

CY 2017 PBP Data Entry System Screens

#19a Reduced Cost Sharing for VBIDS

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

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[CLICK FOR DESCRIPTION OF BENEFIT](#)

This section documents benefits offered under authority of the Medicare Advantage Value-Based Insurance Design model test. Plans only fill out this section if they are authorized to do so by written notification from CMS.

Value Based Insurance Design Attestation

I attest that

1) the benefits entered comply with CMS requirements for benefits offered in the MA-VBID model test,

2) the benefits entered are consistent with the benefit proposals and the actuarial or financial information provided to CMS when applying to participate in the MA-VBID model test, unless otherwise approved by CMS in writing, and

3) the benefit package, formulary or other features of this plan are not structured to discriminate against any Medicare beneficiary.

Does your VBID benefit offer Part C reductions in cost or additional benefits?

☐ Yes

☐ No

Does your VBID benefit offer Part C reductions in cost?

☐ Yes

☐ No

How many packages does your 19a Reduction in Cost Sharing VBID benefit contain? (1-15)

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#19a Reduced Cost Sharing for VBIDS – Base 1

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Which disease states does this benefit apply? (Select all that apply):

- ☐ Diabetes
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Patient with Past Stroke
- ☐ Hypertension
- ☐ Coronary Heart Disease
- ☐ Mood Disorders

Is there a prerequisite for reduction of cost sharing for this package?

☐ Yes

☐ No

Which prerequisites are required for this package?

- ☐ High value provider
- ☐ Participation in a Wellness Program
- ☐ Other, Describe

Select the Medicare-covered benefits that will receive reduced cost sharing:

- 1a: Inpatient Hospital Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 4b: Urgently Needed Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e1: Individual Sessions for Mental Health Specialty Services
- 7e2: Group Sessions for Mental Health Specialty Services
- 7f: Podiatry Services
- 7g: Other Health Care Professional
- 7h1: Individual Sessions for Psychiatric Services
- 7h2: Group Sessions for Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 8a1: Diagnostic Procedures/Tests
- 8a2: Lab Services
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Ray Services
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse
- 9d: Outpatient Blood Services
- 11a: Durable Medical Equipment (DME)
- 11b1: Prosthetic Devices
- 11b2: Medical Supplies
- 11c1: Diabetic Supplies

Select the Non-Medicare-covered benefits that will receive reduced cost sharing:

- 1a: Inpatient Hospital Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 10b1: Transportation Services - Plan Approved Location
- 10b2: Transportation Services - Any Location
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 13g: Dual Eligible SNP with Highly Integrated Services
- 14b: Annual Physical Exam
- 14c1: Health Education
- 14c2: Nutritional/Dietary Benefit
- 14c3: Additional sessions of Smoking and Tobacco Cessation Coun
- 14c4: Fitness Benefit
- 14c5: Enhanced Disease Management
- 14c6: Telemonitoring Services
- 14c7: Remote Access Technologies (including Web/Phone based te
- 14c8: Bathroom Safety Devices
- 14c9: Counseling Services
- 14c10: In-Home Safety Assessment
- 14c11: Personal Emergency Response System (PERS)
- 14c12: Medical Nutrition Therapy (MNT)
- 14c13: Post discharge In-home Medication Reconciliation
- 14c14: Re-admission Prevention
- 14c15: Wigs for Hair Loss Related to Chemotherapy

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#19a Reduced Cost Sharing for VBIDS – Base 2

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Do the benefits in this package apply to OON/POS?

☐ Yes
☐ No

Are any benefits exempt from the plan level deductible?

☐ Yes
☐ No

Select the Medicare-covered benefits that are exempt from the plan level deductible:

- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 4b: Urgently Needed Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e1: Individual Sessions for Mental Health Specialty Services
- 7e2: Group Sessions for Mental Health Specialty Services
- 7f: Podiatry Services
- 7g: Other Health Care Professional
- 7h1: Individual Sessions for Psychiatric Services
- 7h2: Group Sessions for Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 8a1: Diagnostic Procedures/Tests
- 8a2: Lab Services
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Ray Services
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse
- 9d: Outpatient Blood Services
- 11a: Durable Medical Equipment (DME)
- 11b1: Prosthetic Devices
- 11b2: Medical Supplies
- 11c1: Diabetic Supplies
- 11c2: Diabetic Therapeutic Shoes/Inserts
- 12: Dialysis Services
- 14d: Kidney Disease Education Services

Select the Non-Medicare-covered benefits that are exempt from the plan level deductible:

- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 10b1: Transportation Services - Plan Approved Location
- 10b2: Transportation Services - Any Location
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 13g: Dual Eligible SNP with Highly Integrated Services
- 14b: Annual Physical Exam
- 14c1: Health Education
- 14c2: Nutritional/Dietary Benefit
- 14c3: Additional sessions of Smoking and Tobacco Cessation Coun
- 14c4: Fitness Benefit
- 14c5: Enhanced Disease Management
- 14c6: Telemonitoring Services
- 14c7: Remote Access Technologies (including Web/Phone based te
- 14c8: Bathroom Safety Devices
- 14c9: Counseling Services
- 14c10: In-Home Safety Assessment
- 14c11: Personal Emergency Response System (PERS)
- 14c12: Medical Nutrition Therapy (MNT)
- 14c13: Post discharge In-home Medication Reconciliation
- 14c14: Re-admission Prevention
- 14c15: Wigs for Hair Loss Related to Chemotherapy
- 14c16: Weight Management Programs
- 14c17: Alternative Therapies
- 16a1: Oral Exams

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#19a Reduced Cost Sharing for VBIDS – Base 3

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Go To: #19a Reduced Cost Sharing for VBIDS - Base 3

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Do you offer reduced Coinsurance?

☐ Yes
☐ No

Select the Medicare-covered benefits that will receive reduced coinsurance:

- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 4b: Urgently Needed Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e1: Individual Sessions for Mental Health Specialty Services
- 7e2: Group Sessions for Mental Health Specialty Services
- 7f: Podiatry Services
- 7g: Other Health Care Professional
- 7h1: Individual Sessions for Psychiatric Services
- 7h2: Group Sessions for Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 8a1: Diagnostic Procedures/Tests
- 8a2: Lab Services
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Ray Services
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse
- 9d: Outpatient Blood Services
- 11a: Durable Medical Equipment (DME)
- 11b1: Prosthetic Devices
- 11b2: Medical Supplies
- 11c1: Diabetic Supplies
- 11c2: Diabetic Therapeutic Shoes/Inserts
- 12: Dialysis Services
- 14d: Kidney Disease Education Services

Select the Non-Medicare-covered benefits that will receive reduced coinsurance:

- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 10b1: Transportation Services - Plan Approved Location
- 10b2: Transportation Services - Any Location
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 13g: Dual Eligible SNP with Highly Integrated Services
- 14b: Annual Physical Exam
- 14c1: Health Education
- 14c2: Nutritional/Dietary Benefit
- 14c3: Additional sessions of Smoking and Tobacco Cessation Coun
- 14c4: Fitness Benefit
- 14c5: Enhanced Disease Management
- 14c6: Telemonitoring Services
- 14c7: Remote Access Technologies (including Web/Phone based te
- 14c8: Bathroom Safety Devices
- 14c9: Counseling Services
- 14c10: In-Home Safety Assessment
- 14c11: Personal Emergency Response System (PERS)
- 14c12: Medical Nutrition Therapy (MNT)
- 14c13: Post discharge In-home Medication Reconciliation
- 14c14: Re-admission Prevention
- 14c15: Wigs for Hair Loss Related to Chemotherapy
- 14c16: Weight Management Programs
- 14c17: Alternative Therapies
- 16a1: Oral Exams

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Previous Next Exit (Validate) Exit (No Validate)

Indicate Coinsurance for one or more of the following services:

	Minimum Coinsurance	Maximum Coinsurance		Minimum Coinsurance	Maximum Coinsurance
Cardiac Rehabilitation Services			Group Sessions for Mental Health Specialty Services		
Intensive Cardiac Rehabilitation Services			Podiatry Services		
Pulmonary Rehabilitation Services			Other Health Care Professional		
Urgently Needed Services			Individual Sessions for Psychiatric Services		
Partial Hospitalization			Group Sessions for Psychiatric Services		
Home Health Services			Physical Therapy and Speech-Language Pathology Services		
Primary Care Physician Services			Diagnostic Procedures/Tests		
Chiropractic Services			Lab Services		
Occupational Therapy Services			Diagnostic Radiological Services		
Physician Specialist Services			Therapeutic Radiological Services		
Individual Sessions for Mental Health Specialty Services			Outpatient X-Ray Services		

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Previous Next Exit (Validate) Exit (No Validate)

Indicate Coinsurance for one or more of the following services:

	Minimum Coinsurance	Maximum Coinsurance		Minimum Coinsurance	Maximum Coinsurance
Outpatient Hospital Services			Glaucoma Screening		
Ambulatory Surgical Center (ASC) Services			Diabetes Self-Management Training		
Outpatient Substance Abuse			Other 1		
Outpatient Blood Abuse			Other 2		
Durable Medical Equipment (DME)			Other 3		
Prosthetic Devices			Other 4		
Medical Supplies			Other 5		
Diabetic Supplies			Comprehensive Dental		
Diabetic Therapeutic Shoes/Inserts			Eye Exams		
Dialysis Services			Eyewear		
Kidney Disease Education Services			Hearing Exams		

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#19a Reduced Cost Sharing for VBIDS – Base 6

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Previous Next Exit (Validate) Exit (No Validate)

Indicate Coinsurance for one or more of the following services.

	Minimum Coinsurance	Maximum Coinsurance		Minimum Coinsurance	Maximum Coinsurance
Additional Cardiac Rehabilitation Services			Dual Eligible SNP with Highly Integrated Services		
Additional Intensive Cardiac Rehabilitation Services			Annual Physical Exam		
Additional Pulmonary Rehabilitation Services			Health Education		
Chiropractic Services - Routine Care/Other			Nutritional/Dietary Benefit		
Podiatry Services - Routine Foot Care			Additional sessions of Smoking and Tobacco Cessation Counseling		
Transportation Services - Plan Approved Location			Fitness Benefit		
Transportation Services - Any Location			Enhanced Disease Management		
Acupuncture			Telemonitoring Services		
Over-the-Counter (OTC) Items			Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)		
Meal Benefit			Bathroom Safety Devices		
Other 1			Counseling Services		
Other 2			In-Home Safety Assessment		
Other 3			Personal Emergency Response System (PERS)		

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Previous Next Exit (Validate) Exit (No Validate)

Indicate Coinsurance for one or more of the following services.

	Minimum Coinsurance	Maximum Coinsurance		Minimum Coinsurance	Maximum Coinsurance
Medical Nutrition Therapy (MNT)			Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services		
Post discharge In-home Medication Reconciliation			Routine Eye Exams/Other		
Re-admission Prevention			Contact Lenses		
Wigs for Hair Loss Related to Chemotherapy			Eyeglasses (lenses and frames)		
Weight Management Programs			Eyeglass lenses		
Alternative Therapies			Eyeglass frames		
Oral Exams			Upgrades		
Prophylaxis (Cleaning)			Routine Hearing Exams		
Fluoride Treatment			Fitting/Evaluation for Hearing Aid		
Dental X-Rays			Hearing Aids (all types)		
Non-routine Services			Hearing Aids - Inner Ear		
Diagnostic Services			Hearing Aids - Outer Ear		
Restorative Services			Hearing Aids - Over the Ear		
Endodontics/Periodontics/Extractions					

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#19a Reduced Cost Sharing for VBIDS – Base 8

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Do you offer a reduced deductible amount?

☐ Yes
☐ No

Select the Medicare-covered benefits that will receive reduced deductible amounts:

1a: Inpatient Hospital Acute
1b: Inpatient Hospital Psychiatric
2: Skilled Nursing Facility (SNF)
3: Cardiac and Pulmonary Rehabilitation Services
4c: Worldwide Emergency/Urgent Coverage
5: Partial Hospitalization
6: Home Health Services
7a: Primary Care Physician Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7d: Physician Specialist Services
7e: Mental Health Specialty Services
7f: Podiatry Services
7g: Other Health Care Professional
7h: Psychiatric Services
7i: Physical Therapy and Speech-Language Pathology Services
8a: Diagnostic Procedures/Tests/Lab Services
8b: Outpatient Diagnostic/Therapeutic Radiological Services
9a: Outpatient Hospital Services
9b: Ambulatory Surgical Center (ASC) Services
9c: Outpatient Substance Abuse
9d: Outpatient Blood Services
10a: Ambulance Services
10b: Transportation Services
11a: Durable Medical Equipment (DME)
11b: Prosthetics/Medical Supplies
11c: Diabetic Supplies and Services
12: Dialysis Services
13a: Acupuncture
13b: Over-the-Counter (OTC) Items
13c: Meal Benefit
13d: Other 1
13e: Other 2

Indicate deductible for one or more of the following services

	Deductible Amount
Inpatient Hospital Acute	
Inpatient Hospital Psychiatric	
Skilled Nursing Facility (SNF)	
Cardiac and Pulmonary Rehabilitation Services	
Worldwide Emergency/Urgent Coverage	
Partial Hospitalization	
Home Health Services	
Primary Care Physician Services	
Chiropractic Services	
Occupational Therapy Services	
Physician Specialist Services	
Mental Health Specialty Services	
Podiatry Services	

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Indicate deductible for one or more of the following services

	Deductible Amount		Deductible Amount		Deductible Amount		Deductible Amount
Other Health Care Professional		Dialysis Services		Telemonitoring Services		Diabetes Self-Management Training	
Psychiatric Services		Acupuncture		Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)		Other 1	
Physical Therapy and Speech-Language Pathology Services		Over-the-Counter (OTC) Items		Bathroom Safety Devices		Other 2	
Diagnostic Procedures/Tests/Lab Services		Meal Benefit		Counseling Services		Other 3	
Outpatient Diagnostic/Therapeutic Radiological Services		Other 1		In-Home Safety Assessment		Other 4	
Outpatient Hospital Services		Other 2		Personal Emergency Response System (PERS)		Other 5	
Ambulatory Surgical Center (ASC) Services		Other 3		Medical Nutrition Therapy (MNT)		Medicare Part B Rx Drugs	
Outpatient Substance Abuse		Dual Eligible SNP with Highly Integrated Services		Post discharge In-home Medication Reconciliation		Preventive Dental	
Outpatient Blood Services		Annual Physical Exam		Re-admission Prevention		Comprehensive Dental	
Ambulance Services		Health Education		Wigs for Hair Loss Related to Chemotherapy		Eye Exams	
Transportation Services		Nutritional/Dietary Benefit		Weight Management Programs		Eyewear	
Durable Medical Equipment (DME)		Additional sessions of Smoking and Tobacco Cessation Counseling		Alternative Therapies		Hearing Exams	
Prosthetics/Medical Supplies		Fitness Benefit		Kidney Disease Education Services		Hearing Aids	
Diabetic Supplies and Services		Enhanced Disease Management		Glaucoma Screening			

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#19a Reduced Cost Sharing for VBIDS – Base 10

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Do you offer reduced Copay?

☐ Yes
☐ No

Select all the Medicare-covered benefits that will receive reduced copay:

- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 4b: Urgently Needed Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e1: Individual Sessions for Mental Health Specialty Services
- 7e2: Group Sessions for Mental Health Specialty Services
- 7f: Podiatry Services
- 7g: Other Health Care Professional
- 7h1: Individual Sessions for Psychiatric Services
- 7h2: Group Sessions for Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 8a1: Diagnostic Procedures/Tests
- 8a2: Lab Services
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Ray Services
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse
- 9d: Outpatient Blood Services
- 11a: Durable Medical Equipment (DME)
- 11b1: Prosthetic Devices
- 11b2: Medical Supplies
- 11c1: Diabetic Supplies
- 11c2: Diabetic Therapeutic Shoes/Inserts
- 12: Dialysis Services
- 14d: Kidney Disease Education Services

Select all the Non-Medicare-covered benefits that will receive reduced copay:

- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 10b1: Transportation Services - Plan Approved Location
- 10b2: Transportation Services - Any Location
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 13g: Dual Eligible SNP with Highly Integrated Services
- 14b: Annual Physical Exam
- 14c1: Health Education
- 14c2: Nutritional/Dietary Benefit
- 14c3: Additional sessions of Smoking and Tobacco Cessation Coun
- 14c4: Fitness Benefit
- 14c5: Enhanced Disease Management
- 14c6: Telemonitoring Services
- 14c7: Remote Access Technologies (including Web/Phone based te
- 14c8: Bathroom Safety Devices
- 14c9: Counseling Services
- 14c10: In-Home Safety Assessment
- 14c11: Personal Emergency Response System (PERS)
- 14c12: Medical Nutrition Therapy (MNT)
- 14c13: Post discharge In-home Medication Reconciliation
- 14c14: Re-admission Prevention
- 14c15: Wigs for Hair Loss Related to Chemotherapy
- 14c16: Weight Management Programs
- 14c17: Alternative Therapies
- 16a1: Oral Exams

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#19a Reduced Cost Sharing for VBIDS – Base 11

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Indicate Copayment for one or more of the following services:

	Minimum Copay	Maximum Copay		Minimum Copay	Maximum Copay
Cardiac Rehabilitation Services			Group Sessions for Mental Health Specialty Services		
Intensive Cardiac Rehabilitation Services			Podiatry Services		
Pulmonary Rehabilitation Services			Other Health Care Professional		
Urgently Needed Services			Individual Sessions for Psychiatric Services		
Partial Hospitalization			Group Sessions for Psychiatric Services		
Home Health Services			Physical Therapy and Speech-Language Pathology Services		
Primary Care Physician Services			Diagnostic Procedures/Tests		
Chiropractic Services			Lab Services		
Occupational Therapy Services			Diagnostic Radiological Services		
Physician Specialist Services			Therapeutic Radiological Services		
Individual Sessions for Mental Health Specialty Services			Outpatient X-Ray Services		

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#19a Reduced Cost Sharing for VBIDS – Base 12

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Go To: #19a Reduced Cost Sharing for VBIDS - Base 12

Previous Next Exit (Validate) Exit (No Validate)

Indicate Copayment for one or more of the following services:

	Minimum Copay	Maximum Copay		Maximum Copay	Minimum Copay
Outpatient Hospital Services			Glaucoma Screening		
Ambulatory Surgical Center (ASC) Services			Diabetes Self-Management Training		
Outpatient Substance Abuse			Other 1		
Outpatient Blood Abuse			Other 2		
Durable Medical Equipment (DME)			Other 3		
Prosthetic Devices			Other 4		
Medical Supplies			Other 5		
Diabetic Supplies			Comprehensive Dental		
Diabetic Therapeutic Shoes/Inserts			Eye Exams		
Dialysis Services			Eyewear		
Kidney Disease Education Services			Hearing Exams		

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#19a Reduced Cost Sharing for VBIDS – Base 13

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Indicate Copay for one or more of the following services.

	Minimum Copay	Maximum Copay		Minimum Copay	Maximum Copay
Additional Cardiac Rehabilitation Services			Dual Eligible SNP with Highly Integrated Services		
Additional Intensive Cardiac Rehabilitation Services			Annual Physical Exam		
Additional Pulmonary Rehabilitation Services			Health Education		
Chiropractic Services - Routine Care/Other			Nutritional/Dietary Benefit		
Podiatry Services - Routine Foot Care			Additional sessions of Smoking and Tobacco Cessation Counseling		
Transportation Services - Plan Approved Location			Fitness Benefit		
Transportation Services - Any Location			Enhanced Disease Management		
Acupuncture			Telemonitoring Services		
Over-the-Counter (OTC) Items			Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)		
Meal Benefit			Bathroom Safety Devices		
Other 1			Counseling Services		
Other 2			In-Home Safety Assessment		
Other 3			Personal Emergency Response System (PERS)		

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#19a Reduced Cost Sharing for VBIDS – Base 14

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Previous Next Exit (Validate) Exit (No Validate)

Indicate Copay for one or more of the following services.

	Minimum Copay	Maximum Copay		Minimum Copay	Maximum Copay
Medical Nutrition Therapy (MNT)			Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services		
Post discharge In-home Medication Reconciliation			Routine Eye Exams/Other		
Re-admission Prevention			Contact Lenses		
Wigs for Hair Loss Related to Chemotherapy			Eyeglasses (lenses and frames)		
Weight Management Programs			Eyeglass lenses		
Alternative Therapies			Eyeglass frames		
Oral Exams			Upgrades		
Prophylaxis (Cleaning)			Routine Hearing Exams		
Fluoride Treatment			Fitting/Evaluation for Hearing Aid		
Dental X-Rays			Hearing Aids (all types)		
Non-routine Services			Hearing Aids - Inner Ear		
Diagnostic Services			Hearing Aids - Outer Ear		
Restorative Services			Hearing Aids - Over the Ear		
Endodontics/Periodontics/Extractions					

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#19a Reduced Cost Sharing for VBIDS – Notes

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Please describe any additional measures taken to reduce costsharing, and/or other pertinent information regarding how the VBID program is administered to Beneficiaries

Notes:

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VBID #19A #1a Inpatient Hospital-Acute – Base 1

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Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 1

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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

CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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 Medicare-covered benefit costsharing vary by hospital(s) in which an enrollee obtains care?

☐ Yes
☐ No

How many costsharing tiers do you offer?

What is your lowest cost tier?

☐ Tier 1
☐ Tier 2
☐ Tier 3

What is your inpatient hospital benefit period?

☐ Original Medicare
☐ Annual
☐ Per Admission
☐ Other, describe

If "Other, Describe" is selected enter description below:

Do you charge cost sharing on the day of discharge?

☐ Yes
☐ No

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	Begin Day Interval	End Day Interval

CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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):

Coinurance % Interval 1	Begin Day Interval 1	End Day Interval 1:
Coinurance % Interval 2	Begin Day Interval 2	End Day Interval 2:
Coinurance % 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):

Coinurance % Interval 1	Begin Day Interval 1	End Day Interval 1:
Coinurance % Interval 2	Begin Day Interval 2	End Day Interval 2:
Coinurance % Interval 3	Begin Day Interval 3	End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Medicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime 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:																																																												
☐ Zero (No Coinsurance per Day) ☐ One ☐ Two ☐ Three	☐ Zero (No Coinsurance per Day) ☐ One ☐ Two ☐ Three	☐ Zero (No Coinsurance per Day) ☐ One ☐ Two ☐ Three																																																												
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CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 5

Previous Next Exit (Validate) Exit (No Validate)

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

☐ Yes
☐ No

How many costsharing tiers do you offer?

What is your lowest cost tier?

☐ Tier 1
☐ Tier 2
☐ Tier 3

Additional Days Coinsurance Cost Sharing for Tier 1:

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:

Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:

Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:

Additional Days Coinsurance Cost Sharing for Tier 2:

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:

Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:

Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 6

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 6

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Coinsurance Cost Sharing for Tier 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., 91 to 999):

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:

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:
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:
Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

Indicate Coinsurance percentage for Upgrades:

CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 7

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 7

Previous Next Exit (Validate) Exit (No Validate)

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.
MA Organizations are not permitted to tier deductibles.

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

CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 8

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 8

Previous Next Exit (Validate) Exit (No Validate)

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:

CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 9

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 9

Previous Next Exit (Validate) Exit (No Validate)

Medicare-covered Lifetime Reserve Days Tier 1 Medicare-covered Lifetime Reserve Days Tier 2 Medicare-covered Lifetime 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	Interval Days		
	Copay Amount	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 3:			

Medicare-covered Lifetime Reserve Days Tier 2

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	Interval Days		
	Copay Amount	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 3:			

Medicare-covered Lifetime 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	Interval Days		
	Copay Amount	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 3:			

CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 10

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 10

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 1:

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:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

Additional Days Copayment Cost Sharing for Tier 2:

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:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 11

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 11

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

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

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

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

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

CY 2017 PBP Data Entry System Screens

VBID #19A #1a Inpatient Hospital-Acute – Base 12

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1a Inpatient Hospital-Acute - Base 12

Previous Next Exit (Validate) Exit (No Validate)

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

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:

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

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 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

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Medicare-covered benefit costsharing 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

What is your inpatient hospital benefit period?

☐ Original Medicare
☐ Annual
☐ Per Admission
☐ Other, describe

If "Other, Describe" is selected enter description below:

Do you charge cost sharing on the day of discharge?

☐ Yes
☐ No

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
Coinurance % Interval 2	Begin Day Interval 2	End Day Interval 2
Coinurance % Interval 3	Begin Day Interval 3	End Day Interval 3

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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:

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Medicare-covered Lifetime 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 %	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 3:			

Medicare-covered Lifetime 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 %	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 3:			

Medicare-covered Lifetime 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 %	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 3:			

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 5

Previous Next Exit (Validate) Exit (No Validate)

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

☐ Yes
☐ No

How many costsharing tiers do you offer?

What is your lowest cost tier?

☐ Tier 1
☐ Tier 2
☐ Tier 3

Additional Days Coinsurance Cost Sharing for Tier 1:

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:

Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:

Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:

Additional Days Coinsurance Cost Sharing for Tier 2:

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:

Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:

Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 6

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 6

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Coinsurance Cost Sharing for Tier 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., 91 to 999):

Coinurance % Interval 1 Begin Day Interval 1: End Day Interval 1:
[] [] []

Coinurance % Interval 2 Begin Day Interval 2: End Day Interval 2:
[] [] []

Coinurance % Interval 3 Begin Day Interval 3: End Day Interval 3:
[] [] []

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:
[] [] []

Coinurance % Interval 2 Begin Day Interval 2: End Day Interval 2:
[] [] []

Coinurance % Interval 3 Begin Day Interval 3: End Day Interval 3:
[] [] []

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 7

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 7

Previous Next Exit (Validate) Exit (No Validate)

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.
MA Organizations are not permitted to tier deductibles.

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

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 8

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 8

Previous Next Exit (Validate) Exit (No Validate)

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:

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 9

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 9

Previous Next Exit (Validate) Exit (No Validate)

Medicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime 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:																																													
☐ Zero (No Copayment per Day) ☐ One ☐ Two ☐ Three	☐ Zero (No Copayment per Day) ☐ One ☐ Two ☐ Three	☐ 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):	Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):																																													
<table border="1"><thead><tr><th colspan="3">Interval Days</th></tr><tr><th>Copay Amount</th><th>Begin Day</th><th>End Day</th></tr></thead><tbody><tr><td>Interval 1:</td><td></td><td></td></tr><tr><td>Interval 2:</td><td></td><td></td></tr><tr><td>Interval 3:</td><td></td><td></td></tr></tbody></table>	Interval Days			Copay Amount	Begin Day	End Day	Interval 1:			Interval 2:			Interval 3:			<table border="1"><thead><tr><th colspan="3">Interval Days</th></tr><tr><th>Copay Amount</th><th>Begin Day</th><th>End Day</th></tr></thead><tbody><tr><td>Interval 1:</td><td></td><td></td></tr><tr><td>Interval 2:</td><td></td><td></td></tr><tr><td>Interval 3:</td><td></td><td></td></tr></tbody></table>	Interval Days			Copay Amount	Begin Day	End Day	Interval 1:			Interval 2:			Interval 3:			<table border="1"><thead><tr><th colspan="3">Interval Days</th></tr><tr><th>Copay Amount</th><th>Begin Day</th><th>End Day</th></tr></thead><tbody><tr><td>Interval 1:</td><td></td><td></td></tr><tr><td>Interval 2:</td><td></td><td></td></tr><tr><td>Interval 3:</td><td></td><td></td></tr></tbody></table>	Interval Days			Copay Amount	Begin Day	End Day	Interval 1:			Interval 2:			Interval 3:		
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CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 10

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 10

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 1:

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:

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

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

Additional Days Copayment Cost Sharing for Tier 2:

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:

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

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

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 11

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 11

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

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

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

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

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

CY 2017 PBP Data Entry System Screens

VBID #19A #1b Inpatient Hospital Psychiatric – Base 12

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 12

Previous Next Exit (Validate) Exit (No Validate)

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

Inpatient Hospital Psychiatric Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #2 SNF - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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 (MMP Only)

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.

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

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #2 SNF – Base 2

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility 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

What is your SNF benefit period?

☐ Original Medicare
☐ Annual
☐ Per Admission
☐ Other, describe

If "Other, Describe" is selected enter description below:

Do you charge cost sharing on the day of discharge?

☐ Yes
☐ No

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 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	Begin Day Interval	End Day Interval
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:

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #2 SNF - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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 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):

Coinurance % Interval 1: Begin Day Interval 1: End Day Interval 1:

Coinurance % Interval 2: Begin Day Interval 2: End Day Interval 2:

Coinurance % 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 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):

Coinurance % Interval 1: Begin Day Interval 1: End Day Interval 1:

Coinurance % Interval 2: Begin Day Interval 2: End Day Interval 2:

Coinurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #2 SNF - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Additional Days 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

Additional Days Coinsurance Cost Sharing for Tier 1:

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:

Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:

Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

Additional Days Coinsurance Cost Sharing for Tier 2:

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:

Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:

Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #2 SNF – Base 5

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Coinsurance Cost Sharing for Tier 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):

Coinurance % Interval 1: Begin Day Interval 1: End Day Interval 1:
[] [] []

Coinurance % Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Coinurance % Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

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:
[] [] []

Coinurance % Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Coinurance % Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 6

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #2 SNF - Base 6

Previous Next Exit (Validate) Exit (No Validate)

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.
MA Organizations are not permitted to tier deductibles.

Is there an enrollee Deductible?

☐ Yes
☐ No

Indicate Deductible Amount Tier 1:

Indicate Deductible Amount Tier 2:

Indicate Deductible Amount 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 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:
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 7

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #2 SNF - Base 7

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 8

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #2 SNF - Base 8

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:

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

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

Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

Additional Days Copayment Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:

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

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

Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 9

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #2 SNF - Base 9

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

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

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

Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

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:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 10

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19A #2 SNF - Base 10

Previous Next Exit (Validate) Exit (No Validate)

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

SNF Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

#19b Additional Benefits for VBIDS

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: #19b Additional Benefits for VBIDS

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does your VBID benefit offer additional Part C benefits?

☐ Yes
☐ No

How many packages do your Additional Benefits contain? (1-15)

CY 2017 PBP Data Entry System Screens

#19b Additional Benefits for VBIDS – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: #19b Additional Benefits for VBIDS - Base 1

Previous Next Exit (Validate) Exit (No Validate)

Which disease states does this benefit apply? (Select all that apply):

- ☐ Diabetes
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF)
- ☐ Patient with Past Stroke
- ☐ Hypertension
- ☐ Coronary Heart Disease
- ☐ Mood Disorders

Is there a prerequisite for any additional benefits for this package?

☐ Yes

☐ No

Which prerequisites are required for this package?

- ☐ High value provider
- ☐ Participation in a Wellness Program
- ☐ Other, Describe

Select all the Non-Medicare-covered additional benefits offered in this package:

- 1a: Inpatient Hospital Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3: Cardiac and Pulmonary Rehabilitation Services
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 10b: Transportation Services
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 13g: Dual Eligible SNP with Highly Integrated Services
- 14b: Annual Physical Exam
- 14c: Eligible Supplemental Benefits as Defined in Chapter 4
- 16a: Preventive Dental
- 16b: Comprehensive Dental
- 17a: Eye Exams
- 17b: Eyewear
- 18a: Hearing Exams
- 18b: Hearing Aids

CY 2017 PBP Data Entry System Screens

#19b Additional Benefits for VBIDS – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: #19b Additional Benefits for VBIDS - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Do the benefits in this package apply to OON/POS?

☐ Yes
☐ No

Are any benefits exempt from the plan level deductible?

☐ Yes
☐ No

Select all the Non-Medicare-covered additional benefits offered in this package:

- 1a: Inpatient Hospital Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3: Cardiac and Pulmonary Rehabilitation Services
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 10b: Transportation Services
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 13g: Dual Eligible SNP with Highly Integrated Services
- 14b: Annual Physical Exam
- 14c: Eligible Supplemental Benefits as Defined in Chapter 4
- 16a: Preventive Dental
- 16b: Comprehensive Dental
- 17a: Eye Exams
- 17b: Eyewear
- 18a: Hearing Exams
- 18b: Hearing Aids

CY 2017 PBP Data Entry System Screens

#19b Additional Benefits for VBIDS – Notes

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: #19b Additional Benefits for VBIDS - Notes

Previous Next Exit (Validate) Exit (No Validate)

Please describe any additional measures taken to reduce cost sharing, and/or other pertinent information regarding how the VBID program is administered to Beneficiaries

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute – Base 1

Previous Next Exit (Validate) Exit (No Validate)

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 Non-Medicare-covered stay:

☐ Mandatory
☐ Optional

Select type of benefit for Upgrades:

☐ Mandatory
☐ Optional

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:

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute – Base 2

Previous Next Exit (Validate) Exit (No Validate)

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 Medicare-covered benefit costsharing vary by hospital(s) in which an enrollee obtains care?

☐ Yes
☐ No

How many costsharing tiers do you offer?

What is your lowest cost tier?

☐ Tier 1
☐ Tier 2
☐ Tier 3

What is your inpatient hospital benefit period?

☐ Original Medicare
☐ Annual
☐ Per Admission
☐ Other, describe

If "Other, Describe" is selected enter description below:

Do you charge cost sharing on the day of discharge?

☐ Yes
☐ No

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	Begin Day Interval	End Day Interval

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute – Base 3

Previous Next Exit (Validate) Exit (No Validate)

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):

Coinurance % Interval 1	Begin Day Interval 1	End Day Interval 1:
Coinurance % Interval 2	Begin Day Interval 2	End Day Interval 2:
Coinurance % 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):

Coinurance % Interval 1	Begin Day Interval 1	End Day Interval 1:
Coinurance % Interval 2	Begin Day Interval 2	End Day Interval 2:
Coinurance % Interval 3	Begin Day Interval 3	End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Medicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime 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 number of day intervals for the Medicare-covered Lifetime Reserve Days: ☐ Zero (No Coinsurance per Day) ☐ One ☐ Two ☐ Three	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: ☐ Zero (No Coinsurance per Day) ☐ One ☐ Two ☐ Three																																																
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CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute - Base 5

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Additional Days cost sharing vary by hospital(s) in which 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

Additional Days Coinsurance Cost Sharing for Tier 1:

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):

Coinurance % Interval 1 Begin Day Interval 1: End Day Interval 1:

Coinurance % Interval 2 Begin Day Interval 2: End Day Interval 2:

Coinurance % Interval 3 Begin Day Interval 3: End Day Interval 3:

Additional Days Coinsurance Cost Sharing for Tier 2:

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):

Coinurance % Interval 1 Begin Day Interval 1: End Day Interval 1:

Coinurance % Interval 2 Begin Day Interval 2: End Day Interval 2:

Coinurance % Interval 3 Begin Day Interval 3: End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 6

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute – Base 6

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Coinsurance Cost Sharing for Tier 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., 91 to 999):

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:
[] [] []

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:
[] [] []

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

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

Indicate Coinsurance percentage for Upgrades:
[]

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 7

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute - Base 7

Previous Next Exit (Validate) Exit (No Validate)

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.
MA Organizations are not permitted to tier deductibles.

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

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 8

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute - Base 8

Previous Next Exit (Validate) Exit (No Validate)

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:

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 9

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute – Base 9

Previous Next Exit (Validate) Exit (No Validate)

Medicare-covered Lifetime Reserve Days Tier 1 Medicare-covered Lifetime Reserve Days Tier 2 Medicare-covered Lifetime 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	Interval Days		
	Copay Amount	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 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	Interval Days		
	Copay Amount	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 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	Interval Days		
	Copay Amount	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 3:			

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 10

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute - Base 10

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 1:

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:

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

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

Additional Days Copayment Cost Sharing for Tier 2:

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:

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

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

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 11

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute - Base 11

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

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

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

Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

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:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

CY 2017 PBP Data Entry System Screens

VBID 19B #1a Inpatient Hospital-Acute – Base 12

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1a Inpatient Hospital-Acute - Base 12

Previous Next Exit (Validate) Exit (No Validate)

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

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:

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

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 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

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Medicare-covered benefit costsharing vary by hospital(s) in which an enrollee obtains care?

☐ Yes
☐ No

How many costsharing tiers do you offer?

What is your lowest cost tier?

☐ Tier 1
☐ Tier 2
☐ Tier 3

What is your inpatient hospital benefit period?

☐ Original Medicare
☐ Annual
☐ Per Admission
☐ Other, describe

If "Other, Describe" is selected enter description below:

Do you charge cost sharing on the day of discharge?

☐ Yes
☐ No

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:
Coinurance % Interval 2	Begin Day Interval 2:	End Day Interval 2:
Coinurance % Interval 3	Begin Day Interval 3:	End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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):

Coinurance % Interval 1	Begin Day Interval 1:	End Day Interval 1:
Coinurance % Interval 2	Begin Day Interval 2:	End Day Interval 2:
Coinurance % 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):

Coinurance % Interval 1	Begin Day Interval 1:	End Day Interval 1:
Coinurance % Interval 2	Begin Day Interval 2:	End Day Interval 2:
Coinurance % Interval 3	Begin Day Interval 3:	End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Medicare-covered Lifetime 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):

Interval Days	Interval Days		
	Coinsurance %	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 3:			

Medicare-covered Lifetime 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):

Interval Days	Interval Days		
	Coinsurance %	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 3:			

Medicare-covered Lifetime 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):

Interval Days	Interval Days		
	Coinsurance %	Begin Day	End Day
Interval 1:			
Interval 2:			
Interval 3:			

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 5

Previous Next Exit (Validate) Exit (No Validate)

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

☐ Yes
☐ No

How many costsharing tiers do you offer?

What is your lowest cost tier?

☐ Tier 1
☐ Tier 2
☐ Tier 3

Additional Days Coinsurance Cost Sharing for Tier 1:

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:

Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:

Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:

Additional Days Coinsurance Cost Sharing for Tier 2:

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:

Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:

Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 6

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 6

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Coinsurance Cost Sharing for Tier 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., 91 to 999):

Coinurance % Interval 1: Begin Day Interval 1: End Day Interval 1:
[] [] []

Coinurance % Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Coinurance % Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

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:
[] [] []

Coinurance % Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Coinurance % Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 7

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 7

Previous Next Exit (Validate) Exit (No Validate)

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.
MA Organizations are not permitted to tier deductibles.

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:
[]	[]	[]
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
[]	[]	[]
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
[]	[]	[]

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 8

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 8

Previous Next Exit (Validate) Exit (No Validate)

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:

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 9

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 9

Previous Next Exit (Validate) Exit (No Validate)

Medicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime 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:																																																												
☐ Zero (No Copayment per Day) ☐ One ☐ Two ☐ Three	☐ Zero (No Copayment per Day) ☐ One ☐ Two ☐ Three	☐ Zero (No Copayment per Day) ☐ One ☐ Two ☐ Three																																																												
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CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 10

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 10

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 1:

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

Additional Days Copayment Cost Sharing for Tier 2:

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

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 11

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 11

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

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

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

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

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

CY 2017 PBP Data Entry System Screens

VBID 19B #1b Inpatient Hospital Psychiatric – Base 12

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 12

Previous Next Exit (Validate) Exit (No Validate)

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

Inpatient Hospital Psychiatric Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #2 SNF - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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 (MMP Only)

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.

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

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #2 SNF - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility 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

What is your SNF benefit period?

☐ Original Medicare
☐ Annual
☐ Per Admission
☐ Other, describe

If "Other, Describe" is selected enter description below:

Do you charge cost sharing on the day of discharge?

☐ Yes
☐ No

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 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):

Coinurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
Coinurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
Coinurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #2 SNF - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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 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):

Coinurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
Coinurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
Coinurance % 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 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):

Coinurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
Coinurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
Coinurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #2 SNF - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Additional Days cost sharing vary by hospital(s) in which 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

Additional Days Coinsurance Cost Sharing for Tier 1:

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:

Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:

Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

Additional Days Coinsurance Cost Sharing for Tier 2:

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:

Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:

Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #2 SNF - Base 5

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Coinsurance Cost Sharing for Tier 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):

Coinurance % Interval 1: Begin Day Interval 1: End Day Interval 1:

Coinurance % Interval 2: Begin Day Interval 2: End Day Interval 2:

Coinurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

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:

Coinurance % Interval 2: Begin Day Interval 2: End Day Interval 2:

Coinurance % Interval 3: Begin Day Interval 3: End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 6

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #2 SNF - Base 6

Previous Next Exit (Validate) Exit (No Validate)

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.
MA Organizations are not permitted to tier deductibles.

Is there an enrollee Deductible?
☐ Yes
☐ No

Indicate Deductible Amount Tier 1:

Indicate Deductible Amount Tier 2:

Indicate Deductible Amount 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 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:
Copayment Amt Interval 2:	Begin Day Interval 2:	End Day Interval 2:
Copayment Amt Interval 3:	Begin Day Interval 3:	End Day Interval 3:

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 7

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #2 SNF - Base 7

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 8

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #2 SNF - Base 8

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:

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

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

Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

Additional Days Copayment Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:

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

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

Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 9

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #2 SNF - Base 9

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

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

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

Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

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:
[] [] []

Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:
[] [] []

Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:
[] [] []

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 10

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #2 SNF - Base 10

Previous Next Exit (Validate) Exit (No Validate)

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

SNF Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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:		
Indicate Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services:		
Indicate Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:		
Indicate Coinsurance percentage for Additional Cardiac Rehabilitation Services:		
Indicate Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:		
Indicate Coinsurance percentage for Additional Pulmonary Rehabilitation Services:		

CY 2017 PBP Data Entry System Screens

VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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:		
Indicate Copayment amount for Medicare-covered Intensive Cardiac Rehabilitation Services:		
Indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services:		
Indicate Copayment amount for Additional Cardiac Rehabilitation Services:		
Indicate Copayment amount for Additional Intensive Cardiac Rehabilitation Services:		
Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:		

CY 2017 PBP Data Entry System Screens

VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services - Base 4

Previous Next Exit (Validate) Exit (No Validate)

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 Services Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #4c Worldwide Emergency/Urgent Coverage – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #4c Worldwide Emergency/Urgent Coverage - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

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

☐ Yes
☐ No

Select type of benefit for Worldwide Emergency/Urgent Coverage:

☐ Mandatory
☐ Optional

Does this benefit include emergency transportation? If yes, describe the benefit in the notes.

☐ Yes
☐ No

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

☐ Yes
☐ No

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

☐ Yes
☐ No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Enrollee Out-of-Pocket Cost:

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

CY 2017 PBP Data Entry System Screens

VBID 19B #4c Worldwide Emergency/Urgent Coverage – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #4c Worldwide Emergency/Urgent Coverage - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?

☐ Yes
☐ No

Indicate Minimum Coinsurance percentage for Worldwide Emergency/Urgent Coverage:

Indicate Maximum Coinsurance percentage for Worldwide Emergency/Urgent Coverage:

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

☐ Yes
☐ No

Is there an enrollee Copayment?

☐ Yes
☐ No

Indicate Minimum Copayment amount for Worldwide Emergency/Urgent Coverage:

Indicate Maximum Copayment amount for Worldwide Emergency/Urgent Coverage:

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

☐ Yes
☐ No

Is there an enrollee Deductible?

☐ Yes
☐ No

Indicate Deductible Amount:

CY 2017 PBP Data Entry System Screens

VBID 19B #4c Worldwide Emergency/Urgent Coverage – Base 3

The screenshot shows a web-based data entry application. The title bar reads "PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File", "Help", and "Add Variable". Below the menu is a toolbar with buttons for "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "VBID 19B #4c Worldwide Emergency/Urgent Coverage - Base 3". The main content area contains the following text:

Authorization is not applicable for this Service Category.

Referral is not applicable for this Service Category.

Worldwide Emergency/Urgent Coverage Notes

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

Notes:

Below the "Notes:" label is a large, empty text area with a vertical scrollbar on the right side.

CY 2017 PBP Data Entry System Screens

VBID 19B #7b Chiropractic Services – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #7b Chiropractic Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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/Other

Select type of benefit for Routine Care/Other:

☐ Mandatory
☐ Optional

Is this benefit unlimited for Routine Care/Other?

☐ Yes
☐ No, indicate number

Indicate number of visits for Routine Care/Other:

Do you offer a combined Acupuncture and Chiropractor Services benefit?

☐ Yes
☐ No

Select Routine Care/Other 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

CY 2017 PBP Data Entry System Screens

VBID 19B #7b Chiropractic Services – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #7b Chiropractic Services – Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?

☐ Yes
☐ No

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

☐ Medicare-covered Chiropractic Services
☐ Routine Care/Other

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/Other:

Indicate the Maximum Coinsurance percentage per visit for Routine Care/Other:

CY 2017 PBP Data Entry System Screens

VBID 19B #7b Chiropractic Services – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #7b Chiropractic Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?

☐ Yes
☐ No

Indicate Deductible Amount:

Indicate Minimum Copayment amount per visit for Routine Care/Other:

Indicate Maximum Copayment amount per visit for Routine Care/Other:

Is there an enrollee Copayment?

☐ Yes
☐ No

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

☐ Medicare-covered Chiropractic Services
☐ Routine Care/Other

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 Chiropractic Services?

☐ Yes
☐ No

CY 2017 PBP Data Entry System Screens

VBID 19B #7b Chiropractic Services – Base 4

The screenshot shows a web-based data entry application. The title bar reads "PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000". The menu bar includes "File", "Help", and "Add Variable". The toolbar contains four buttons: "Previous" (left arrow), "Next" (right arrow), "Exit (Validate)" (green checkmark), and "Exit (No Validate)" (red X). A "Go To:" dropdown menu is set to "VBID 19B #7b Chiropractic Services - Base 4".

Chiropractic Services Notes

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

Notes:

A large, empty text area with a vertical scrollbar is provided for entering notes.

CY 2017 PBP Data Entry System Screens

VBID 19B #7f Podiatry Services – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #7f Podiatry Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

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

☐ Yes
☐ No

Select enhanced benefits:

☐ Routine Foot Care

Select type of benefit for Routine Foot Care:

☐ Mandatory
☐ Optional

Is this benefit unlimited for Routine Foot Care?

☐ Yes
☐ No

Indicate number of Routine Foot Care visits:

Select the Routine Foot 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

CY 2017 PBP Data Entry System Screens

VBID 19B #7f Podiatry Services – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #7f Podiatry Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?

☐ Yes
☐ No

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

☐ Medicare-covered Podiatry Services
☐ Routine Foot Care

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Foot Care:

Indicate Maximum Coinsurance percentage for Routine Foot Care:

Is there an enrollee Copayment?

☐ Yes
☐ No

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

☐ Medicare-covered Podiatry Services
☐ Routine Foot Care

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 Foot Care:

Indicate Maximum Copayment amount per visit for Routine Foot Care:

Is there an enrollee Deductible?

☐ Yes
☐ No

Indicate Deductible Amount:

CY 2017 PBP Data Entry System Screens

VBID 19B #7f Podiatry Services – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #7f Podiatry Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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

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

Is a referral required for Podiatrist Services?

☐ Yes

☐ No

Podiatry Services Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #9d Outpatient Blood Services – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #9d Outpatient Blood Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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 Minimum Coinsurance percentage per unit for Medicare-covered Benefits:

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

CY 2017 PBP Data Entry System Screens

VBID 19B #9d Outpatient Blood Services – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #9d Outpatient Blood Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?

☐ Yes
☐ No

Indicate Deductible Amount:

Is there an enrollee Copayment?

☐ Yes
☐ No

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

Indicate Maximum 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

Outpatient Blood Services Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #10b Transportation Services – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #10b Transportation Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

Indicate number of trips for Any Location:

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

CY 2017 PBP Data Entry System Screens

VBID 19B #10b Transportation Services – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #10b Transportation Services – Base 2

Previous Next Exit (Validate) Exit (No Validate)

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 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: Indicate Maximum Coinsurance percentage: Is there an enrollee Deductible? ☐ Yes ☐ No Indicate Deductible Amount:
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CY 2017 PBP Data Entry System Screens

VBID 19B #10b Transportation Services – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #10b Transportation Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?

☐ Yes

☐ No

Indicate Minimum Copayment amount per trip:

Indicate Maximum 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

Transportation Services Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #13a Acupuncture – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13a Acupuncture - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Acupuncture 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:

Do you offer a combined Acupuncture and Chiropractor Services benefit?

☐ Yes
☐ No

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

CY 2017 PBP Data Entry System Screens

VBID 19B #13a Acupuncture – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13a Acupuncture - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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 per treatment:

Indicate Maximum Copayment amount per treatment:

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?

☐ Yes
☐ No

CY 2017 PBP Data Entry System Screens

VBID 19B #13a Acupuncture – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Previous Next Exit (Validate) Exit (No Validate) Go To: VBID 19B #13a Acupuncture - Base 3

Acupuncture Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #13b OTC Items – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13b OTC Items - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Medicare-Medicaid plans may not use this section to provide benefit information about any OTC 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 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 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

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

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?

☐ Yes
☐ No

CY 2017 PBP Data Entry System Screens

VBID 19B #13b OTC Items – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13b OTC Items - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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:

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.

CY 2017 PBP Data Entry System Screens

VBID 19B #13b OTC Items – Base 3

The screenshot displays the 'PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000' window. The interface includes a menu bar with 'File', 'Help', and 'Add Variable'. Below the menu is a toolbar with 'Previous', 'Next', 'Exit (Validate)', and 'Exit (No Validate)' buttons. A 'Go To:' dropdown menu is set to 'VBID 19B #13b OTC Items - Base 3'. The main area is titled 'OTC Items Notes' and contains a text box with the instruction: 'Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.' Below this is a large, empty text area for notes.

CY 2017 PBP Data Entry System Screens

VBID 19B #13c Meal Benefit – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13c Meal Benefit - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide a Meal Benefit as a supplemental benefit under Part C?

☐ Yes
☐ No

Select type of benefit:

☐ Mandatory
☐ Optional

How many days does your Meal Benefit last?

What is the maximum number of meals the benefit provides?

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

CY 2017 PBP Data Entry System Screens

VBID 19B #13c Meal Benefit – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13c Meal Benefit - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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 the Meal Benefit?
☐ Yes
☐ No

CY 2017 PBP Data Entry System Screens

VBID 19B #13c Meal Benefit – Base 3

The screenshot displays the 'PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000' window. The interface includes a menu bar with 'File', 'Help', and 'Add Variable'. Below the menu bar is a toolbar with 'Previous' and 'Next' navigation buttons, 'Exit (Validate)' and 'Exit (No Validate)' buttons, and a 'Go To:' dropdown menu currently set to 'VBID 19B #13c Meal Benefit - Base 3'. The main content area is titled 'Meal Benefit Notes' and contains the instruction: 'Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.' Below this instruction is a large, empty text box labeled 'Notes:' for data entry.

CY 2017 PBP Data Entry System Screens

VBID 19B #13d Other 1 – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13d Other 1 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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 homehealth, 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

CY 2017 PBP Data Entry System Screens

VBID 19B #13d Other 1 – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13d Other 1 – Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #13d Other 1 – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13d Other 1 – Base 3

Previous Next Exit (Validate) Exit (No Validate)

Other 1 Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #13e Other 2 – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13e Other 2 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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 homehealth, 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

CY 2017 PBP Data Entry System Screens

VBID 19B #13e Other 2 – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13e Other 2 – Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #13e Other 2 – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13e Other 2 – Base 3

Previous Next Exit (Validate) Exit (No Validate)

Other 2 Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #13f Other 3 – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13f Other 3 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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 homehealth, 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

CY 2017 PBP Data Entry System Screens

VBID 19B #13f Other 3 – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #13f Other 3 - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #13f Other 3 – Base 3

The screenshot shows a web-based data entry application. The title bar reads "PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File", "Help", and "Add Variable". Below the menu is a toolbar with four buttons: "Previous" (left arrow), "Next" (right arrow), "Exit (Validate)" (green checkmark), and "Exit (No Validate)" (red X). To the right of these buttons is a "Go To:" label followed by a dropdown menu currently displaying "VBID 19B #13f Other 3 - Base 3". The main content area is divided into two sections. The top section is labeled "Other 3 Notes:" and contains a single line of instructional text: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." The bottom section is labeled "Notes:" and features a large, empty text area with a vertical scrollbar on the right side.

CY 2017 PBP Data Entry System Screens

VBID 19B #14b Annual Physical Exam – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14b Annual Physical Exam - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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:

CY 2017 PBP Data Entry System Screens

VBID 19B #14b Annual Physical Exam – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14b Annual Physical Exam - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?

☐ Yes
☐ No

Indicate Minimum Coinsurance percentage for each Annual Physical Exam:

Indicate Maximum Coinsurance percentage for each Annual Physical Exam:

Is there an enrollee Deductible?

☐ Yes
☐ No

Indicate Deductible Amount:

Is there an enrollee Copayment?

☐ Yes
☐ No

Indicate Minimum Copayment amount for each Annual Physical Exam:

Indicate Maximum Copayment amount for each Annual Physical Exam:

CY 2017 PBP Data Entry System Screens

VBID 19B #14b Annual Physical Exam – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14b Annual Physical Exam - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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

Annual Physical Exam Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 1

Previous Next Exit (Validate) Exit (No Validate)

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/Dietary Benefit
- Additional sessions of Smoking and Tobacco Cessation Counseling
- Fitness Benefit*
- Enhanced Disease Management
- Telemonitoring Services*
- Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)*
- Bathroom Safety Devices*
- Counseling Services
- In-Home Safety Assessment
- Personal Emergency Response System (PERS)
- Medical Nutrition Therapy (MNT)
- Post discharge In-home Medication Reconciliation
- Re-admission Prevention
- Wigs for Hair Loss Related to Chemotherapy
- Weight Management Programs*
- Alternative Therapies*

* = A note is required when this benefit is offered.

Select type of benefit for Health Education:

☐ Mandatory
☐ Optional

Select type of benefit for Nutritional/Dietary Benefit:

☐ Mandatory
☐ Optional

Is this benefit unlimited for Nutritional/Dietary Benefit?

☐ Yes
☐ No, indicate number

Indicate number of visits for Nutritional/Dietary Benefit:

Indicate setting for Nutritional/Dietary Benefit:

☐ Individual Sessions
☐ Group Sessions
☐ Both Sessions (Individual and Group)

Select type of benefit for Additional sessions of Smoking and Tobacco Cessation Counseling:

☐ Mandatory
☐ Optional

Indicate number of visits offered in addition to Medicare:

Select type of benefit for Fitness Benefit:

☐ Mandatory
☐ Optional

Select type of benefit for Enhanced Disease Management:

☐ Mandatory
☐ Optional

Select type of benefit for Telemonitoring Services:

☐ Mandatory
☐ Optional

Select type of benefit for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline):

☐ Mandatory
☐ Optional

Select type of benefit for Bathroom Safety Devices:

☐ Mandatory
☐ Optional

Select type of benefit for Counseling Services:

☐ Mandatory
☐ Optional

Is this benefit unlimited for Counseling Services?

☐ Yes
☐ No, indicate number

Indicate number of visits for Counseling Services:

Indicate setting for Counseling Services:

☐ Individual Sessions
☐ Group Sessions
☐ Both Sessions (Individual and Group)

Indicate duration of sessions (in minutes):

Select type of benefit for In-Home Safety Assessment:

☐ Mandatory
☐ Optional

Select type of benefit for Personal Emergency Response System (PERS):

☐ Mandatory
☐ Optional

CY 2017 PBP Data Entry System Screens

VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 2

Previous Next Exit (Validate) Exit (No Validate)

Select type of benefit for Medical Nutrition Therapy (MNT):

☐ Mandatory
☐ Optional

Do you offer Additional Sessions for Medicare-covered diseases?

☐ Yes
☐ No

Indicate the limit for Additional Sessions:

☐ Visits
☐ Hours

Indicate numerical limit on the services provided for Additional Sessions:

Do you offer Coverage for non-Medicare-covered diseases? (Specify the diseases and describe the coverage in the notes field)

☐ Yes
☐ No

Indicate units a limit will be provided in for Coverage for non-Medicare covered diseases:

☐ Visits
☐ Hours

Indicate numerical limit on the services provided for Coverage for non-Medicare covered diseases:

Select type of benefit for Post discharge In-home Medication Reconciliation:

☐ Mandatory
☐ Optional

Select type of benefit for Re-admission Prevention:

☐ Mandatory
☐ Optional

What does your Re-admission Prevention benefit include (check all that apply):

☐ Meals
☐ Medication Reconciliation
☐ In-Home Safety Assessment
☐ Other, Describe

Enter name of Service:

Please describe the Meal benefit included in Re-admission Prevention:

How many days does your Meal Benefit last?

What is the maximum number of meals the benefit provides?

Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:

☐ Mandatory
☐ Optional

Select type of benefit for Weight Management Programs:

☐ Mandatory
☐ Optional

Select type of benefit for Alternative Therapies:

☐ Mandatory
☐ Optional

Indicate number of visits offered for Alternative Therapies:

CY 2017 PBP Data Entry System Screens

VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there a service-specific Maximum Plan Benefit Coverage amount for Eligible Supplemental Benefits as Defined in Chapter 4?

☐ Yes
☐ No

Select which Eligible Supplemental Benefits as Defined in Chapter 4 have a Maximum Plan Benefit Coverage amount (Select all that apply):

- Health Education
- Nutritional/Dietary Benefit
- Additional sessions of Smoking and Tobacco Cessation Counseling
- Fitness Benefit
- Enhanced Disease Management
- Telemonitoring Services
- Remote Access Technologies (including Web/Phone based technologies)
- Bathroom Safety Devices
- Counseling Services
- In-Home Safety Assessment
- Personal Emergency Response System (PERS)
- Medical Nutrition Therapy (MNT)
- Post discharge In-home Medication Reconciliation
- Re-admission Prevention
- Wigs for Hair Loss Related to Chemotherapy
- Weight Management Programs

Indicate Maximum Plan Benefit Coverage amount for Health Education:

Select Maximum Plan Benefit Coverage periodicity for Health Education:

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

Indicate Maximum Plan Benefit Coverage amount for Nutritional/Dietary Benefit:

Select Maximum Plan Benefit Coverage periodicity for Nutritional/Dietary Benefit:

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

Indicate Maximum Plan Benefit Coverage amount for Additional sessions of Smoking and Tobacco Cessation Counseling:

Select Maximum Plan Benefit Coverage periodicity for Additional sessions of Smoking and Tobacco Cessation Counseling:

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

Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:

Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:

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

Indicate Maximum Plan Benefit Coverage amount for Enhanced Disease Management:

Select Maximum Plan Benefit Coverage periodicity for Enhanced Disease Management:

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

Indicate Maximum Plan Benefit Coverage amount for Telemonitoring Services:

Select Maximum Plan Benefit Coverage periodicity for Telemonitoring Services:

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

Indicate Maximum Plan Benefit Coverage amount for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline):

Select Maximum Plan Benefit Coverage periodicity for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline):

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

Indicate Maximum Plan Benefit Coverage amount for Bathroom Safety Devices:

Select Maximum Plan Benefit Coverage periodicity for Bathroom Safety Devices:

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

Indicate Maximum Plan Benefit Coverage amount for Counseling Services:

Select Maximum Plan Benefit Coverage periodicity for Counseling Services:

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

Indicate Maximum Plan Benefit Coverage amount for In-Home Safety Assessment:

Select Maximum Plan Benefit Coverage periodicity for In-Home Safety Assessment:

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

CY 2017 PBP Data Entry System Screens

VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Indicate Maximum Plan Benefit Coverage amount for Personal Emergency Response System (PERS): 	Indicate Maximum Plan Benefit Coverage amount for Re-admission Prevention: 	Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:
Select Maximum Plan Benefit Coverage periodicity for Personal Emergency Response System (PERS): ☐ Every three years ☐ Every two years ☐ Every year ☐ Every six months ☐ Every three months ☐ Other, Describe	Select Maximum Plan Benefit Coverage periodicity for Re-admission Prevention: ☐ Every three years ☐ Every two years ☐ Every year ☐ Every six months ☐ Every three months ☐ Other, Describe	Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies: ☐ Every three years ☐ Every two years ☐ Every year ☐ Every six months ☐ Every three months ☐ Other, Describe
Indicate Maximum Plan Benefit Coverage amount for Medical Nutrition Therapy (MNT): 	Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy: 	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Eligible Supplemental Benefits as Defined in Chapter 4? ☐ Yes ☐ No
Select Maximum Plan Benefit Coverage periodicity for Medical Nutrition Therapy (MNT): ☐ Every three years ☐ Every two years ☐ Every year ☐ Every six months ☐ Every three months ☐ Other, Describe	Select Maximum Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy: ☐ Every three years ☐ Every two years ☐ Every year ☐ Every six months ☐ Every three months ☐ Other, Describe	Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Indicate Maximum Plan Benefit Coverage amount for Post discharge In-home Medication Reconciliation: 	Indicate Maximum Plan Benefit Coverage amount for Weight Management Programs: 	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
Select Maximum Plan Benefit Coverage periodicity for Post discharge In-home Medication Reconciliation: ☐ Every three years ☐ Every two years ☐ Every year ☐ Every six months ☐ Every three months ☐ Other, Describe	Select Maximum Plan Benefit Coverage periodicity for Weight Management Programs: ☐ Every three years ☐ Every two years ☐ Every year ☐ Every six months ☐ Every three months ☐ Other, Describe	

CY 2017 PBP Data Entry System Screens

VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 5

Previous Next Exit (Validate) Exit (No Validate)

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/Dietary Benefit
- Additional sessions of Smoking and Tobacco Cessation Counseling
- Fitness Benefit
- Enhanced Disease Management
- Telemonitoring Services
- Remote Access Technologies (including Web/Phone based technologies)
- Bathroom Safety Devices
- Counseling Services
- In-Home Safety Assessment
- Personal Emergency Response System (PERS)
- Medical Nutrition Therapy (MNT)
- Post discharge In-home Medication Reconciliation
- Re-admission Prevention
- Wigs for Hair Loss Related to Chemotherapy

Indicate Minimum Coinsurance percentage for Fitness Benefit:

Indicate Maximum Coinsurance percentage for Fitness Benefit:

Indicate Minimum Coinsurance percentage for Enhanced Disease Management:

Indicate Maximum Coinsurance percentage for Enhanced Disease Management:

Indicate Minimum Coinsurance percentage for Enhanced Disease Management:

Indicate Maximum Coinsurance percentage for Enhanced Disease Management:

Indicate Minimum Coinsurance percentage for Telemonitoring Services:

Indicate Maximum Coinsurance percentage for Telemonitoring Services:

Indicate Minimum Coinsurance percentage for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline):

Indicate Maximum Coinsurance percentage for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline):

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 Medical Nutrition Therapy (MNT):

Indicate Maximum Coinsurance percentage for 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.

CY 2017 PBP Data Entry System Screens

VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 6

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 6

Previous Next Exit (Validate) Exit (No Validate)

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/Dietary Benefit
- Additional sessions of Smoking and Tobacco Cessation Counseling
- Fitness Benefit
- Enhanced Disease Management
- Telemonitoring Services
- Remote Access Technologies (including Web/Phone based technologies)
- Bathroom Safety Devices
- Counseling Services
- In-Home Safety Assessment
- Personal Emergency Response System (PERS)
- Medical Nutrition Therapy (MNT)
- Post discharge In-home Medication Reconciliation
- Re-admission Prevention
- Wigs for Hair Loss Related to Chemotherapy
- Weight Management Programs
- Alternative Therapies

Indicate Minimum Copayment amount for Health Education:

Indicate Maximum Copayment amount for Health Education:

Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:

Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:

Indicate Minimum Copayment amount for Additional sessions of Smoking and Tobacco Cessation Counseling:

Indicate Maximum Copayment amount for Additional sessions of Smoking and Tobacco Cessation Counseling:

Indicate Minimum Copayment amount for Fitness Benefit:

Indicate Maximum Copayment amount for Fitness Benefit:

Indicate Minimum Copayment amount for Enhanced Disease Management:

Indicate Maximum Copayment amount for Enhanced Disease Management:

Indicate Minimum Copayment amount for Telemonitoring Services:

Indicate Maximum Copayment amount for Telemonitoring Services:

Indicate Minimum Copayment amount for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline):

Indicate Maximum Copayment amount for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline):

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 Medical Nutrition Therapy (MNT):

Indicate Maximum Copayment amount for 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:

Indicate Minimum Copayment amount for Weight Management Programs:

Indicate Maximum Copayment amount for Weight Management Programs:

Indicate Minimum Copayment amount for Alternative Therapies:

Indicate Maximum Copayment amount for Alternative Therapies:

CY 2017 PBP Data Entry System Screens

VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 7

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 7

Previous Next Exit (Validate) Exit (No Validate)

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.

* = This notes field is required when the corresponding benefit is offered.

Health Education Notes:

Nutritional/Dietary Benefit Notes:

Additional sessions of Smoking and Tobacco Cessation Counseling Notes:

Fitness Benefit Notes:*

Enhanced Disease Management Notes:

Telemonitoring Services Notes:*

CY 2017 PBP Data Entry System Screens

VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 8

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 8

Previous Next Exit (Validate) Exit (No Validate)

Remote Access Technology (including Web/Phone based technologies and Nursing Hotline) Notes:*

Bathroom Safety Devices Notes:*

Counseling Services Notes:

In-Home Safety Assessment Notes:

Personal Emergency Response System (PERS) Notes:

Medical Nutrition Therapy (MNT) Notes:

Post discharge In-home Medication Reconciliation Notes:

Re-admission Prevention Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 9

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Previous Next Exit (Validate) Exit (No Validate) Go To: VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 9

Wigs for Hair Loss Related to Chemotherapy Notes:

Weight Management Notes:.*

Alternative Therapies Notes:.*

CY 2017 PBP Data Entry System Screens

VBID 19B #16a Preventive Dental – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16a Preventive Dental - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #16a Preventive Dental – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16a Preventive Dental - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Select type of benefit for Dental X-Rays:

☐ Mandatory

☐ Optional

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

☐ Yes

☐ No

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

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

CY 2017 PBP Data Entry System Screens

VBID 19B #16a Preventive Dental – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16a Preventive Dental - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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:
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CY 2017 PBP Data Entry System Screens

VBID 19B #16a Preventive Dental – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16a Preventive Dental - Base 4

Previous Next Exit (Validate) Exit (No Validate)

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:

CY 2017 PBP Data Entry System Screens

VBID 19B #16a Preventive Dental – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16a Preventive Dental - Base 5

Previous Next Exit (Validate) Exit (No Validate)

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

Preventive Dental Services Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #16b Comprehensive – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16b Comprehensive Dental - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

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

Select type of benefit for Diagnostic Services:

☐ Mandatory
☐ Optional

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

CY 2017 PBP Data Entry System Screens

VBID 19B #16b Comprehensive – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16b Comprehensive Dental - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Select type of benefit for Restorative Services: ☐ Mandatory ☐ Optional	Select type of benefit for Endodontics/Periodontics/Extractions: ☐ Mandatory ☐ Optional	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: ☐ Mandatory ☐ Optional
Is this benefit unlimited for Restorative Services? ☐ Yes ☐ No, indicate number	Is this benefit unlimited for Endodontics/Periodontics/Extractions? ☐ Yes ☐ No, indicate number	Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services? ☐ Yes ☐ No, indicate number
Indicate number of visits for Restorative Services:	Indicate number of visits for Endodontics/Periodontics/Extractions:	Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:
Select the Restorative Services periodicity: ☐ Every three years ☐ Every two years ☐ Every year ☐ Every six months ☐ Every three months ☐ Other, Describe	Select the Endodontics/Periodontics/Extractions periodicity: ☐ Every three years ☐ Every two years ☐ Every year ☐ Every six months ☐ Every three months ☐ Other, Describe	Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity: ☐ Every three years ☐ Every two years ☐ Every year ☐ Every six months ☐ Every three months ☐ Other, Describe

CY 2017 PBP Data Entry System Screens

VBID 19B #16b Comprehensive – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16b Comprehensive Dental - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #16b Comprehensive – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16b Comprehensive Dental - Base 4

Previous Next Exit (Validate) Exit (No Validate)

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:

CY 2017 PBP Data Entry System Screens

VBID 19B #16b Comprehensive – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16b Comprehensive Dental - Base 5

Previous Next Exit (Validate) Exit (No Validate)

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:

CY 2017 PBP Data Entry System Screens

VBID 19B #16b Comprehensive – Base 6

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #16b Comprehensive Dental - Base 6

Previous Next Exit (Validate) Exit (No Validate)

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

Comprehensive Dental Services Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #17a Eye Exams – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #17a Eye Exams - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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/Other

Select type of benefit for Routine Eye Exams/Other:

☐ Mandatory
☐ Optional

Is this benefit unlimited for Routine Eye Exams/Other?

☐ Yes
☐ No, indicate number

Indicate number of exams for Routine Eye Exams/Other:

Select the Routine Eye Exams/Other 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

CY 2017 PBP Data Entry System Screens

VBID 19B #17a Eye Exams – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #17a Eye Exams - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance? ☐ Yes ☐ No	Is there an enrollee Copayment? ☐ Yes ☐ No
Select which Eye Exams have a Coinsurance (Select all that apply): ☐ Medicare-covered Benefits ☐ Routine Eye Exams/Other	Select which Eye Exams have a Copayment (Select all that apply): ☐ Medicare-covered Benefits ☐ Routine Eye Exams/Other
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Copayment amount for Medicare-covered Benefits:
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Copayment amount for Medicare-covered Benefits:
Indicate Minimum Coinsurance percentage for Routine Eye Exams/Other:	Indicate Minimum Copayment amount per Routine Eye Exams/Other:
Indicate Maximum Coinsurance percentage for Routine Eye Exams/Other:	Indicate Maximum Copayment amount per Routine Eye Exams/Other:
Is there an enrollee Deductible? ☐ Yes ☐ No	
Indicate Deductible Amount:	

CY 2017 PBP Data Entry System Screens

VBID 19B #17a Eye Exams – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #17a Eye Exams - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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

Eye Exams Notes

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

Notes:

CY 2017 PBP Data Entry System Screens

VBID 19B #17b Eyewear – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #17b Eyewear - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #17b Eyewear – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #17b Eyewear - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #17b Eyewear – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #17b Eyewear - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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

☐ Yes
☐ No

Select the Maximum Plan Benefit Coverage type:

☐ Covered under Eye Exams Category 17a
☐ 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

CY 2017 PBP Data Entry System Screens

VBID 19B #17b Eyewear – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #17b Eyewear - Base 4

Previous Next Exit (Validate) Exit (No Validate)

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 Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Eyeglass frames:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Eyeglass frames:

Indicate Minimum Coinsurance percentage for Contact lenses:

Indicate Minimum Coinsurance percentage for Upgrades:

Indicate Maximum Coinsurance percentage for Contact lenses:

Indicate Maximum Coinsurance percentage for Upgrades:

Indicate Minimum Coinsurance percentage for Eyeglasses (lenses and frames):

Indicate Maximum Coinsurance percentage for Eyeglasses (lenses and frames):

Indicate Minimum Coinsurance percentage for Eyeglass lenses:

Indicate Maximum Coinsurance percentage for Eyeglass lenses:

CY 2017 PBP Data Entry System Screens

VBID 19B #17b Eyewear – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #17b Eyewear - Base 5

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?

☐ Yes
☐ No

Indicate Deductible Amount:

Indicate Minimum Copayment amount for Contact lenses:

Indicate Minimum Copayment amount for Eyeglass frames:

Indicate Maximum Copayment amount for Contact lenses:

Indicate Maximum Copayment amount for Eyeglass frames:

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 Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):

Indicate Minimum Copayment amount for Upgrades:

Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):

Indicate Maximum Copayment amount for Upgrades:

Indicate Minimum Copayment amount for Eyeglass lenses:

Indicate Maximum Copayment amount for Eyeglass lenses:

CY 2017 PBP Data Entry System Screens

VBID 19B #17b Eyewear – Base 6

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #17b Eyewear - Base 6

Previous Next Exit (Validate) Exit (No Validate)

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:

CY 2017 PBP Data Entry System Screens

VBID 19B #18a Hearing Exams – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #18a Hearing Exams - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #18a Hearing Exams – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #18a Hearing Exams - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there a service-specific Maximum Plan Benefit Coverage amount? ☐ Yes ☐ No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? ☐ Yes ☐ No	Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:
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 Enrollee Out-of-Pocket Cost amount:	Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:
Indicate Maximum Plan Benefit Coverage 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	Indicate Minimum Coinsurance percentage for Routine Hearing Exams:
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 an enrollee Coinsurance? ☐ Yes ☐ No	Indicate Maximum Coinsurance percentage for Routine Hearing Exams:
Is there an enrollee Deductible? ☐ Yes ☐ No	Select which Hearing Exam Benefits have a Coinsurance (Select all that apply): ☐ Medicare-covered Benefits ☐ Routine Hearing Exams ☐ Fitting/Evaluation for Hearing Aid	Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:
Indicate Deductible Amount:		Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

CY 2017 PBP Data Entry System Screens

VBID 19B #18a Hearing Exams – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #18a Hearing Exams - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #18a Hearing Exams – Base 4

The screenshot displays the 'PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000' window. The interface includes a menu bar with 'File', 'Help', and 'Add Variable'. Below the menu bar is a toolbar with 'Previous' (left arrow), 'Next' (right arrow), 'Exit (Validate)' (green checkmark), and 'Exit (No Validate)' (red X). A 'Go To:' dropdown menu is set to 'VBID 19B #18a Hearing Exams - Base 4'. The main content area is titled 'Hearing Exams Notes' and contains a text box with the instruction: 'Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.' Below this is a large, empty text area for notes, with a vertical scrollbar on the right side.

CY 2017 PBP Data Entry System Screens

VBID 19B #18b Hearing Aids – Base 1

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #18b Hearing Aids - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

CY 2017 PBP Data Entry System Screens

VBID 19B #18b Hearing Aids – Base 2

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #18b Hearing Aids - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?

☐ Per ear
☐ Both ears combined

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

CY 2017 PBP Data Entry System Screens

VBID 19B #18b Hearing Aids – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #18b Hearing Aids - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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

☐ Yes
☐ No

Indicate Minimum Coinsurance percentage for Hearing Aids (all types):

Indicate Minimum Coinsurance percentage for Hearing Aids - Over the Ear:

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

☐ Covered under Hearing Exams Category - 18a
☐ Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Coinsurance percentage for Hearing Aids (all types):

Indicate Maximum Coinsurance percentage for Hearing Aids - Over the 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 Minimum Coinsurance percentage for Hearing Aids - Inner Ear:

Indicate Maximum Coinsurance percentage for Hearing Aids - Inner Ear:

Indicate Minimum Coinsurance percentage for Hearing Aids - Outer Ear:

Is there an enrollee Coinsurance?

☐ Yes
☐ No

Indicate Maximum Coinsurance percentage for Hearing Aids - Outer Ear:

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

CY 2017 PBP Data Entry System Screens

VBID 19B #18b Hearing Aids – Base 4

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #18b Hearing Aids - Base 4

Previous Next Exit (Validate) Exit (No Validate)

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 Minimum Copayment amount per Hearing Aid - Inner Ear:

Indicate Maximum Copayment amount per Hearing Aid - Inner Ear:

Indicate Minimum Copayment amount per two Hearing Aids - Inner Ear:

Indicate Maximum Copayment amount per two Hearing Aids - Inner Ear:

Indicate Minimum Copayment amount per Hearing Aid - Outer Ear:

Indicate Maximum Copayment amount per Hearing Aid - Outer Ear:

Indicate Minimum Copayment amount per two Hearing Aids - Outer Ear:

Indicate Maximum Copayment amount per two Hearing Aids - Outer Ear:

Indicate Minimum Copayment amount per Hearing Aid - Over the Ear:

Indicate Maximum Copayment amount per Hearing Aid - Over the Ear:

Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear:

Indicate Maximum Copayment amount per two Hearing Aids - Over the Ear:

Is there an enrollee Deductible?

☐ Yes
☐ No

Indicate Deductible Amount:

CY 2017 PBP Data Entry System Screens

VBID 19B #18b Hearing Aids – Base 5

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File Help Add Variable

Go To: VBID 19B #18b Hearing Aids - Base 5

Previous Next Exit (Validate) Exit (No Validate)

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

Hearing Aids Notes

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

Notes: