#19a Reduced Cost Sharing for VBIDS

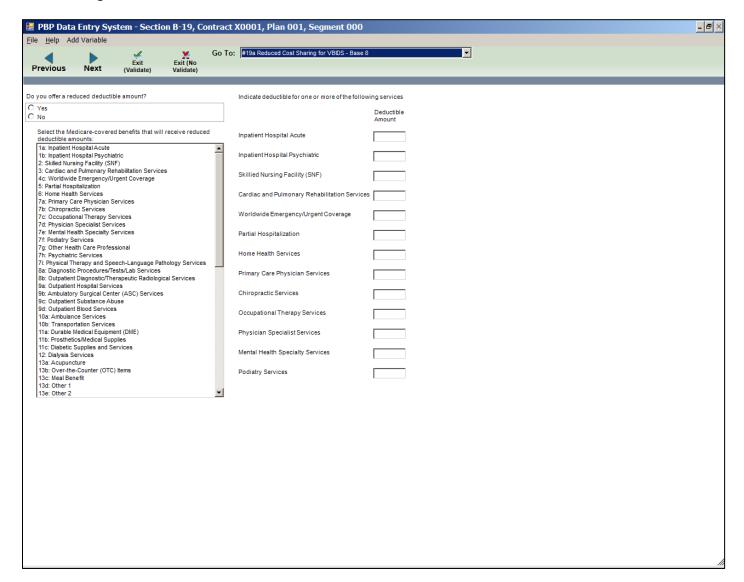File   Help   Add Variable

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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)

[   ]

#19a Reduced Cost Sharing for VBIDS – Base 1

#19a Reduced Cost Sharing for VBIDS – Base 2

#19a Reduced Cost Sharing for VBIDS – Base 3

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

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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

#19a Reduced Cost Sharing for VBIDS – Base 4

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

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Go To: #19a Reduced Cost Sharing for VBIDS - Base 4

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Indicate Coinsurance for one or more of the following services:

	Minimum Coinsurance	Maximum Coinsurance		Miniumum 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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#19a Reduced Cost Sharing for VBIDS – Base 5

#19a Reduced Cost Sharing for VBIDS – Base 6
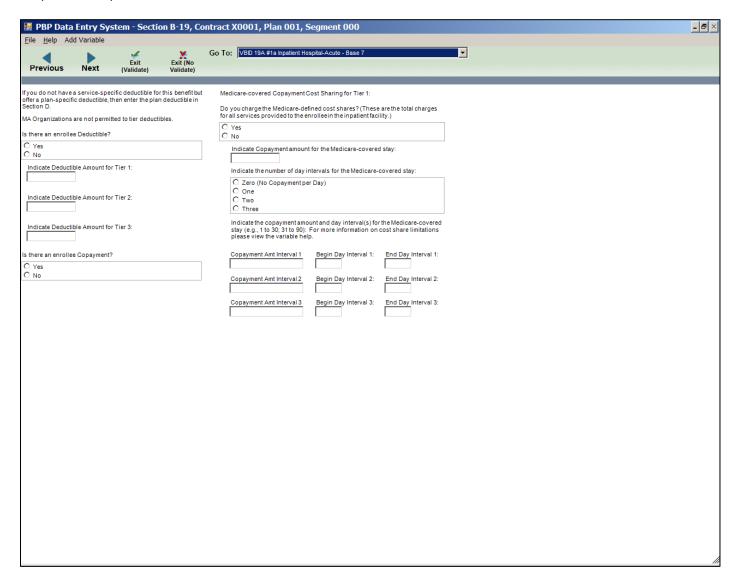
PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

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Go To: #19a Reduced Cost Sharing for VBIDS - Base 6

Indicate Coinsurance for one or more of the following services.

Service	Minimum Coinsurance	Maximum Coinsurance	Service	Miniumum 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)		

#19a Reduced Cost Sharing for VBIDS – Base 7

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

File   Help   Add Variable

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Go To: #19a Reduced Cost Sharing for VBIDS - Base 7

Indicate Coinsurance for one or more of the following services.

Service	Minimum Coinsurance	Maximum Coinsurance	Service	Miniumum 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

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#19a Reduced Cost Sharing for VBIDS – Base 9

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

File   Help   Add Variable

Go To: #19a Reduced Cost Sharing for VBIDS - Base 9

Previous   Next   Exit (Validate)   Exit (No Validate)

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			

#19a Reduced Cost Sharing for VBIDS – Base 10

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

File   Help   Add Variable

Go To: #19a Reduced Cost Sharing for VBIDS - Base 10

◄ Previous   ► Next   ✓ Exit (Validate)   ✗ Exit (No Validate)

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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CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#19a Reduced Cost Sharing for VBIDS – Base 11

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: #19a Reduced Cost Sharing for VBIDS - Base 11 ▾

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		

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#19a Reduced Cost Sharing for VBIDS – Base 12

#19a Reduced Cost Sharing for VBIDS – Base 13

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

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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
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)		

#19a Reduced Cost Sharing for VBIDS – Base 14

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

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◄ Previous   ► Next   ✔ Exit (Validate)   ✘ Exit (No Validate)

Go To: #19a Reduced Cost Sharing for VBIDS - Base 14

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					

#19a Reduced Cost Sharing for VBIDS – Notes

12/4/2015
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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

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

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

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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 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

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 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: [____]
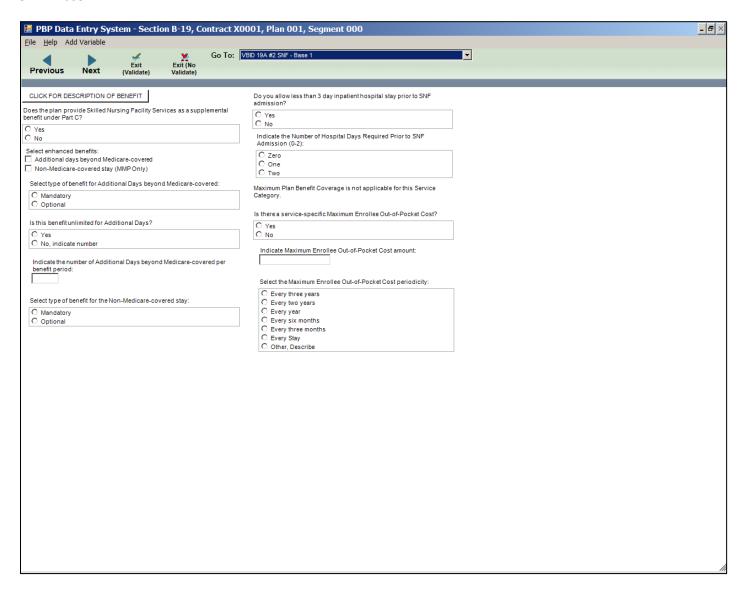
VBID #19A #1a Inpatient Hospital-Acute – Base 3

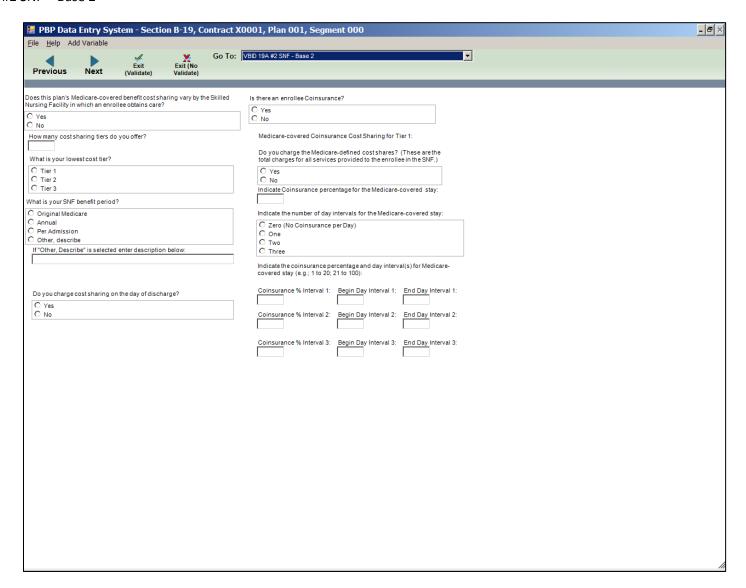**PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000**

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):

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:
[   ]   [   ]   [   ]

VBID #19A #1a Inpatient Hospital-Acute – Base 4
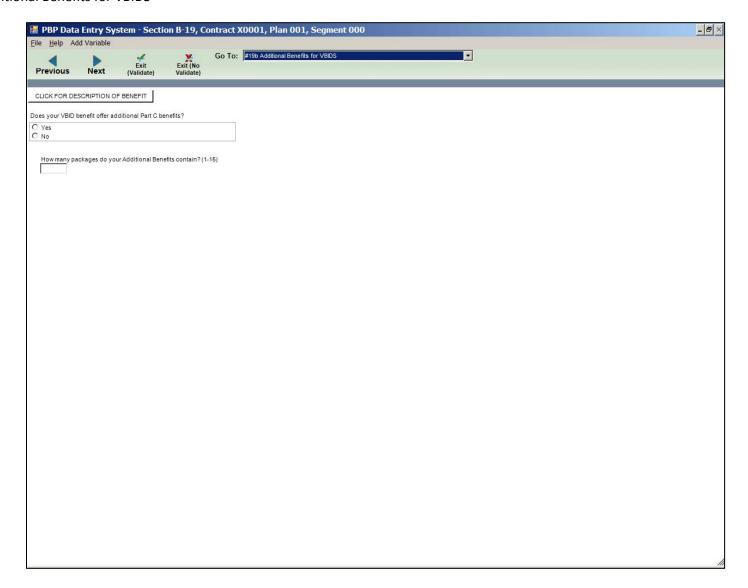
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File   Help   Add Variable

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

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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

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

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

Coinsurance %   Begin Day   End Day

Interval 1:
Interval 2:
Interval 3:

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

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

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

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

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

Medicare-covered Copayment Cost Sharing for Tier 2:

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

○ Yes
○ No

Indicate Copayment amount for the Medicare-covered stay:

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

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

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

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

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

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

Medicare-covered Copayment Cost Sharing for Tier 3:

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

○ Yes
○ No

Indicate Copayment amount for the Medicare-covered stay:

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

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

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

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

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

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

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

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

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File   Help   Add Variable

◄ **Previous**   ► **Next**   ✓ **Exit (Validate)**   ✗ **Exit (No Validate)**   Go To: `VBID 19A #1a Inpatient Hospital-Acute - Base 10 ▼`

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:

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

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

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

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

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: VBID 19A #1b Inpatient Hospital Psychiatric - Base 2

Does this plan's Medicare-covered benefit 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

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 1   Begin Day Interval 1:   End Day Interval 1:

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

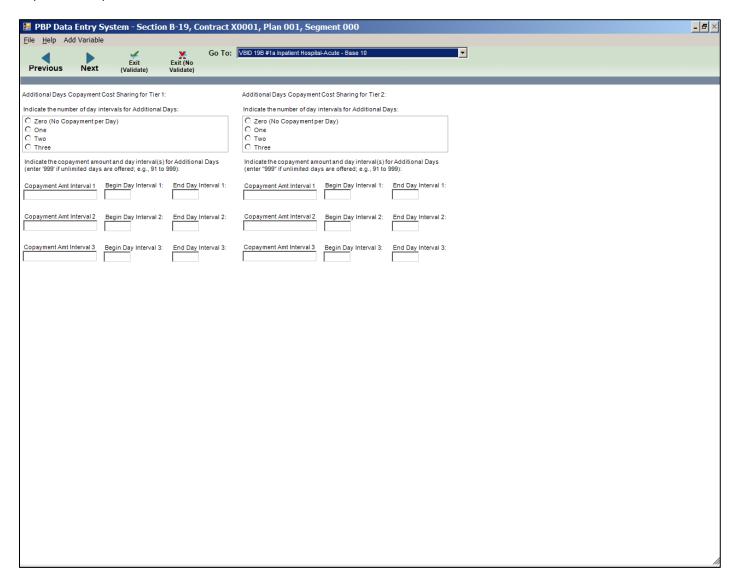Coinsurance % Interval 3   Begin Day Interval 3:   End Day Interval 3:

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

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

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

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

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

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

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

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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

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

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

VBID 19A #2 SNF – Base 1

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 19A #2 SNF - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?
- ○ Yes
- ○ No

Select enhanced benefits:
- ☐ Additional days beyond Medicare-covered
- ☐ Non-Medicare-covered stay (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

VBID 19A #2 SNF – Base 2

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 19A #2 SNF - Base 2

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 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

File Help Add Variable

Previous Next Exit (Validate) Exit (No Validate) Go To: VBID 19A #2 SNF - Base 3

Medicare-covered Coinsurance Cost Sharing for Tier 2:

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

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

Coinsurance % Interval 1:   Begin Day Interval 1:   End Day Interval 1:

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 SNF.)
- ○ Yes
- ○ No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

Coinsurance % Interval 1:   Begin Day Interval 1:   End Day Interval 1:

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

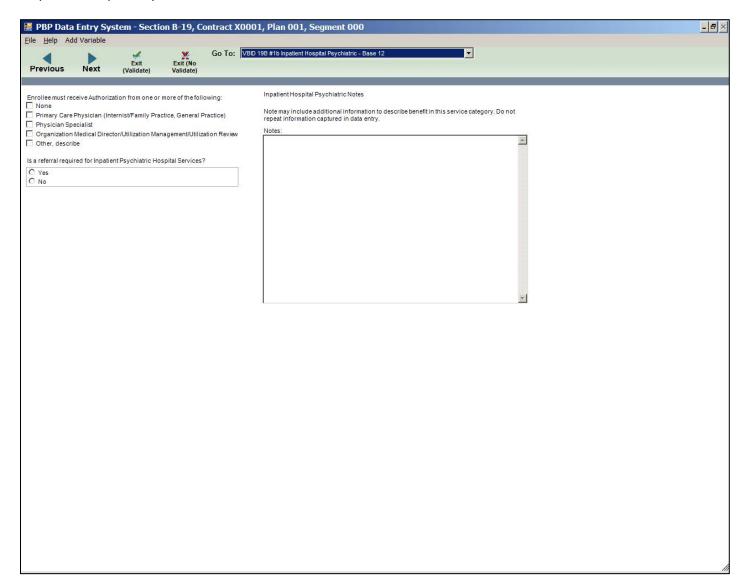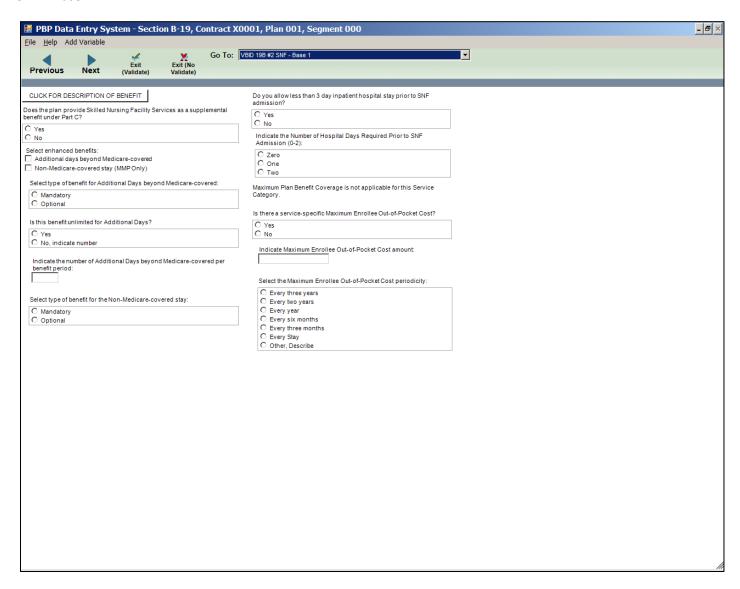Coinsurance % Interval 3:   Begin Day Interval 3:   End Day Interval 3:

VBID 19A #2 SNF – Base 4

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 19A #2 SNF - Base 4

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:

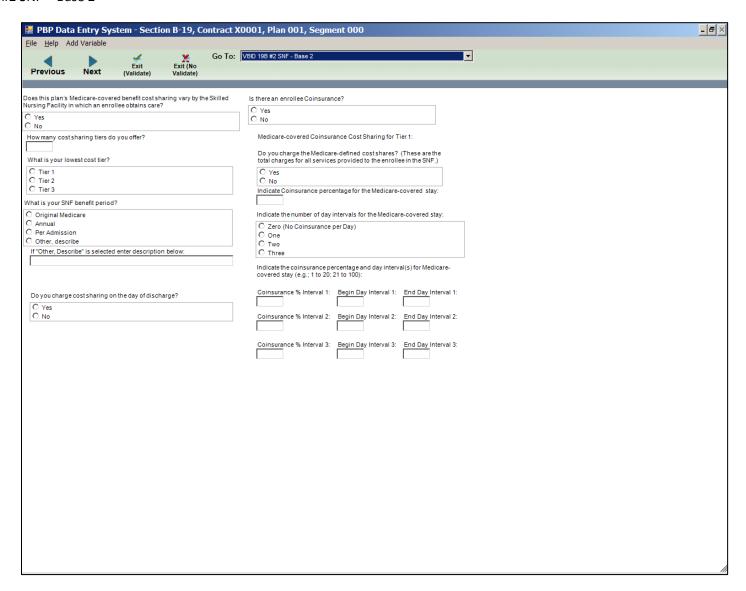Coinsurance % Interval 3:   Begin Day Interval 3:   End Day Interval 3:

VBID 19A #2 SNF – Base 5

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VBID 19A #2 SNF – Base 6

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

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: VBID 19A #2 SNF - Base 7

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:
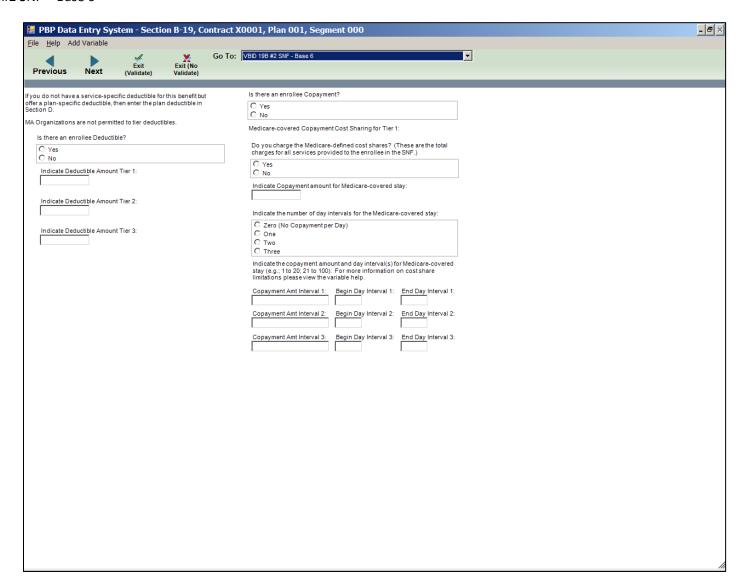[   ]   [   ]   [   ]

VBID 19A #2 SNF – Base 8

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VBID 19A #2 SNF – Base 9

CY 2017 PBP Data Entry System Screens

VBID 19A #2 SNF – Base 10

#19b Additional Benefits for VBIDS

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: #19b Additional Benefits for VBIDS

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)

#19b Additional Benefits for VBIDS – Base 1

#19b Additional Benefits for VBIDS – Base 2

#19b Additional Benefits for VBIDS – Notes

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

CY 2017 PBP Data Entry System Screens

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

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

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

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

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

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

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

CY 2017 PBP Data Entry System Screens

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

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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VBID 19B #1a Inpatient Hospital-Acute – Base 10
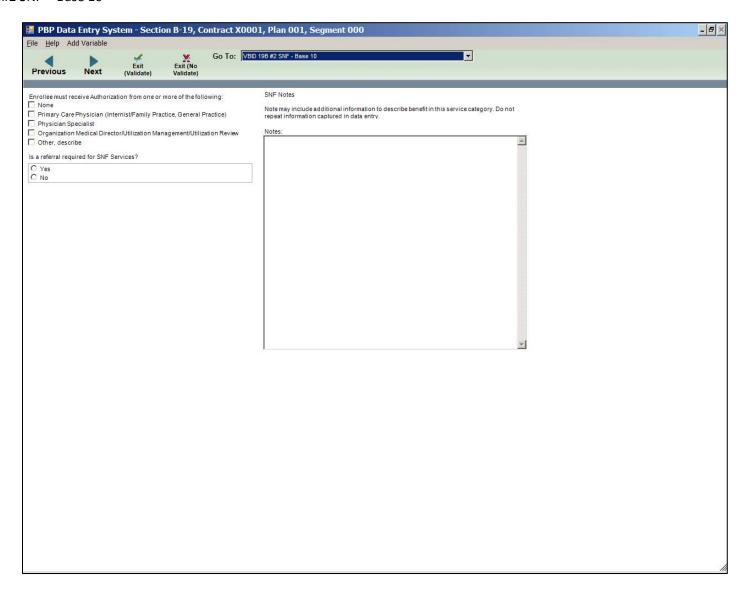
VBID 19B #1a Inpatient Hospital-Acute – Base 11

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

File   Help   Add Variable

Previous   Next   Exit (Validate)   Exit (No Validate)

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

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:

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

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

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

◄ Previous   ► Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: [VBID 19B #1b Inpatient Hospital Psychiatric - Base 2 ▼]

Does this plan's Medicare-covered benefit 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

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 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 3

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

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

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 5

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., 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

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

CY 2017 PBP Data Entry System Screens

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

CY 2017 PBP Data Entry System Screens

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

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

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

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✖ Exit (No Validate)   Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 11

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:
[   ]   [   ]   [   ]

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

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: VBID 19B #1b Inpatient Hospital Psychiatric - Base 12

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:

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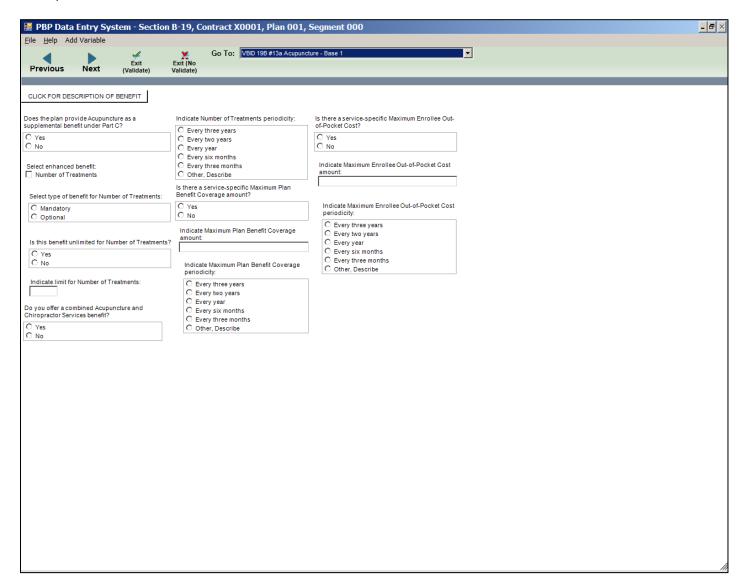
VBID 19B #2 SNF – Base 1

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

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: VBID 19B #2 SNF - Base 2

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 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 3

File   Help   Add Variable

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: VBID 19B #2 SNF - Base 3

Medicare-covered Coinsurance Cost Sharing for Tier 2:

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

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

Coinsurance % Interval 1:   Begin Day Interval 1:   End Day Interval 1:

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 SNF.)
- ○ Yes
- ○ No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

Coinsurance % Interval 1:   Begin Day Interval 1:   End Day Interval 1:

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

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

VBID 19B #2 SNF – Base 4

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

◀ Previous   ▶ Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: VBID 19B #2 SNF - Base 5 ▼

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):

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:

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VBID 19B #2 SNF – Base 6

VBID 19B #2 SNF – Base 7

CY 2017 PBP Data Entry System Screens

VBID 19B #2 SNF – Base 8

VBID 19B #2 SNF – Base 9

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

File Help Add Variable

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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:

VBID 19B #2 SNF – Base 10

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

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

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

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

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

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

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

VBID 19B #7b Chiropractic Services – Base 1

VBID 19B #7b Chiropractic Services – Base 2

VBID 19B #7b Chiropractic Services – Base 3

VBID 19B #7b Chiropractic Services – Base 4

VBID 19B #7f Podiatry Services – Base 1

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VBID 19B #7f Podiatry Services – Base 2

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VBID 19B #7f Podiatry Services – Base 3

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

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

VBID 19B #10b Transportation Services – Base 1

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

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Transportation Services as a supplemental benefit under Part C?
- Yes
- No

Select enhanced benefit:
- Plan-approved Location
- Any Location

Select type of benefit for Plan-approved Location:
- Mandatory
- Optional

Is this benefit unlimited for number of trips for Plan-approved Location?
- Yes
- No

Indicate number of trips for Plan-approved Location:

Select Plan-approved Location Trips periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Select Type of Transportation for Plan-approved Location:
- One-way
- Round Trip
- Days
- Other, describe

Indicate number of days for Plan-approved Location:

Select Mode of Transportation for Plan-approved Location:
- Taxi
- Bus/Subway
- Van
- Medical Transport
- Other, describe

Select type of benefit for Any Location:
- Mandatory
- Optional

Is this benefit unlimited for number of trips for Any Location?
- Yes
- No

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

VBID 19B #10b Transportation Services – Base 2

VBID 19B #10b Transportation Services – Base 3

VBID 19B #13a Acupuncture – Base 1

VBID 19B #13a Acupuncture – Base 2

VBID 19B #13a Acupuncture – Base 3

VBID 19B #13b OTC Items – Base 1

VBID 19B #13b OTC Items – Base 2

VBID 19B #13b OTC Items – Base 3

VBID 19B #13c Meal Benefit – Base 1

VBID 19B #13c Meal Benefit – Base 2

VBID 19B #13c Meal Benefit – Base 3

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VBID 19B #13d Other 1 – Base 1

VBID 19B #13d Other 1 – Base 2

VBID 19B #13d Other 1 – Base 3

VBID 19B #13e Other 2 – Base 1

VBID 19B #13e Other 2 – Base 2

VBID 19B #13e Other 2 – Base 3

VBID 19B #13f Other 3 – Base 1

VBID 19B #13f Other 3 – Base 2

VBID 19B #13f Other 3 – Base 3

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

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

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

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

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

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

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

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CY 2017 PBP Data Entry System Screens

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

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

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

CY 2017 PBP Data Entry System Screens

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

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

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

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VBID 19B #16a Preventive Dental – Base 1

VBID 19B #16a Preventive Dental – Base 2

CY 2017 PBP Data Entry System Screens

VBID 19B #16a Preventive Dental – Base 3

VBID 19B #16a Preventive Dental – Base 4

VBID 19B #16a Preventive Dental – Base 5

VBID 19B #16b Comprehensive – Base 1

VBID 19B #16b Comprehensive – Base 2

VBID 19B #16b Comprehensive – Base 3

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VBID 19B #16b Comprehensive – Base 4

VBID 19B #16b Comprehensive – Base 5

VBID 19B #16b Comprehensive – Base 6

VBID 19B #17a Eye Exams – Base 1

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

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

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Eye Exams as a supplemental benefit under Part C?
- ○ Yes
- ○ No

Select enhanced benefit:
- ☐ Routine Eye Exams/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
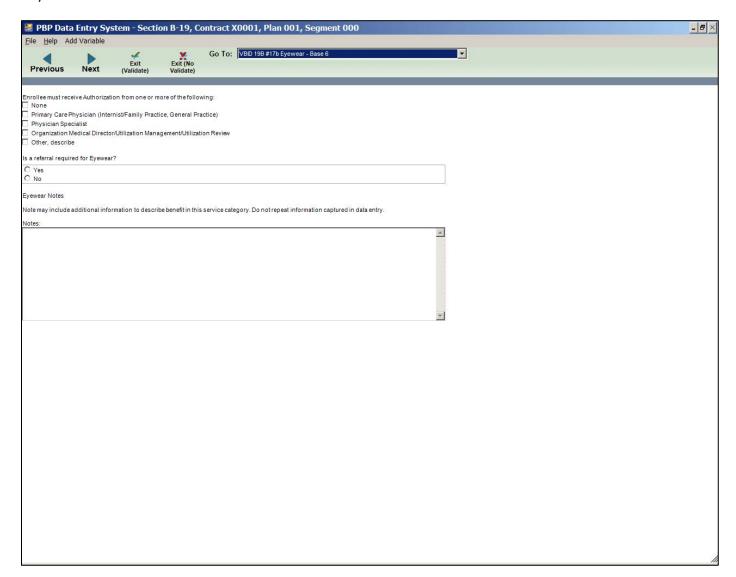- ○ Other, Describe

VBID 19B #17a Eye Exams – Base 2

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 #17a Eye Exams - Base 2

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Select which Eye Exams have a Coinsurance (Select all that apply):
- ☐ Medicare-covered Benefits
- ☐ Routine Eye Exams/Other

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Eye Exams/Other:

Indicate Maximum Coinsurance percentage for Routine Eye Exams/Other:

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Select which Eye Exams have a Copayment (Select all that apply):
- ☐ Medicare-covered Benefits
- ☐ Routine Eye Exams/Other

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount per Routine Eye Exams/Other:

Indicate Maximum Copayment amount per Routine Eye Exams/Other:

VBID 19B #17a Eye Exams – Base 3

VBID 19B #17b Eyewear – Base 1

VBID 19B #17b Eyewear – Base 2

VBID 19B #17b Eyewear – Base 3

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VBID 19B #17b Eyewear – Base 4

CY 2017 PBP Data Entry System Screens

VBID 19B #17b Eyewear – Base 5

VBID 19B #17b Eyewear – Base 6

VBID 19B #18a Hearing Exams – Base 1

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

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 an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:
[_____]

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

Select which Hearing Exam Benefits have a Coinsurance (Select all that apply):
- ☐ Medicare-covered Benefits
- ☐ Routine Hearing Exams
- ☐ Fitting/Evaluation for Hearing Aid

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:
[_____]

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:
[_____]

Indicate Minimum Coinsurance percentage for Routine Hearing Exams:
[_____]

Indicate Maximum Coinsurance percentage for Routine Hearing Exams:
[_____]

Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:
[_____]

Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:
[_____]

VBID 19B #18a Hearing Exams – Base 3

VBID 19B #18a Hearing Exams – Base 4

VBID 19B #18b Hearing Aids – Base 1

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 #18b Hearing Aids - Base 1
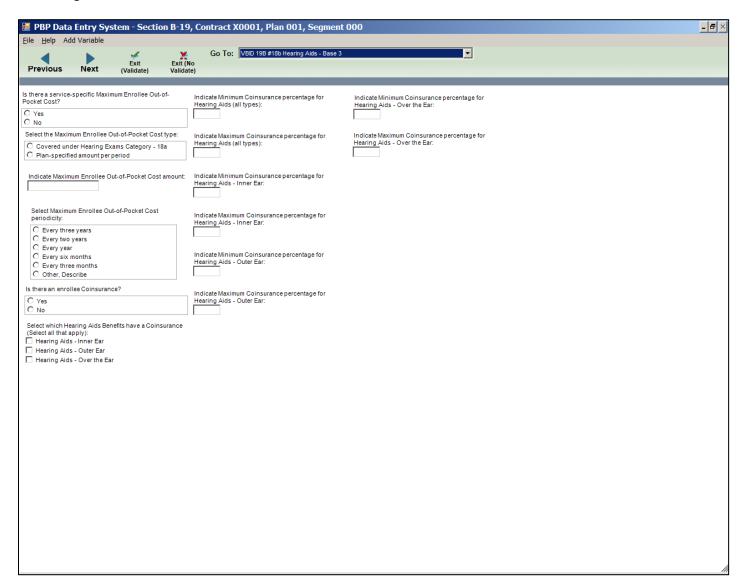
CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Hearing Aids as a supplemental benefit under Part C?
- ○ Yes
- ○ No

Select enhanced benefits:
- ☐ Hearing Aids (all types)
- ☐ Hearing Aids - Inner Ear
- ☐ Hearing Aids - Outer Ear
- ☐ Hearing Aids - Over the Ear

Select type of benefit for Hearing Aids (all types):
- ○ Mandatory
- ○ Optional

Is this benefit unlimited for Hearing Aids (all types)?
- ○ Yes
- ○ No, indicate number

Indicate quantity for Hearing Aids (all types):
[   ]

Select Hearing Aids (all types) periodicity:
- ○ Every three years
- ○ Every two years
- ○ Every year
- ○ Every six months
- ○ Every three months
- ○ Other, Describe

Select type of benefit for Hearing Aids - Inner Ear:
- ○ Mandatory
- ○ Optional

Is this benefit unlimited for Hearing Aids - Inner Ear?
- ○ Yes
- ○ No, indicate number

Indicate quantity for Hearing Aids - Inner Ear:
[   ]

Select Hearing Aids - Inner Ear periodicity:
- ○ Every three years
- ○ Every two years
- ○ Every year
- ○ Every six months
- ○ Every three months
- ○ Other, Describe

Select type of benefit for Hearing Aids - Outer Ear:
- ○ Mandatory
- ○ Optional

Is this benefit unlimited for Hearing Aids - Outer Ear?
- ○ Yes
- ○ No, indicate number

Indicate quantity for Hearing Aids - Outer Ear:
[   ]

Select Hearing Aids - Outer Ear periodicity:
- ○ Every three years
- ○ Every two years
- ○ Every year
- ○ Every six months
- ○ Every three months
- ○ Other, Describe

VBID 19B #18b Hearing Aids – Base 2

VBID 19B #18b Hearing Aids – Base 3

VBID 19B #18b Hearing Aids – Base 4

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VBID 19B #18b Hearing Aids – Base 5