amount for Nursing Hotline:

Indicate Copayment amount for Enhanced Disease Management:

Indicate Copayment amount for Tele-Monitoring:

Indicate Copayment amount for Web/Phone-Based Technology:

Indicate Minimum Copayment amount for Bathroom Safety Devices:

Indicate Maximum Copayment amount for Bathroom Safety Devices:

Indicate Minimum Copayment amount for Counseling Services:

Indicate Maximum Copayment amount for Counseling Services:

Indicate Minimum Copayment amount for In-Home Safety Assessment:

Indicate Maximum Copayment amount for In-Home Safety Assessment:

Indicate Minimum Copayment amount for Personal Emergency Response System (PERS):

Indicate Maximum Copayment amount for Personal Emergency Response System (PERS):

Indicate Minimum Copayment amount for Additional sessions of Medical Nutrition Therapy (MNT):

Indicate Maximum Copayment amount for Additional sessions of Medical Nutrition Therapy (MNT):

Indicate Minimum Copayment amount for Post discharge In-home Medication Reconciliation:

Indicate Maximum Copayment amount for Post discharge In-home Medication Reconciliation:

Indicate Minimum Copayment amount for Re-admission Prevention:

Indicate Maximum Copayment amount for Re-admission Prevention:

Indicate Minimum Copayment amount for Wigs for Hair Loss Related to Chemotherapy:

Indicate Maximum Copayment amount for Wigs for Hair Loss Related to Chemotherapy:

# PBP 2015 Data Entry System Screens

## #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 5

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 5

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

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

Is a referral required for Eligible Supplemental Benefits as Defined in Chapter 4?

Yes

No

Eligible Supplemental Benefits as Defined in Chapter 4 Notes:

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Health Education Notes (Optional):

Nutritional Benefit Notes (Optional):

Additional Smoking and Tobacco Use Cessation Notes (Optional):

Nursing Hotline Notes (Optional):

Enhanced Disease Management Notes (Optional):

Tele-Monitoring Notes (Optional):

# PBP 2015 Data Entry System Screens

## #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 6

The screenshot displays a software window titled "PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a navigation bar with buttons for "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "#14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 6". The main area contains eight text input fields arranged in a 4x2 grid, each with a vertical scrollbar. The fields are labeled as follows:

- Web/Phone-Based Technology Notes (Optional):
- Personal Emergency Response System (PERS) Notes (Optional):
- Bathroom Safety Devices Notes (Optional):
- Membership in Health Club/Fitness Classes Notes (Optional):
- Counseling Services Notes (Optional):
- Additional sessions of Medical Nutrition Therapy (MNT) Notes (Optional):
- In-Home Safety Assessment Notes (Optional):
- Post discharge In-home Medication Reconciliation Notes (Optional):

# PBP 2015 Data Entry System Screens

## #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 7

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 7

Re-admission Prevention Notes (Optional):

Wigs for Hair Loss Related to Chemotherapy Notes (Optional):



# PBP 2015 Data Entry System Screens

## #14d – Kidney Disease Education Services Base 1

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14d - Kidney Disease Education Services Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

# PBP 2015 Data Entry System Screens

## #14d – Kidney Disease Education Services Base 2

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14d - Kidney Disease Education Services Base 2

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Enrollee must receive Authorization from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

Is a referral required for Kidney Disease Education Services?  
 Yes  
 No

# PBP 2015 Data Entry System Screens

## #14d – Kidney Disease Education Services Base 3

The screenshot shows a software window titled "PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a set of navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" field contains the text "#14d - Kidney Disease Education Services Base 3". Below this is a section for "Kidney Disease Education Services Notes" with a text area and a scroll bar. A note below the text area reads: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." The "Notes (Optional):" section is currently empty.

# PBP 2015 Data Entry System Screens

## #14e Diabetes Self-Management Training – Base 1

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14e Diabetes Self-Management Training - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

# PBP 2015 Data Entry System Screens

## #14e Diabetes Self-Management Training – Base 2

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #14e Diabetes Self-Management Training - Base 2

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate whether a separate physician/professional service cost share applies:

Sometimes, describe  
 No

Is there an enrollee Coinsurance for a separate physician/professional service?

Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:

Indicate Maximum Coinsurance percentage for a separate physician/professional service:

Is there an enrollee Copayment for a separate physician/professional service?

Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:

Indicate Maximum Copayment amount for a separate physician/professional service:

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

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

Is a referral required for Diabetes Self-Management Training?

Yes  
 No

# PBP 2015 Data Entry System Screens

## #14e Diabetes Self-Management Training – Base 3

The screenshot shows a software window titled "PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a set of navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" field contains the text "#14e Diabetes Self-Management Training - Base 3". Below this is a section labeled "Diabetes Self-Management Training Notes" with a text area for input. A note below the text area reads: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." The "Notes:" label is positioned to the left of a large, empty text box with a vertical scrollbar on the right side.

# PBP 2015 Data Entry System Screens

## #15 Medicare Part B Rx Drugs – Base 1

PBP Data Entry System - Section B-15, Contract X0001, Plan 001, Segment 000

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Go To: #15 Medicare Part B Rx Drugs - Base 1

Is there an enrollee Coinsurance?

Yes  
 No

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost Amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every month  
 Other, Describe

Select which Medicare Part B Rx Drugs have a Coinsurance (Select all that apply):

Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate the Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:

# PBP 2015 Data Entry System Screens

## #15 Medicare Part B Rx Drugs – Base 2

PBP Data Entry System - Section B-15, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #15 Medicare Part B Rx Drugs - Base 2

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Indicate Minimum Copayment Amount for other Medicare Part B Drugs:

Indicate Maximum Copayment Amount for other Medicare Part B Drugs:

Is there an enrollee Copayment?

Yes  
 No

Is Authorization Required?

Yes  
 No

Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):

Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

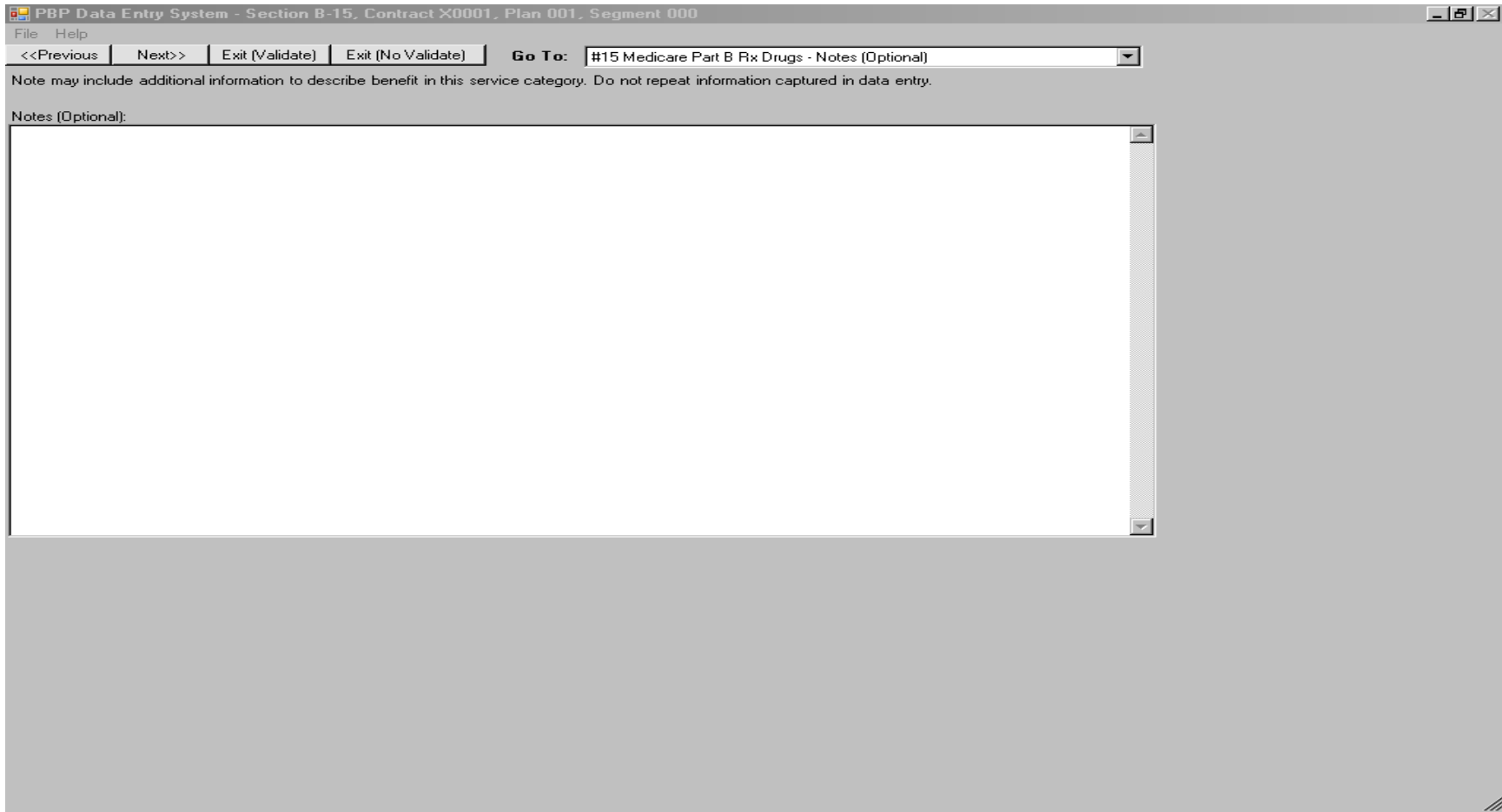
Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy Drugs:



# PBP 2015 Data Entry System Screens

## #15 Medicare Part B Rx Drugs – Notes (Optional)



PBP Data Entry System - Section B-15, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #15 Medicare Part B Rx Drugs - Notes (Optional)

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Empty text area for notes]

# PBP 2015 Data Entry System Screens

## #15 Home Infusion Bundled Services

PBP Data Entry System - Section B-15, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #15 Home Infusion Bundled Services

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?

Yes  
 No

Does the plan pay for Part D drug home infusion services and supplies as a Medicaid benefit?

Yes  
 No

If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 7, 2013 at 12:00pm Eastern Time.

You must also ensure that your benefit includes not only the home infusion drug, but any services and supplies associated with the home infusion drug's administration.

If your organization elects to provide Part D home infusion drugs as part of a supplemental bundled service then those services must be provided at \$0 cost sharing. As described in the CY 2010 Call Letter this waiver is conditioned on the application of zero cost sharing for the bundle of home infusion services provided under a supplemental benefit.

# PBP 2015 Data Entry System Screens

## #16a Preventive Dental – Base 1

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16a Preventive Dental - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Oral Exams  
 Prophylaxis (Cleaning)  
 Fluoride Treatment  
 Dental X-Rays

Select type of benefit for Oral Exams:

Mandatory  
 Optional

Is this benefit unlimited for Oral Exams?

Yes  
 No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select type of benefit for Prophylaxis (Cleaning):

Mandatory  
 Optional

Is this benefit unlimited for Prophylaxis (Cleaning)?

Yes  
 No, indicate number

Indicate number of visits for Prophylaxis (Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select type of benefit for Fluoride Treatment:

Mandatory  
 Optional

Is this benefit unlimited for Fluoride Treatment?

Yes  
 No, indicate number

Indicate number of visits for Fluoride Treatment:

Select the Fluoride Treatment periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #16a Preventive Dental – Base 2

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16a Preventive Dental - Base 2

Select type of benefit for Dental X-Rays:

Mandatory  
 Optional

Is this benefit unlimited for Dental X-Rays?

Yes  
 No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?

In-network services only  
 Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #16a Preventive Dental – Base 3

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #16a Preventive Dental - Base 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  
 Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Preventive Dental Services have a Coinsurance (Select all that apply):  
 Oral Exams  
 Prophylaxis (Cleaning)  
 Fluoride Treatment  
 Dental X-Rays

Is there a combination of services included in a single cost per Office Visit?  
 Yes  
 No

Select which combination of services are included in a single cost per Office Visit:  
 Oral Exams  
 Prophylaxis (Cleaning)  
 Fluoride Treatment  
 Dental X-Rays

Indicate Coinsurance percentage for Office Visit:

Indicate Minimum Coinsurance percentage for Oral Exams:

Indicate Maximum Coinsurance percentage for Oral Exams:

Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Minimum Coinsurance percentage for Fluoride Treatment:

Indicate Maximum Coinsurance percentage for Fluoride Treatment:

Indicate Minimum Coinsurance percentage for Dental X-Rays:

Indicate Maximum Coinsurance percentage for Dental X-Rays:

# PBP 2015 Data Entry System Screens

## #16a Preventive Dental – Base 4

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #16a Preventive Dental - Base 4

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Select which Preventive Dental Services have a Copayment (Select all that apply):

Oral Exams  
 Prophylaxis (Cleaning)  
 Fluoride Treatment  
 Dental X-Rays

Is there a combination of services included in a single cost per Office Visit?

Yes  
 No

Select which combination of services are included in a single cost per Office Visit:

Oral Exams  
 Prophylaxis (Cleaning)  
 Fluoride Treatment  
 Dental X-Rays

Indicate Copayment amount for Office Visit:

Indicate Minimum Copayment amount for Oral Exams:

Indicate Maximum Copayment amount for Oral Exams:

Indicate Minimum Copayment amount for Prophylaxis (Cleaning):

Indicate Maximum Copayment amount for Prophylaxis (Cleaning):

Indicate Minimum Copayment amount for Fluoride Treatment:

Indicate Maximum Copayment amount for Fluoride Treatment:

Indicate Minimum Copayment amount for Dental X-Rays:

Indicate Maximum Copayment amount for Dental X-Rays:

# PBP 2015 Data Entry System Screens

## #16a Preventive Dental – Base 5

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16a Preventive Dental - Base 5

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

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

Is a referral required for Preventive Dental Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

[Empty text area]

# PBP 2015 Data Entry System Screens

## #16b Comprehensive Dental – Base 1

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #16b Comprehensive Dental - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Non-routine Services  
 Diagnostic Services  
 Restorative Services  
 Endodontics/Periodontics/Extractions  
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory  
 Optional

Select type of benefit for Diagnostic Services:

Mandatory  
 Optional

Is this benefit unlimited for Non-routine Services?

Yes  
 No, indicate number

Indicate number of visits for Non-routine Services:

Select the Non-routine Services periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is this benefit unlimited for Diagnostic Services?

Yes  
 No, indicate number

Indicate number of visits for Diagnostic Services:

Select the Diagnostic Services periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe



# PBP 2015 Data Entry System Screens

## #16b Comprehensive Dental – Base 2

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16b Comprehensive Dental - Base 2

<p>Select type of benefit for Restorative Services:</p> <p><input type="radio"/> Mandatory <input type="radio"/> Optional</p>	<p>Select type of benefit for Endodontics/Periodontics/Extractions:</p> <p><input type="radio"/> Mandatory <input type="radio"/> Optional</p>	<p>Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:</p> <p><input type="radio"/> Mandatory <input type="radio"/> Optional</p>
<p>Is this benefit unlimited for Restorative Services?</p> <p><input type="radio"/> Yes <input type="radio"/> No, indicate number</p>	<p>Is this benefit unlimited for Endodontics/Periodontics/Extractions?</p> <p><input type="radio"/> Yes <input type="radio"/> No, indicate number</p>	<p>Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?</p> <p><input type="radio"/> Yes <input type="radio"/> No, indicate number</p>
<p>Indicate number of visits for Restorative Services:</p> <input type="text"/>	<p>Indicate number of visits for Endodontics/Periodontics/Extractions:</p> <input type="text"/>	<p>Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:</p> <input type="text"/>
<p>Select the Restorative Services periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Select the Endodontics/Periodontics/Extractions periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>

# PBP 2015 Data Entry System Screens

## #16b Comprehensive Dental – Base 3

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16b Comprehensive Dental - Base 3

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Select the Maximum Plan Benefit Coverage type:

Covered under Preventive Dental Category 16a  
 Plan-specified amount per period

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?

In-network services only  
 Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

\_\_\_\_\_

Select the Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Yes  
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Preventive Dental Category 16a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

\_\_\_\_\_

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #16b Comprehensive Dental – Base 4

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16b Comprehensive Dental - Base 4

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):  
 Medicare-covered Benefits  
 Non-routine Services  
 Diagnostic Services  
 Restorative Services  
 Endodontics/Periodontics/Extractions  
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Non-routine Services:

Indicate Maximum Coinsurance percentage for Non-routine Services:

Indicate Minimum Coinsurance percentage for Diagnostic Services:

Indicate Maximum Coinsurance percentage for Diagnostic Services:

Indicate Minimum Coinsurance percentage for Restorative Services:

Indicate Maximum Coinsurance percentage for Restorative Services:

Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions:

Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:

Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

# PBP 2015 Data Entry System Screens

## #16b Comprehensive Dental – Base 5

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16b Comprehensive Dental - Base 5

Is there an enrollee Copayment?

Yes  
 No

Select which Comprehensive Dental Services have a Copayment (Select all that apply):

Medicare-covered Benefits  
 Non-routine Services  
 Diagnostic Services  
 Restorative Services  
 Endodontics/Periodontics/Extractions  
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Non-routine Services:

Indicate Maximum Copayment amount for Non-routine Services:

Indicate Minimum Copayment amount for Diagnostic Services:

Indicate Maximum Copayment amount for Diagnostic Services:

Indicate Minimum Copayment amount for Restorative Services:

Indicate Maximum Copayment amount for Restorative Services:

Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions:

Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions:

Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

# PBP 2015 Data Entry System Screens

## #16b Comprehensive Dental – Base 6

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #16b Comprehensive Dental - Base 6

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

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

Is a referral required for Comprehensive Dental Services?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #17a Eye Exams – Base 1

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #17a Eye Exams - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Does the plan provide Eye Exams as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:  
 Routine Eye Exams

Select type of benefit for Routine Eye Exams:

Mandatory  
 Optional

Is this benefit unlimited for Routine Eye Exams?

Yes  
 No, indicate number

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?

In-network services only  
 Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #17a Eye Exams – Base 2

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #17a Eye Exams - Base 2

Is there an enrollee Coinsurance?

Yes  
 No

Select which Eye Exams have a Coinsurance (Select all that apply):

Medicare-covered Benefits  
 Routine Eye Exams

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Eye Exams:

Indicate Maximum Coinsurance percentage for Routine Eye Exams:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Select which Eye Exams have a Copayment (Select all that apply):

Medicare-covered Benefits  
 Routine Eye Exams

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount per Routine Eye Exam:

Indicate Maximum Copayment amount per Routine Eye Exam:

# PBP 2015 Data Entry System Screens

## #17a Eye Exams – Base 3

**PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000**

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #17a Eye Exams - Base 3

Indicate whether a separate physician/professional service cost share applies:

Sometimes, describe  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:

Indicate Maximum Coinsurance percentage for a separate physician/professional service:

Is there an enrollee Copayment for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:

Indicate Maximum Copayment amount for a separate physician/professional service:

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

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

Is a referral required for Eye Exams?  
 Yes  
 No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):



# PBP 2015 Data Entry System Screens

## #17b Eyewear – Base 1

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #17b Eyewear - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.

Does the plan provide Eyewear as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Contact lenses  
 Eyeglasses (lenses and frames)  
 Eyeglass lenses  
 Eyeglass frames  
 Upgrades

Select type of benefit for Contact lenses:

Mandatory  
 Optional

Is this benefit unlimited for Contact lenses?

Yes  
 No, indicate number

Indicate quantity (number of pairs) for Contact lenses:

Select Contact lenses periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select type of benefit for Eyeglasses (lenses and frames):

Mandatory  
 Optional

Is this benefit unlimited for Eyeglasses (lenses and frames)?

Yes  
 No, indicate number

Indicate quantity for Eyeglasses (lenses and frames):

Select Eyeglasses (lenses and frames) periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #17b Eyewear – Base 2

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #17b Eyewear - Base 2

Select type of benefit for Eyeglass lenses:

Mandatory  
 Optional

Select type of benefit for Eyeglass frames:

Mandatory  
 Optional

Is this benefit unlimited for Eyeglass lenses?

Yes  
 No, indicate number

Is this benefit unlimited for Eyeglass frames?

Yes  
 No, indicate number

Indicate quantity (number of pairs) for Eyeglass lenses:

Indicate quantity for Eyeglass frames:

Select Eyeglass lenses periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select Eyeglass frames periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select type of benefit for Upgrades:

Mandatory  
 Optional

# PBP 2015 Data Entry System Screens

## #17b Eyewear – Base 3

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #17b Eyewear - Base 3

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Select the Maximum Plan Benefit Coverage type:

Covered under Eye Exams Category  
 Plan-specified amount per period

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?

In-network services only  
 Both In-network and Out-of-network services

Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?

Yes  
 No

Indicate Combined Maximum Plan Benefit Coverage amount:

Select the Combined Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select the type of Eyewear with Individual Max Plan Benefit Coverage amount:

Contact lenses  
 Eyeglasses (lenses and frames)  
 Eyeglass lenses  
 Eyeglass frames  
 Upgrades

Indicate Max Plan Benefit Coverage amount for Contact lenses:

Select the Individual Maximum Plan Benefit Coverage periodicity for Contact lenses:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Indicate Max Plan Benefit Coverage amount for Eyeglasses (lenses and frames):

Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglasses (lenses and frames):

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Indicate Max Plan Benefit Coverage amount for Eyeglass lenses:

Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglass lenses:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Indicate Max Plan Benefit Coverage amount for Eyeglass frames:

Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglass frames:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Indicate Max Plan Benefit Coverage amount for Upgrades:

Select the Individual Maximum Plan Benefit Coverage periodicity for Upgrades:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #17b Eyewear – Base 4

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #17b Eyewear - Base 4

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

Yes  
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Eye Exams Category 17a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Select which Eyewear Benefits have a Coinsurance (Select all that apply):

Medicare-covered Benefits  
 Contact lenses  
 Eyeglasses (lenses and frames)  
 Eyeglass lenses  
 Eyeglass frames  
 Upgrades

Indicate Coinsurance percentage for Medicare-covered Benefits:

Indicate Coinsurance percentage for Contact lenses:

Indicate Coinsurance percentage for Eyeglasses (lenses and frames):

Indicate Coinsurance percentage for Eyeglass lenses:

Indicate Coinsurance percentage for Eyeglass frames:

Indicate Coinsurance percentage for Upgrades:

# PBP 2015 Data Entry System Screens

## #17b Eyewear – Base 5

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #17b Eyewear - Base 5

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Select which Eyewear Benefits have a Copayment (Select all that apply):

- Medicare-covered Benefits
- Contact lenses
- Eyeglasses (lenses and frames)
- Eyeglass lenses
- Eyeglass frames
- Upgrades

Indicate Copayment amount for Medicare-covered Benefits:

Indicate Copayment amount for Contact lenses:

Indicate Copayment amount for Eyeglasses (lenses and frames):

Indicate Copayment amount for Eyeglass lenses:

Indicate Copayment amount for Eyeglass frames:

Indicate Copayment amount for Upgrades:

# PBP 2015 Data Entry System Screens

## #17b Eyewear – Base 6

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #17b Eyewear - Base 6

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

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

Is a referral required for Eyewear?

Yes

No

Eyewear Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #18a Hearing Exams – Base 1

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #18a Hearing Exams - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.

Does the plan provide Hearing Exams as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Routine Hearing Exams  
 Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Exams:

Mandatory  
 Optional

Is this benefit unlimited for Routine Hearing Exams?

Yes  
 No, indicate number

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select type of benefit for Fitting/Evaluation for Hearing Aid:

Mandatory  
 Optional

Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?

Yes  
 No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #18a Hearing Exams – Base 2

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #18a Hearing Exams - Base 2

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:</p> <p><input type="text"/></p>
<p>Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?</p> <p><input type="radio"/> In-network services only <input type="radio"/> Both In-network and Out-of-network services</p>	<p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <p><input type="text"/></p>	<p>Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:</p> <p><input type="text"/></p>
<p>Indicate Maximum Plan Benefit Coverage amount:</p> <p><input type="text"/></p>	<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Indicate Minimum Coinsurance percentage for Routine Hearing Exams:</p> <p><input type="text"/></p>
<p>Select the Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Indicate Maximum Coinsurance percentage for Routine Hearing Exams:</p> <p><input type="text"/></p>
<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Select which Hearing Exam Benefits have a Coinsurance (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Benefits <input type="checkbox"/> Routine Hearing Exams <input type="checkbox"/> Fitting/Evaluation for Hearing Aid</p>	<p>Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:</p> <p><input type="text"/></p>
<p>Indicate Deductible Amount:</p> <p><input type="text"/></p>		<p>Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:</p> <p><input type="text"/></p>



# PBP 2015 Data Entry System Screens

## #18a Hearing Exams – Base 3

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

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

Go To: #18a Hearing Exams - Base 3

Is there an enrollee Copayment?

Yes  
 No

Select which Hearing Exam Benefits have a Copayment(Select all that apply):

Medicare-covered Benefits  
 Routine Hearing Exams  
 Fitting/Evaluation for Hearing Aid

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Routine Hearing Exams:

Indicate Maximum Copayment amount for Routine Hearing Exams:

Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:

Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:

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

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

Is a referral required for Hearing Exams?

Yes  
 No

# PBP 2015 Data Entry System Screens

## #18a Hearing Exams – Base 4

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #18a Hearing Exams - Base 4

Hearing Exams Notes

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #18b Hearing Aids – Base 1

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #18b Hearing Aids - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Hearing Aids as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Hearing Aids (all types)  
 Hearing Aids - Inner Ear  
 Hearing Aids - Outer Ear  
 Hearing Aids - Over the Ear

Select type of benefit for Hearing Aids (all types):

Mandatory  
 Optional

Is this benefit unlimited for Hearing Aids (all types)?

Yes  
 No, indicate number

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select type of benefit for Hearing Aids - Inner Ear:

Mandatory  
 Optional

Is this benefit unlimited for Hearing Aids - Inner Ear?

Yes  
 No, indicate number

Indicate quantity for Hearing Aids - Inner Ear:

Select Hearing Aids - Inner Ear periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Select type of benefit for Hearing Aids - Outer Ear:

Mandatory  
 Optional

Is this benefit unlimited for Hearing Aids - Outer Ear?

Yes  
 No, indicate number

Indicate quantity for Hearing Aids - Outer Ear:

Select Hearing Aids - Outer Ear periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #18b Hearing Aids – Base 2

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #18b Hearing Aids - Base 2

Select type of benefit for Hearing Aids - Over the Ear:

Mandatory  
 Optional

Is this benefit unlimited for Hearing Aids - Over the Ear?

Yes  
 No, indicate number

Indicate quantity for Hearing Aids - Over the Ear:

Select Hearing Aids - Over the Ear periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes  
 No

Select the Maximum Plan Benefit Coverage type:

Covered under Hearing Exams Category - 18a  
 Plan-specified amount per period

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?

In-network services only  
 Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# PBP 2015 Data Entry System Screens

## #18b Hearing Aids – Base 3

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #18b Hearing Aids - Base 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  
 Yes  
 No

Indicate Coinsurance percentage for Hearing Aids (all types):

Select the Maximum Enrollee Out-of-Pocket Cost type:  
 Covered under Hearing Exams Category - 18a  
 Plan-specified amount per period

Indicate Coinsurance percentage for Hearing Aids - Inner Ear:

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Coinsurance percentage for Hearing Aids - Outer Ear:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Indicate Coinsurance percentage for Hearing Aids - Over the Ear:

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Hearing Aids Benefits have a Coinsurance (Select all that apply):  
 Hearing Aids - Inner Ear  
 Hearing Aids - Outer Ear  
 Hearing Aids - Over the Ear

# PBP 2015 Data Entry System Screens

## #18b Hearing Aids – Base 4

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #18b Hearing Aids - Base 4

Is there an enrollee Copayment?  
 Yes  
 No

Select which Hearing Aids Benefits have a Copayment (Select all that apply):  
 Hearing Aid - Inner Ear  
 Hearing Aid - Outer Ear  
 Hearing Aids - Over the Ear

Indicate Minimum Copayment amount per Hearing Aid (all types):

Indicate Maximum Copayment amount per Hearing Aid (all types):

Indicate Copayment amount per Hearing Aid - Inner Ear:

Indicate Copayment amount per two Hearing Aids - Inner Ear:

Indicate Copayment amount per Hearing Aid - Outer Ear:

Indicate Copayment amount per two Hearing Aids - Outer Ear:

Indicate Copayment amount per Hearing Aid - Over the Ear:

Indicate Copayment amount per two Hearing Aids - Over the Ear:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

# PBP 2015 Data Entry System Screens

## #18b Hearing Aids – Base 5

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #18b Hearing Aids - Base 5

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

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

Is a referral required for Hearing Aids?

Yes

No

Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes (Optional):

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Base 1

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Base 1

**CLICK FOR DESCRIPTION OF BENEFIT**

Does the plan provide Outpatient Drugs as a supplemental benefit under Part C?

Yes  
 No

Select type of benefit:

Mandatory  
 Optional

Indicate the number of drug groupings that are offered:

1  
 2  
 3  
 4  
 5

Is there a Maximum Plan Benefit Coverage amount for drugs?

Yes  
 No

Indicate type of Maximum Plan Benefit Coverage:

All drug groups covered by plan  
 Combination of drug groups  
 Individual drug groups

Is the Maximum Plan Benefit Coverage net of the enrollee copay?

Yes  
 No

Indicate Maximum Plan Benefit Coverage periodicity for drugs:

Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Other, describe

Indicate Max Plan Benefit Coverage amount annually for drugs:

Indicate Max Plan Benefit Coverage amount semi-annually for drugs:

Indicate Max Plan Benefit Coverage amount quarterly for drugs:

Indicate Max Plan Benefit Coverage amount monthly for drugs:

Indicate Max Plan Benefit Coverage amount for Other for drugs:



# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Base 2

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Base 2

Can any unused amounts be carried forward to the next period within the contract period?

Yes  
 No

Select what combination of drug groups are included in the Maximum Plan Benefit:

Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5

Indicate Maximum Plan Benefit Coverage periodicity for combination of drug groups:

Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Other, describe

Indicate Max Plan Benefit Coverage amount annually for combination of drug groups:

Indicate Max Plan Benefit Coverage amount semi-annually for combination of drug groups:

Indicate Max Plan Benefit Coverage amount quarterly for combination of drug groups:

Indicate Max Plan Benefit Coverage amount monthly for combination of drug groups:

Indicate Max Plan Benefit Coverage amount for Other for combination of drug groups:

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Base 3

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Base 3

Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached?

Yes  
 No

Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived:

Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5

Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available?

Yes  
 No

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

Yes  
 No

Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost:

Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5  
 Medicare Covered Benefits

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:

Every year  
 Every six months  
 Every three months

Is there an enrollee Coinsurance for Medicare-covered Benefits?

Yes  
 No

Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply):

Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Base 4

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Base 4

Is there an enrollee Deductible?  
 Yes  
 No

Select what combination of drug groups applies for Deductible:  
 Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5  
 Medicare Covered Benefits

Indicate Deductible amount:

Is there an enrollee Copayment for Medicare-covered Benefits?  
 Yes  
 No

Select which Medicare-covered Outpatient Drugs have a Copayment (Select all that apply):  
 Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Indicate Minimum Copayment amount for Medicare Part B Chemotherapy Drugs:

Indicate Maximum Copayment amount for Medicare Part B Chemotherapy Drugs:

Indicate Minimum Copayment for other Medicare Part B Drugs:

Indicate Maximum Copayment for other Medicare Part B Drugs:

Enrollee must receive Authorization for drugs from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist/Dentist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Notes (Optional)

The screenshot shows a software window titled "PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000". The window has a menu bar with "File" and "Help". Below the menu bar are navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" field contains the text "#20 Outpatient Drugs - Notes (Optional)".

The main content area is titled "Outpatient Drugs Notes" and contains the following text: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." Below this text is a large, empty text area labeled "Notes (Optional):" with a vertical scrollbar on the right side.

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Group 1 – Base 1

The screenshot shows a software window titled "PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a navigation bar with buttons for "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "#20 Outpatient Drugs - Group 1 - Base 1".

On the left side, there are several input sections:

- "Select a label for Group 1:" with a dropdown menu.
- "Select the drug type(s) covered for Group 1:" with checkboxes for "Generic", "Preferred Brand", and "Brand".
- "Is there a Maximum Plan Benefit Coverage amount for Group 1?" with radio buttons for "Yes" and "No".
- "Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:" with checkboxes for "Annually", "Semi-annually", "Quarterly", "Monthly", "Per Prescription", and "Other, describe".

On the right side, there are five text input fields for coverage amounts:

- "Indicate Maximum Plan Benefit Coverage annual amount for Group 1:"
- "Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:"
- "Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:"
- "Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:"
- "Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:"
- "Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:"

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Group 1 – Base 2

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 1 - Base 2

Select from where Group 1 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 1?  
 Yes  No

Is there an enrollee Copayment for Group 1?  
 Yes  No

Indicate Coinsurance percentage for Group 1 Designated Retail Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 1 Designated Retail Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 1 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 1 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 1 HMO-Owned Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 1 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 1 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 1 Mail Order: <input type="text"/>	Up to a _____ day supply covered for Group 1 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 1 Other: <input type="text"/>	Indicate Copayment amount for Group 1 Other: <input type="text"/>	Up to a _____ day supply covered for Group 1 Other: <input type="text"/>

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Group 2 – Base 1

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 2 - Base 1

Select a label for Group 2:

Select the drug type(s) covered for Group 2:

Generic  
 Preferred Brand  
 Brand

Is there a Maximum Plan Benefit Coverage amount for Group 2?  
 Yes  
 No

Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:  
 Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Per Prescription  
 Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 2:

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Group 2 – Base 2

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 2 - Base 2

Select from where Group 2 Drugs can be acquired:

Designated Retail Pharmacy

HMO-Owned Pharmacy

Mail Order

Other, describe

Is there an enrollee Coinsurance for Group 2?

Yes

No

Is there an enrollee Copayment for Group 2?

Yes

No

Indicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy:	Indicate Copayment amount for Group 2 Designated Retail Pharmacy:	Up to a _____ day supply covered for Group 2 Designated Retail Pharmacy:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Group 2 for HMO-Owned Pharmacy:	Indicate Copayment amount for Group 2 HMO-Owned Pharmacy:	Up to a _____ day supply covered for Group 2 HMO-Owned Pharmacy:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Group 2 for Mail Order:	Indicate Copayment amount for Group 2 Mail Order:	Up to a _____ day supply covered for Group 2 Mail Order:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Indicate Coinsurance percentage for Group 2 for Other:	Indicate Copayment amount for Group 2 Other:	Up to a _____ day supply covered for Group 2 Other:
<input type="text"/>	<input type="text"/>	<input type="text"/>



# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Group 3 – Base 1

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 3 - Base 1

Select a label for Group 3:

Select the drug type(s) covered for Group 3:

Generic  
 Preferred Brand  
 Brand

Is there a Maximum Plan Benefit Coverage amount for Group 3?  
 Yes  
 No

Indicate Maximum Plan Benefit Coverage Group 3 periodicity:  
 Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Per Prescription  
 Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 3:

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 3:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 3:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 3:

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Group 3 – Base 2

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 3 - Base 2

Select from where Group 3 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 3?  
 Yes  
 No

Is there an enrollee Copayment for Group 3?  
 Yes  
 No

Indicate Coinsurance percentage for Group 3 Designated Retail Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 3 Designated Retail Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 3 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 3 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 3 HMO-Owned Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 3 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 3 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 3 Mail Order: <input type="text"/>	Up to a _____ day supply covered for Group 3 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 3 Other: <input type="text"/>	Indicate Copayment amount for Group 3 Other: <input type="text"/>	Up to a _____ day supply covered for Group 3 Other: <input type="text"/>

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Group 4 – Base 1

The screenshot shows a software window titled "PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000". The window contains a menu bar with "File" and "Help". Below the menu bar are navigation buttons: "<<Previous", "Next>>", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "#20 Outpatient Drugs - Group 4 - Base 1".

The main form area is divided into several sections:

- Select a label for Group 4:** A dropdown menu.
- Select the drug type(s) covered for Group 4:** Three checkboxes: "Generic", "Preferred Brand", and "Brand".
- Is there a Maximum Plan Benefit Coverage amount for Group 4?:** Two radio buttons: "Yes" and "No".
- Indicate Maximum Plan Benefit Coverage Group 4:** Five checkboxes: "Annually", "Semi-annually", "Quarterly", "Monthly", "Per Prescription", and "Other, describe".

On the right side of the form, there are five text input fields corresponding to the following prompts:

- Indicate Maximum Plan Benefit Coverage annual amount for Group 4:
- Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 4:
- Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4:
- Indicate Maximum Plan Benefit Coverage monthly amount for Group 4:
- Indicate Maximum Plan Benefit Coverage amount per prescription for Group 4:
- Indicate Maximum Plan Benefit Coverage amount for Other for Group 4:

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Group 4 – Base 2

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 4 - Base 2

Select from where Group 4 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 4?  
 Yes  
 No

Is there an enrollee Copayment for Group 4?  
 Yes  
 No

Indicate Coinsurance percentage for Group 4 Designated Retail Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 4 Designated Retail Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 4 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 4 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 4 HMO-Owned Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 4 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 4 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 4 Mail Order: <input type="text"/>	Up to a _____ day supply covered for Group 4 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 4 Other: <input type="text"/>	Indicate Copayment amount for Group 4 Other: <input type="text"/>	Up to a _____ day supply covered for Group 4 Other: <input type="text"/>

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Group 5 – Base 1

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 5 - Base 1

Select a label for Group 5:

Select the drug type(s) covered for Group 5:

Generic  
 Preferred Brand  
 Brand

Is there a Maximum Plan Benefit Coverage amount for Group 5?

Yes  
 No

Indicate Maximum Plan Benefit Coverage for Group 5 periodicity:

Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Per Prescription  
 Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 5:

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 5:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 5:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 5:

# PBP 2015 Data Entry System Screens

## #20 Outpatient Drugs – Group 5 – Base 2

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Outpatient Drugs - Group 5 - Base 2

Select from where Group 5 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 5?  
 Yes  
 No

Is there an enrollee Copayment for Group 5?  
 Yes  
 No

Indicate Coinsurance percentage for Group 5 Designated Retail Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 5 Designated Retail Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 5 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 5 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 5 HMO-Owned Pharmacy: <input type="text"/>	Up to a _____ day supply covered for Group 5 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 5 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 5 Mail Order: <input type="text"/>	Up to a _____ day supply covered for Group 5 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 5 Other: <input type="text"/>	Indicate Copayment amount for Group 5 Other: <input type="text"/>	Up to a _____ day supply covered for Group 5 Other: <input type="text"/>

# PBP 2015 Data Entry System Screens

## #20 Home Infusion Bundled Services

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: #20 Home Infusion Bundled Services

Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?

Yes  
 No

If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 7, 2013 at 12:00pm Eastern Time.

You must also ensure that your benefit includes not only the home infusion drug, but any services and supplies associated with the home infusion drug's administration.

If your organization elects to provide Part D home infusion drugs as part of a bundled service then those services must be provided at \$0 cost sharing. As described in the CY 2010 Call Letter this waiver is conditioned on the application of zero cost sharing for the bundle of home infusion services provided under a supplemental benefit.