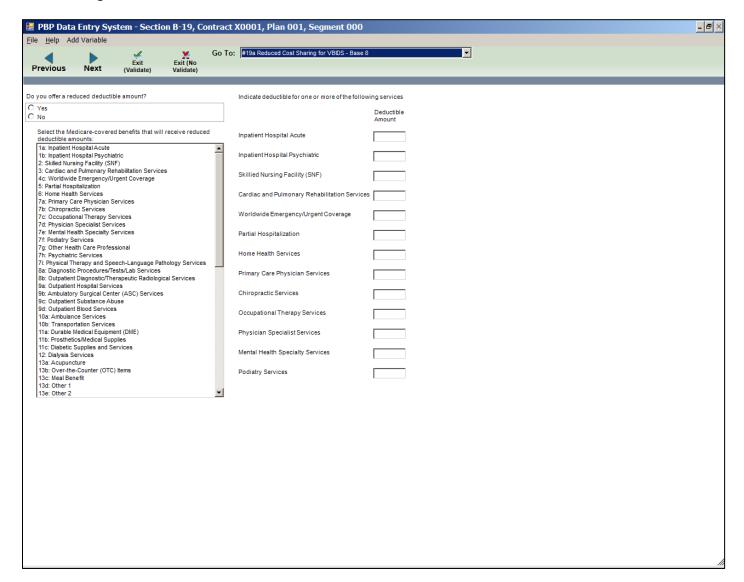


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Indicate Coinsurance for one or more of the	following service	s:			
	Minimum Coinsurance	Maximum Coinsuran	ce	Miniumum Maximum Coinsurance Coinsurance	
Cardiac Rehabilitation Services			Group Sessions for Mental Health Specialty Services		
Intensive 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		
Primary Care Physician Services			Pathology 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		
Specially Services					

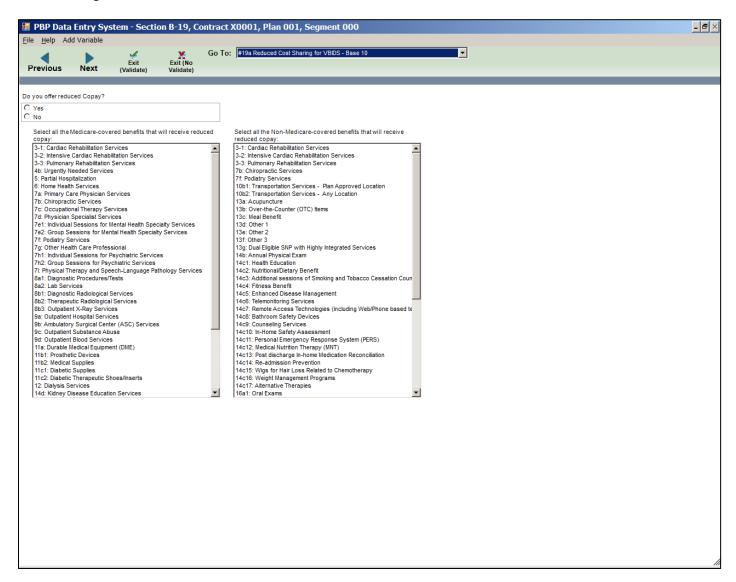
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Indicate Coins	surance for one or I	more of the fo	llowing service	s: Maximum		Miniumum Maximum
5 t + 111			Coinsurance	Coinsuran		Coinsurance Coinsurance
	spital Services				Glaucoma Screening	
	rgical Center (ASC) Services			Diabetes Self-Management Training	
Outpatient Sub	ostance Abuse				Other 1	
Outpatient Blo	od Abuse				Other 2	
Durable Medic	al Equipment (DME	≣)			Other 3	
Prosthetic Dev	rices				Other 4	
Medical Suppli	ies				Other 5	
Diabetic Suppl	lies				Comprehensive Dental	
Diabetic Thera	peutic Shoes/Inse	rts			Eye Exams	
Dialysis Servic	ces				Eyewear	
Kidney Diseas	e Education Service	ces			Hearing Exams	

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File Help Add Variable Previous Next (Validate)	Go To: Exit (No Validate)	#19a Reduced Cost Sharing for VBIDS - Base 6	
Indicate Coinsurance for one or more of the fol	llowing services.		
	Minimum Maximum Coinsurance Coinsuran	CB	Miniumum Maximum Coinsurance 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		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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Indicate Coinsurance for one or more of the following	lowing services.			
	Minimum Maximu Coinsurance Coinsur		Miniumum Maximum Coinsurance 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				



	Exit Exit Exit Exit Va	xit (No ilidate)	Go To: #19a Reduced Co	st Sharing for VE	BIDS - Base 9	<u> </u>			
ndicate deductible for one or more o	of the following s	ervices							
	Deductible Amount			Deductible Amount		Deductible Amount		Deductible Amount	
ther Health Care Professional		Dialysis	Services		Telemonitoring Services		Diabetes Self-Management Training		
sychiatric Services		Acupun	cture		Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)		Other 1		
hysical Therapy and Speech- anguage Pathology Services		Over-th	e-Counter (OTC) Items		Bathroom Safety Devices		Other 2		
iagnostic Procedures/Tests/Lab ervices		Meal Be	nefit		Counseling Services		Other 3		
utpatient Diagnostic/Therapeutic adiological Services		Other 1			In-Home Safety Assessment		Other 4		
utpatient Hospital Services		Other 2			Personal Emergency Response System (PERS)		Other 5		
mbulatory Surgical Center (ASC) ervices		Other 3			Medical Nutrition Therapy (MNT)		Medicare Part B Rx Drugs		
utpatient Substance Abuse			gible SNP with Highly ed Services		Post discharge In-home Medication Reconciliation		Preventive Dental		
utpatient Blood Services		Annual	Physical Exam		Re-admission Prevention		Comprehensive Dental		
mbulance Services		Health E	ducation		Wigs for Hair Loss Related to Chemotherapy		Eye Exams		
ransportation Services		Nutritio	nal/Dietary Benefit		Weight Management Programs		Eyewear		
urable Medical Equipment (DME)		Addition	nal sessions of Smoking and o Cessation Counseling		Alternative Therapies		Hearing Exams		
rosthetics/Medical Supplies		Fitness	Benefit		Kidney Disease Education Services		Hearing Aids		
iabetic Supplies and Services		Enhanc	ed Disease Management		Glaucoma Screening				

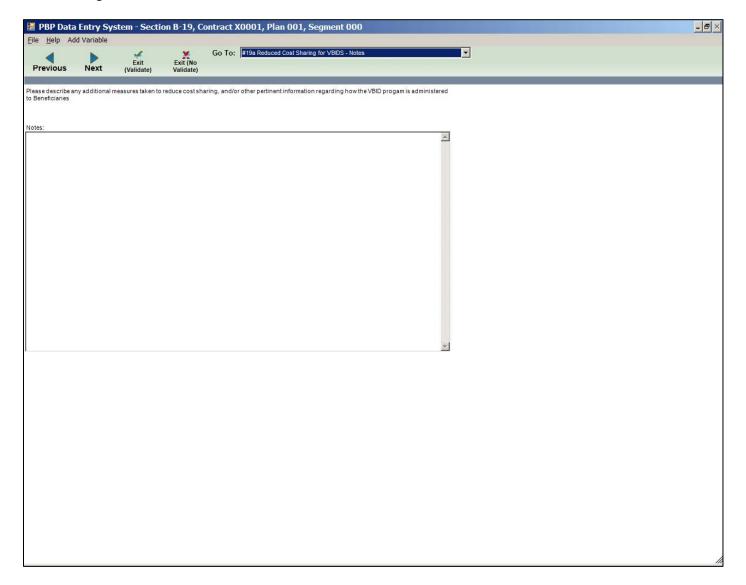


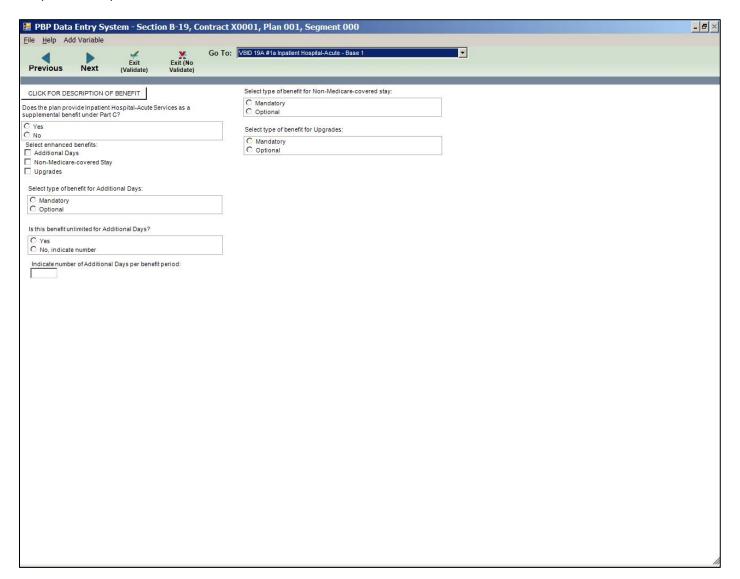
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Indicate Copayment for one or more of the foll	owing services:					
	Minimum Copay	Maximum Copay		Minimum Copay	Maximum Copay	
Cardiac Rehabilitation Services			Group Sessions for Mental Health Specialty Services			
ntensive Cardiac Rehabilitation Services			Podiatry Services			
Pulmonary Rehabilitation Services			Other Health Care Professional			
Jrgently Needed Services			Individual Sessions for Psychiatric Services			
Partial Hospitalization			Group Sessions for Psychiatric Services			
Home Health Services			Physical Therapy and Speech-Language Pathology Services			
rimary Care Physician Services			Diagnostic Procedures/Tests			
Chiropractic Services			Lab Services			
Occupational Therapy Services			Diagnostic Radiological Services			
Physician Specialist Services			Therapeutic Radiological Services			
ndividual Sessions for Mental Health Specialty Services			Outpatient X-Ray Services			

ndicate Copayment for utpatient Hospital Serv mbulatory Surgical Cer	one or more of the foll		2				
		Minimum Copay	Maximum Copay		Maximum Copay	Minimum Copay	
nbulatory Surgical Cer	vices			Glaucoma Screening			
	nter (ASC) Services			Diabetes Self-Management Training			
utpatient Substance Ab	ouse			Other 1			
utpatient Blood Abuse				Other 2			
urable Medical Equipm	ient (DME)			Other 3			
rosthetic Devices				Other 4			
edical Supplies				Other 5			
abetic Supplies				Comprehensive Dental			
abetic Therapeutic Sh	oes/Inserts			Eye Exams			
alysis Services				Eyewear			
dney Disease Education	on Services			Hearing Exams			

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #19a R	educed Cost Sharing for VBIDS - Base 13		<u> </u>	
Indicate Copa	y for one or mo	re of the following	services.					
			Minimum Copay	Maximum Copay		Minimum Copay	Maximum Copay	
Additional Car	diac Rehabilita	tion Services			Dual Eligible SNP with Highly Integrated Services			
Additional Inte	ensive Cardiac I	Rehabilitation			Annual Physical Exam			
Additional Pul	monary Rehabi	litation Services			Health Education			
Chiropractic S	ervices - Routi	ine Care/Other			Nutritional/Dietary Benefit			
Podiatry Servi	ces - Routine F	oot Care			Additional sessions of Smoking and Tobacco Cessation Counseling			
Transportation Location	n Services - Pla	an Approved			Fitness Benefit			
Transportation	n Services - An	y Location			Enhanced Disease Management			
Acupuncture					Telemonitoring Services			
Over-the-Cour	nter (OTC) Item	ıs			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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File Help Add Variable Previous Next (Validate)	Exit (No Validate)	Go To: #19a	Reduced Cost Sharing for VBIDS - Base 14		<u> </u>	
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 Diagnostic Services			Hearing Aids - Inner Ear			
Restorative Services			Hearing Aids - Outer Ear Hearing Aids - Over the Ear			
Endodontics/Periodontics/Extractions			Healing Alus - Over the Lai			
Endodoniosi direcentesi Endodoniosi						





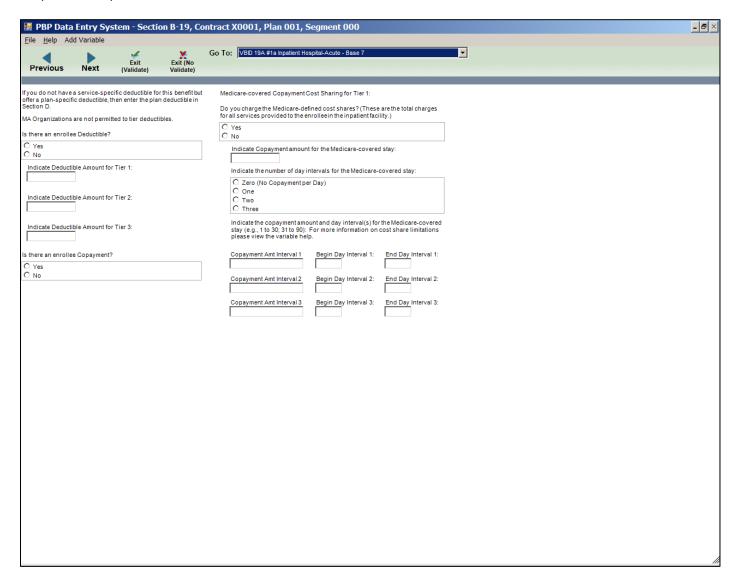
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Elle Help Add Variable Previous Next Exit Exit (No (Validate) Validate) Go To:	VBID 19A #1a Inpatient Hospital-Acute - Base 2	
Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Indicate the Maximum Enrollee Out-of-Pocket Cost amount: Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every year C Every year C Every year C Every Stay C Other, Describe 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? C Tier 1 C Tier 2 C Tier 3 What is yourinpatient hospital benefit period? C original Medicare C Annual C Per Admission C Other, Describe" is selected enter description below:	Do you charge cost sharing on the day of discharge? C Yes C No Is there an enrollee Coinsurance? C Yes C 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.) C Yes C No Indicate Coinsurance percentage for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Coinsurance per Day) C One C Two C 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: Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 3: End Day Interval 3:	

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(Validate)		
Medicare-covered Coinsurance Cost Sharing for Tier 2:	Medicare-covered Coinsurance Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
O Yes O No	C Yes C No	
Indicate Coinsurance percentage for the Medicare-covered stay:	Indicate Coinsurance percentage for the Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Coinsurance per Day) C One	C Zero (No Coinsurance per Day) C One	
O Two O Three	C Two	
Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):	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 1 Begin Day Interval 1 End Day Interval 1:	
Coinsurance % Interval 2 Begin Day Interval 2 End Day Interval 2:	Coinsurance % Interval 2 Begin Day Interval 2 End Day Interval 2:	
Coinsurance % Interval 3 Begin Day Interval 3 End Day Interval 3:	Coinsurance % Interval 3 Begin Day Interval 3 End Day Interval 3:	

■ PBP Data Entry System - Section B-	19, Contract X0001, Plan 001, Segme	ent 000	_ & ×
File Help Add Variable	Go To: VBD 19A #1a Inpatient Hospital-Act	ute - Base 4	
Previous Next (Validate) Vali	idate)		
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:	
C Zero (No Coinsurance per Day) C One C Two C Three	C Zero (No Coinsurance per Day) C One C Two C Three	C Zero (No Coinsurance per Day) C One C Two C Three	
Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	
Interval Days	Interval Days	Interval Days	
Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day	
Interval 1:	Interval 1:	Interval 1:	
Interval 3:	Interval 2: Interval 3:	Interval 3:	

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■ ▶	Exit	Exit (No	Go To: VB	3D 19A #1a Inpatient Hospital-Acute - Base 5 ▼	
Previous Ne	xt (Validate)	Validate)	_		
Does this plan's Addition enrollee obtains care? C Yes C No How many cost sharin What is your lowest or C Tier 1 C Tier 2 C Tier 3 Additional Days Coinsurance Indicate the number of da C Zero (No Coinsurance C Two C Three Indicate the coinsurance and indicate the coinsurance with unline Coinsurance % Interval 1 Coinsurance % Interval 2 Coinsurance % Interval 3	ing tiers do you offer? sost tier? ance Cost Sharing for Ti y intervals for Additions e per Day) percentage and dayin nited days are offered; 1 Begin Day Interval 1:	er 1: Il Days: terval(s) for Addit a.g., 91 to 999): End Day Intervi	ional al 1:	Additional Days Coinsurance Cost Sharing for Tier 2: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One C 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:	

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Eile Help Add Variable Go To: VBD 19A #1a Inpatient Hospital-Acute - Base 6 ▼	
Exit Exit (No	
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Additional Days Coinsurance Cost Sharing for Tier 3: Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay? Indicate the number of day intervals for Additional Days: C Yes	
C Zero (No Coinsurance per Day)	
C One Indicate Coinsurance percentage for the Non-Medicare-covered stay: C Two	
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: C One C Two C Three	
Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2: 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 3 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 1 Begin Day Interval 1: End 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:	

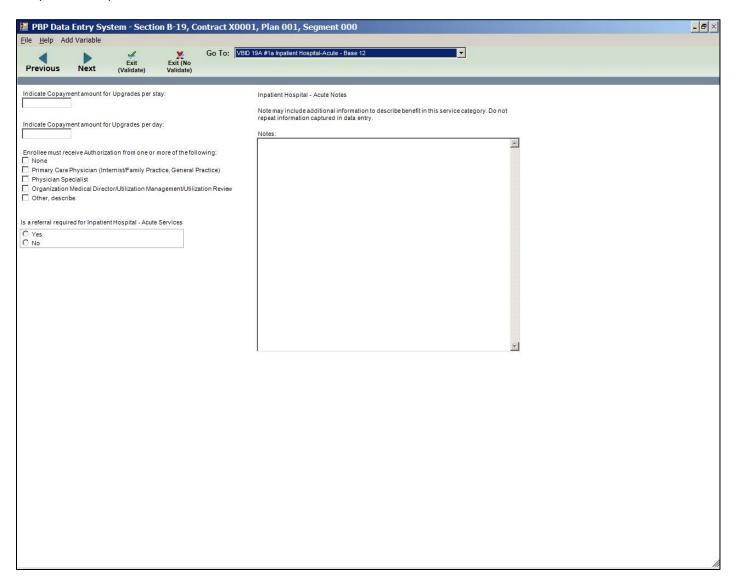


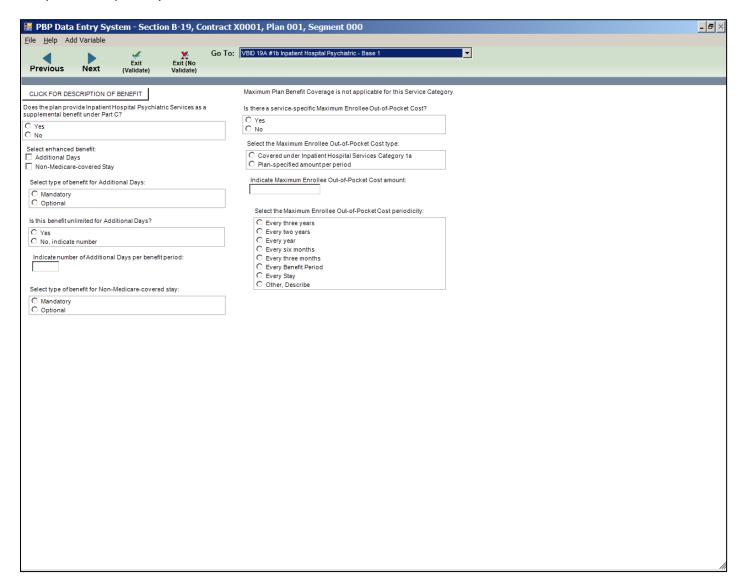
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Madiana				2		Mediana annual Community	Cont Charles for Time?				
Medicare-cove Do you charge					ne total	Medicare-covered Copayment Do you charge the Medicare-de		e are the total charges			
charges for all	services prov	vided to the	enrollee in t	the inpatient fa	acility.)	for all services provided to the	enrollee in the inpatient faci	ility.)	_		
C Yes C No						O Yes O No					
Indicate Cop	ayment amou	unt for the N	Medicare-co	vered stay:		Indicate Copayment amount	for the Medicare-covered :	stay:			
Indicate the nu	mber of day i	intervals fo	r the Medica	ire-covered st	ay:	Indicate the number of day in	tervals for the Medicare-co	overed stay:			
C Zero (No C C One C Two	opaymentp	er Day)				C Zero (No Copayment per C One C Two	Day)				
C Three						C Three					
Indicate the co covered stay (e share limitation	a.g., 1 to 30:3	31 to 90): F	or more info) for the Medic ormation on co	are- ost	Indicate the copayment amor stay (e.g., 1 to 30; 31 to 90): I please view the variable help	For more information on co	he Medicare-covered ost share limitations			
Copayment Am				End Day Inte		Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:			
Copayment Am						Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:			
Copayment An	nt Interval 3	Begin Day	/ Interval 3:	End Day Int	erval 3:	Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:			

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Previous Next (Validate) Va	lidate)		_
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:	
C Zero (No Copayment per Day)	C Zero (No Copayment per Day) C One	C Zero (No Copayment per Day) C One	
C Two	C Two C Three	C Two C 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):	
Interval Days	Interval Days	Interval Days	
Copay Amount Begin Day End Day	Copay Amount Begin Day End Day	Copay Amount Begin Day End Day	
Interval 1:	Interval 1:	Interval 1:	
Interval 2:	Interval 2:	Interval 2:	
Interval 3:	Interval 3:	Interval 3:	

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Indicate the number of day intervals for Additional Days: C Zero (No Copayment per Day)	Go To:	VBID 19A #1a Inpatient Hospital-Acute - Base 10 ▼	
	Indicate the number of day intervals for Additional Days: C Zero (No Copayment per Day) C One C Two C 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:	Indicate the number of day intervals for Additional Days: C Zero (No Copayment per Day) C One C Two C 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:	

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Eile Help Add Variable Previous Next (Validate) Fig. 60 To: Exit Exit (No Validate)	VBID 19A #1a Inpatient Hospital-Acute - Base 11	
Additional Days Copayment Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days: C Zero (No Copayment per Day) C One C Two C 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 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? C yes No Indicate Copayment amount for the Non-Medicare-covered stay: Indicate the number of day intervals for the Non-Medicare-covered stay: C Zero (No Copayment per Day) O One C 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 2: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	





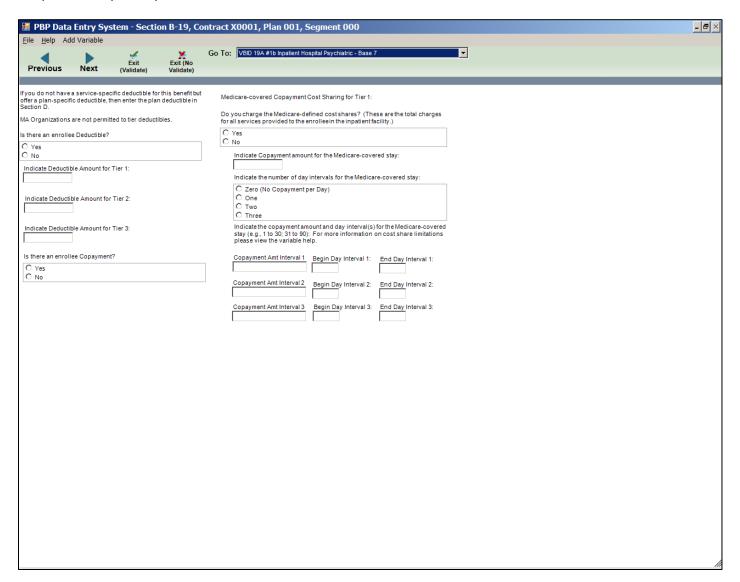
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Exit Exit (No	VBID 19A #1b Inpatient Hospital Psychiatric - Base 2	
Previous Next (Validate) Validate)		
Does this plan's Medicare-covered benefit costsharing vary by hospital(s) in which an enrollee obtains care? C Yes No How many cost sharing tiers do you offer? What is your lowest cost tier? C Tier 1 C Tier 2 C Tier 3 What is yourinpatient hospital benefit period? C Original Medicare C Annual C Per Admission C Other, describe If "Other, Describe" is selected enter description below:	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.) C Yes C No Indicate Coinsurance percentage for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Coinsurance per Day) C One C Two C 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:	
Do you charge cost sharing on the day of discharge? C Yes C No	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
Is there an enrollee Coinsurance? C Yes C No		

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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.) C Yes No	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.) C Yes C No	
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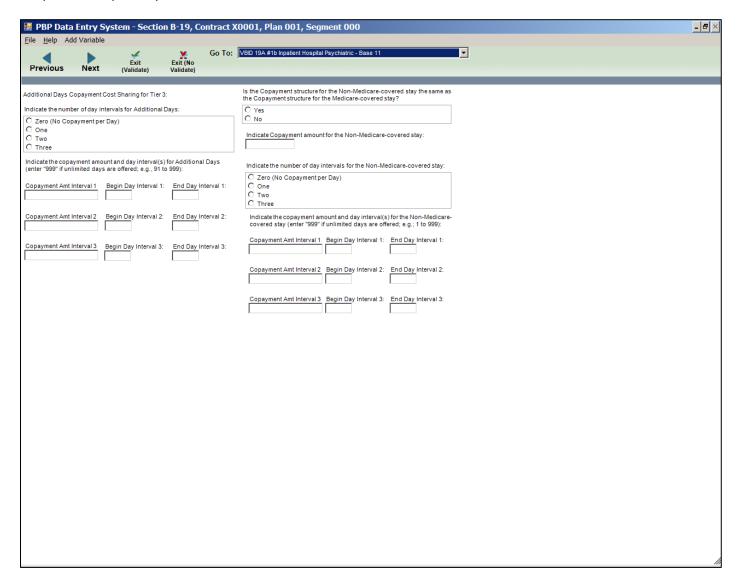


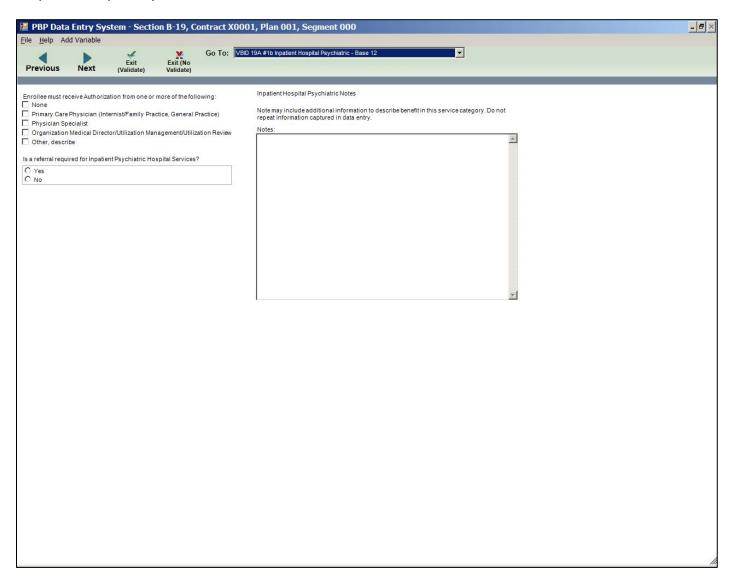
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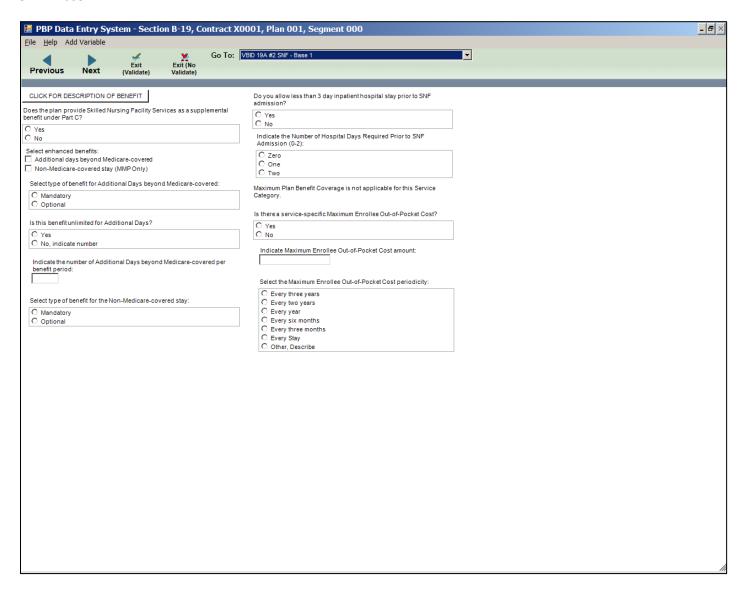
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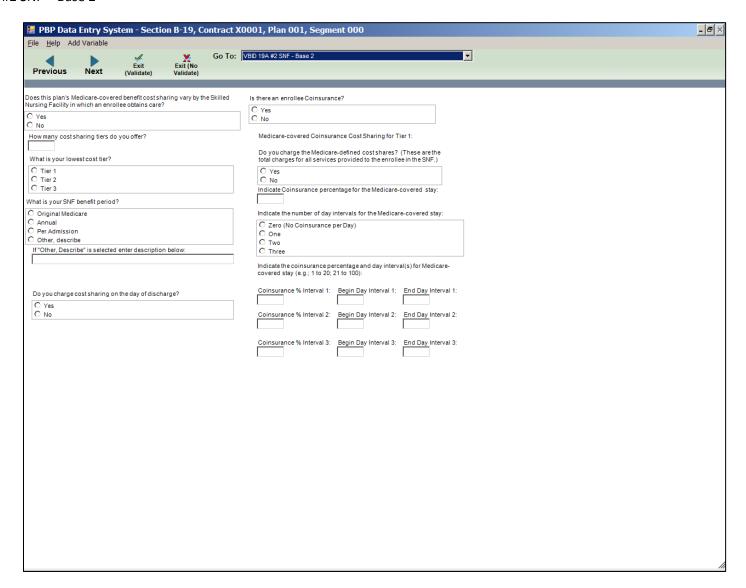
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CY 2017 PBP Data Entry System Screens





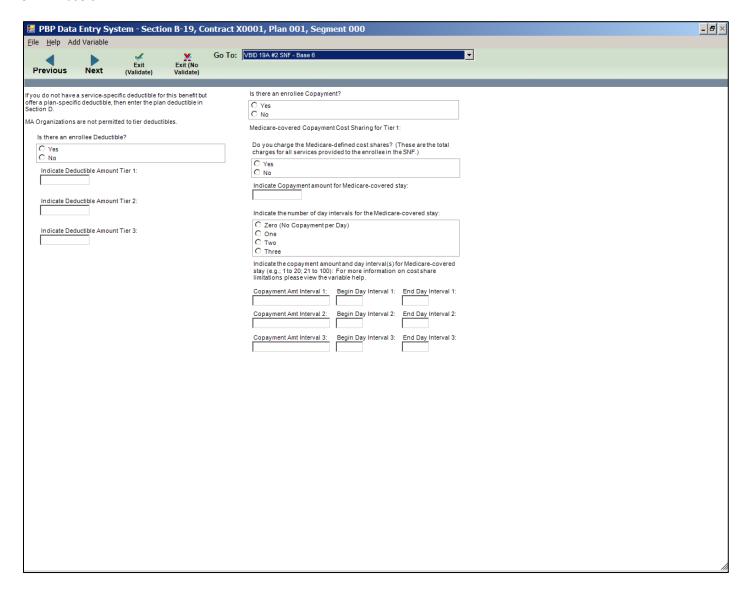




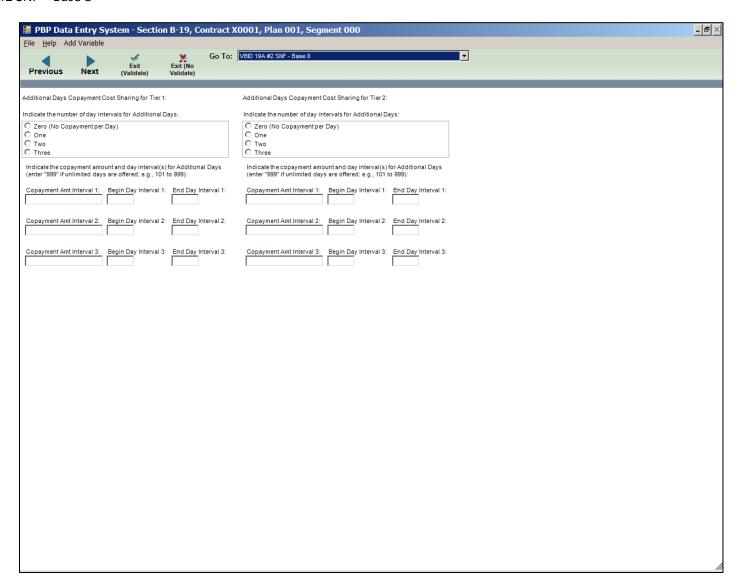
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C Yes C No	. 30, 11003 р		.,		C Yes C No	
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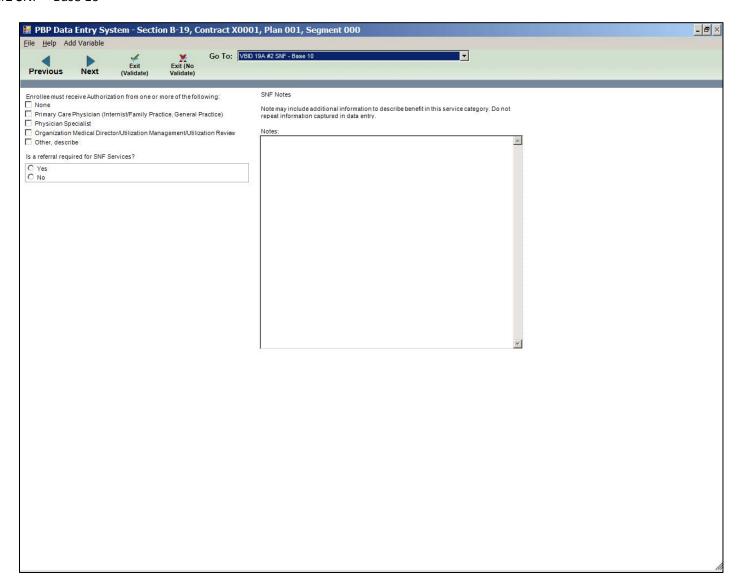
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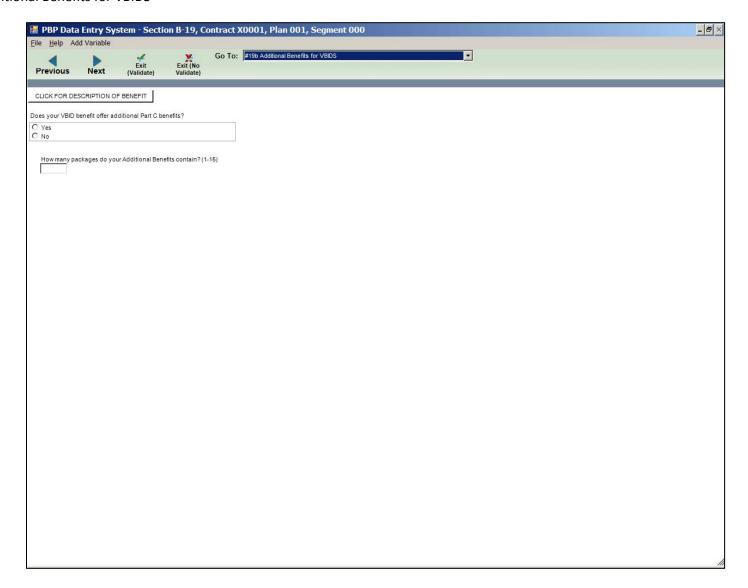
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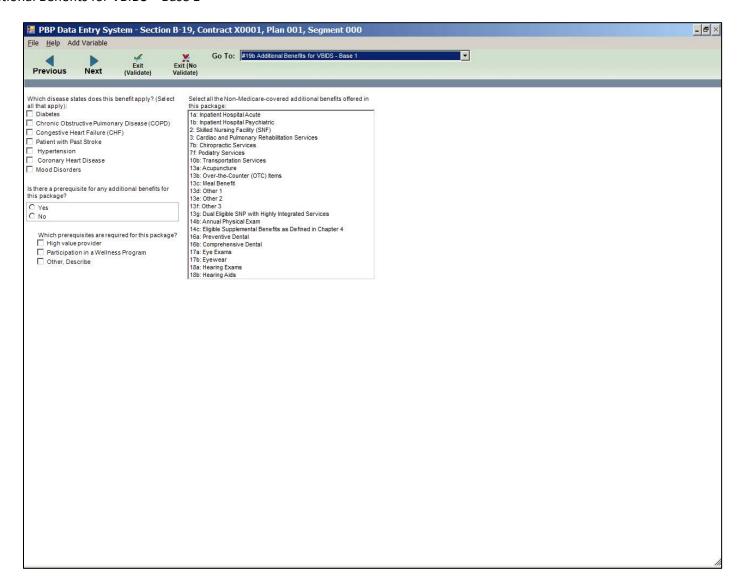
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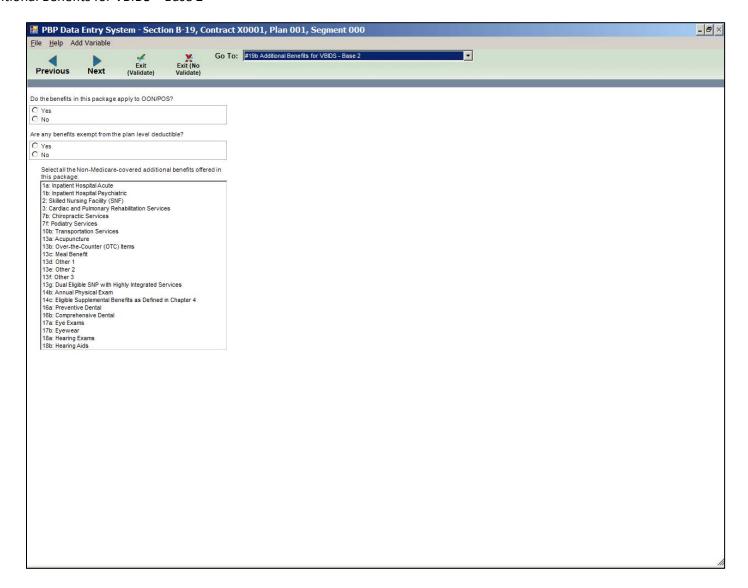
#19b Additional Benefits for VBIDS



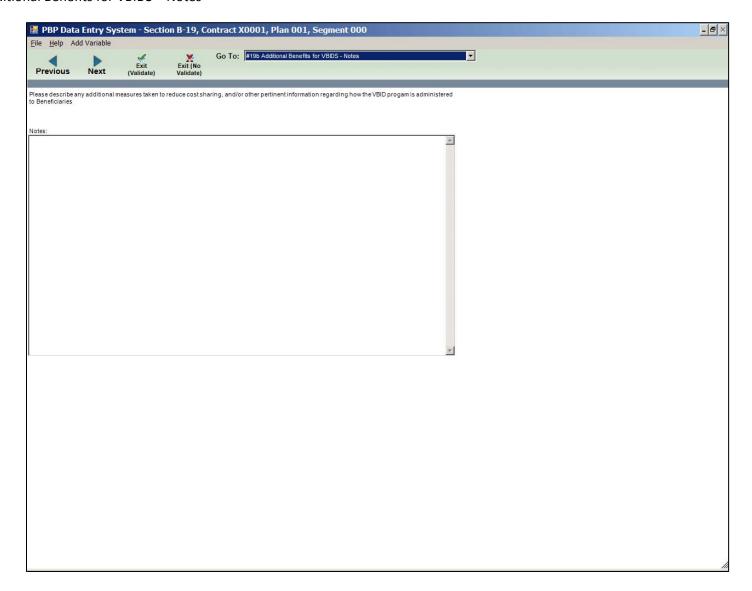
#19b Additional Benefits for VBIDS - Base 1

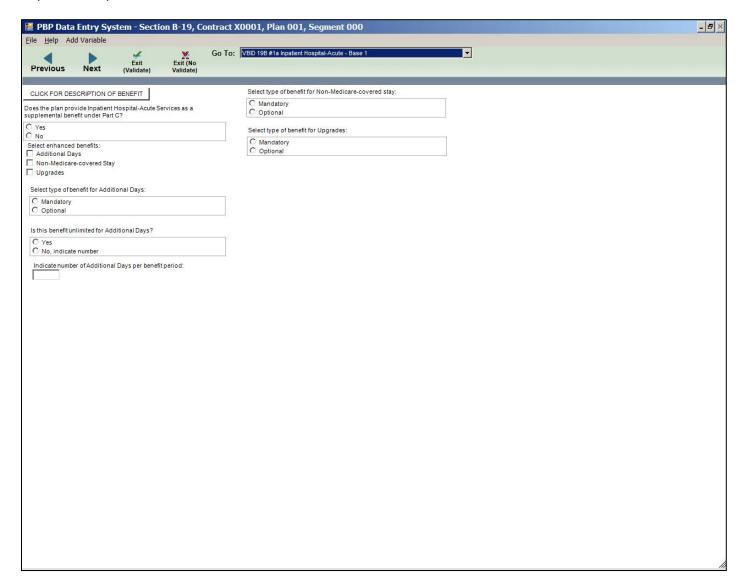


#19b Additional Benefits for VBIDS - Base 2



#19b Additional Benefits for VBIDS - Notes





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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?	Do you charge cost sharing on the day of discharge? C Yes C No	
C Yes C No	Is there an enrollee Coinsurance?	
Indicate the Maximum Enrollee Out-of-Pocket Cost amount:	C Yes O No	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Medicare-covered Coinsurance Cost Sharing for Tier 1:	
C Every three years C Every two years C Every year	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.) C Yes	
C Every six months C Every three months C Every Benefit Period	No Indicate Coinsurance percentage for the Medicare-covered stay:	
C Every Stay C Other, Describe	Indicate the number of day intervals for the Medicare-covered stay:	
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C Yes C No	C Two	
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What is your inpatient hospital benefit period?		
C Original Medicare C Annual C Per Admission C Other, describe	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
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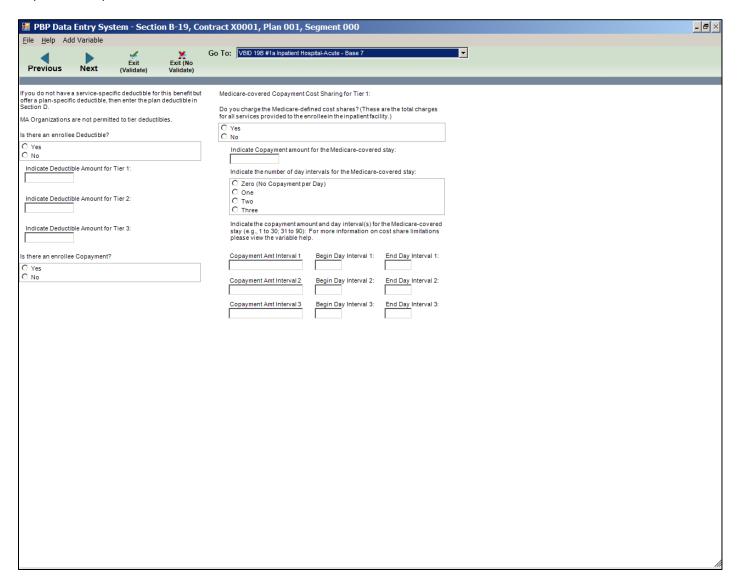
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Medicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3	
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	
C Zero (No Coinsurance per Day) C One C Two C Three	C Zero (No Coinsurance per Day) C One C Two C Three	C Zero (No Coinsurance per Day) C One C Two C Three	
Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	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 D	Day Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day	
Interval 1:	Interval 1:	Interval 1:	
Interval 2: Interval 3:	Interval 2: Interval 3:	Interval 3:	

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Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care? O Yes No How many cost sharing tiers do you offer? What is your lowest cost tier? O Tier 1 O Tier 2 O Tier 3 Additional Days Coinsurance Cost Sharing for Tier 1: Indicate the number of day intervals for Additional Days: O Zero (No Coinsurance per Day) O ne O Two O 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 3: End Day Interval 3:	Additional Days Coinsurance Cost Sharing for Tier 2: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day interval (s) for Additional Days (enter "989" if unlimited days are offered; e.g., 91 to 999); Coinsurance % Interval 1 Begin 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:	

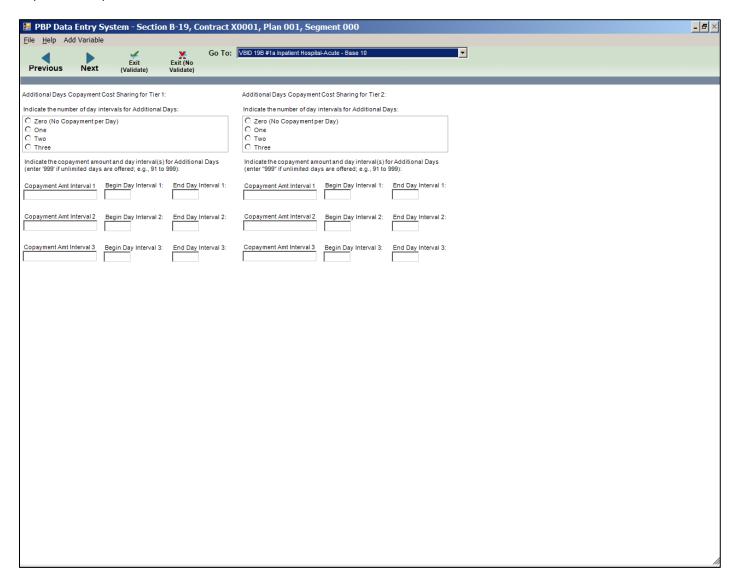
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Additional Days Indicate the num C Zero (No Co C One C Two C Three Indicate the co Days (enter % Coinsurance %	o Coinsurance per sinsurance per 99° if unlimited 6 Interval 1	Cost Sharing for T	nterval(s) for Addi e.g., 91 to 999): : End Day Interval	val 1: val 2:	Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay? C Yes No Indicate Coinsurance percentage for the Non-Medicare-covered stay: Indicate the number of day intervals for the Non-Medicare-covered stay: C Zero (No Coinsurance per Day) O 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:	

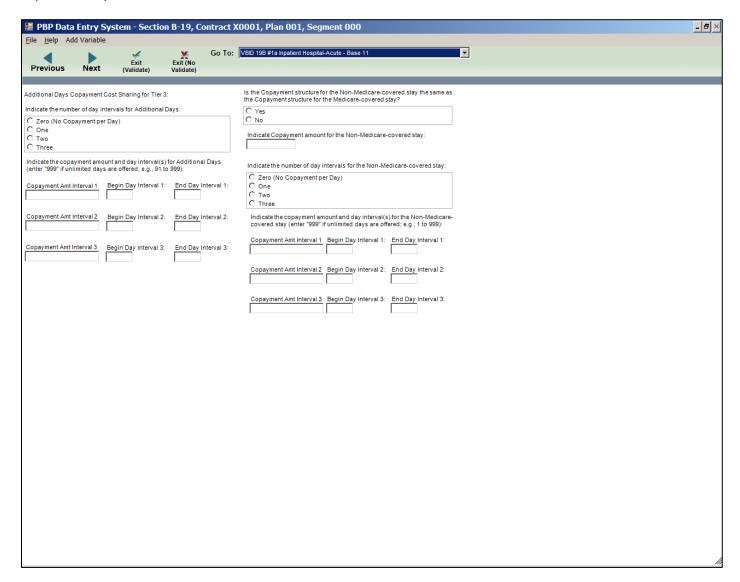


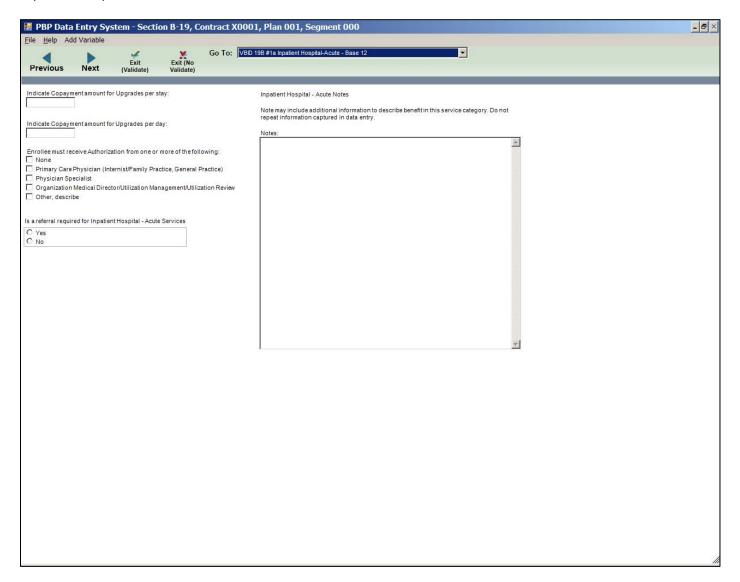
■ PBP Data Entry System - Section B-19, Contra	ct X0001, Plan 001, Segment 000	_ & ×
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Previous Next Exit Exit (No (Validate) Validate)		
Medicare-covered Copayment Cost Sharing for Tier 2:	Medicare-covered Copayment Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrolleein the inpatient facility.)	
O Yes O No	C Yes C No	
Indicate Copayment amount for the Medicare-covered stay:	Indicate Copayment amount for the Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Copayment per Day) C One C Two	C Zero (No Copayment per Day) O One C Two	
C Three	C 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.	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 1 Begin Day Interval 1: End Day Interval 1:	
Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	
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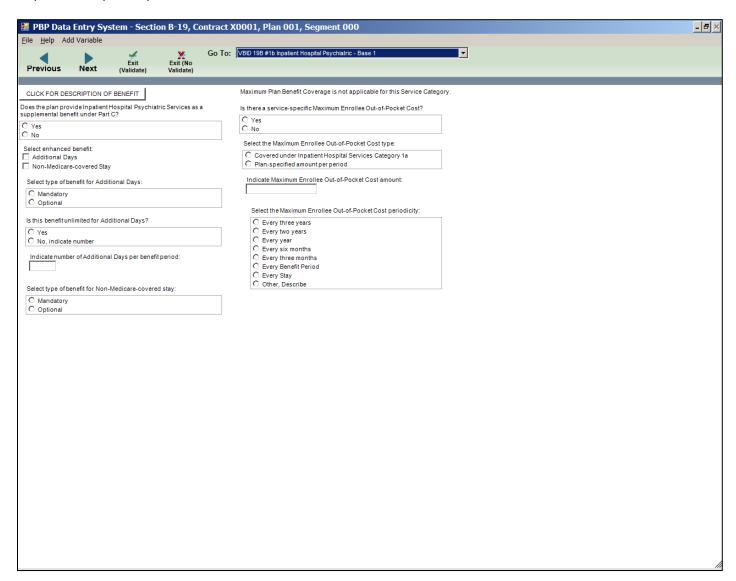
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Medicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3	
Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	
C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copayment per Day) C One C Two C 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):	
Interval Days	Interval Days	Interval Days	
Copay Amount Begin Day End Day	Copay Amount Begin Day End Day	Copay Amount Begin Day End Day	
Interval 1:	Interval 1:	Interval 1:	
Interval 2:	Interval 2:	Interval 2:	
Interval 3:	Interval 3:	Interval 3:	









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Does this plan's Medicare-covered benefit costsharing vary by hospital(s) in which an enrollee obtains care? Or yes Or yes Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.) Or you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.) Or you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.) Or you charge the Medicare-covered stay: Indicate Coinsurance percentage for the Medicare-covered stay: Indicate the number of day intervals for the Medicare-covered stay: Or one Or the coinsurance percentage and day intervals for the Medicare-covered stay: Or one Or three Indicate the coinsurance percentage and day interval (s) for the Medicare-covered stay (e.g., 1 to 30, 31 to 30); Or three Indicates the coinsurance percentage and day interval 1: End Day Interval 1: End Day Interval 2: End Day Interval 3: End Day Interval 4: End Day Interval 4: End Day Interval 4: End Day Interval 4: End	- ■	•	Exit	Exit (No Validate)	Go To:	VBID 19B #1b Inpatient Hospital Psychiatric - Base 2	
C Tier 1 C Tier 2 C Tier 3 Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Coinsurance per Day) C One C Two C Original Medicare C Annual C Per Admission C Other, describe If "Other, Describe" is selected enter description below: C Yes C Y	Which an enrolled	e obtains care?		haring vary by h	ospital(s) in	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.) C Yes C No	
C Per Admission C Other, describe If "Other, Describe" is selected enter description below: Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1: End Day Interval 2: Coinsurance % Interval 2: Coinsurance % Interval 3 Begin Day Interval 3: Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3: Coinsurance % Interval 3: End Day Interval 3: Coinsurance % Interva	C Tier 1 C Tier 2 C Tier 3 What is your inpa C Original Medi C Annual	itient hospital b	enefit period?			C Zero (No Coinsurance per Day) C One C Two C Three	
Is there an enrollee Coinsurance?	Other, descri	ibe ibe" is selected				Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
	is there an enroll	ee Coinsuranc	e?				
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Previous Next (Validate) Validate)		
Medicare-covered Coinsurance Cost Sharing for Tier 2:	Medicare-covered Coinsurance Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
C Yes	O Yes	
C No	C No	
Indicate Coinsurance percentage for the Medicare-covered stay:	Indicate Coinsurance percentage for the Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Coinsurance per Day) C One	C Zero (No Coinsurance per Day) C One	
O Two O Three	C Two	
Indicate the coinsurance percentage and day interval(s) for the	Indicate the coinsurance percentage and day interval(s) for the	
Medicare-covered stay (e.g., 1 to 30; 31 to 90):	Medicare-covered stay (e.g., 1 to 30; 31 to 90):	
Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
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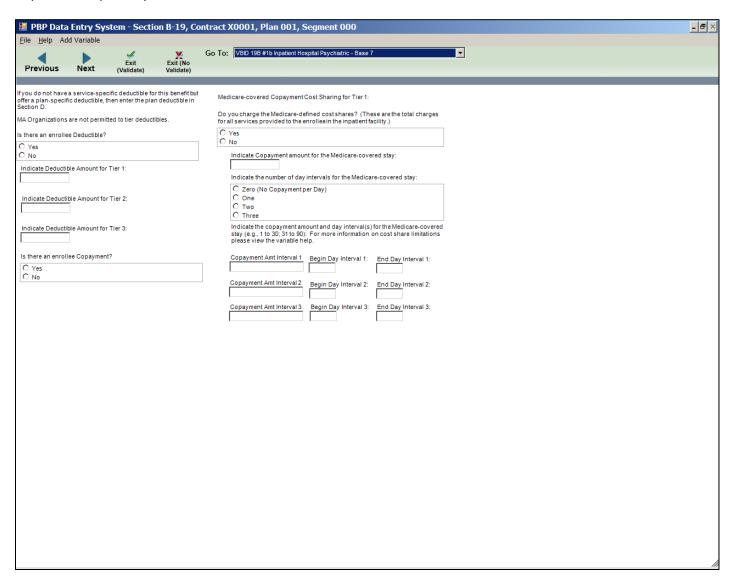
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Medicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3	
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	
C Zero (No Coinsurance per Day) C One C Two C Three	C Zero (No Coinsurance per Day) C One C Two C Three	C Zero (No Coinsurance per Day) C One C Two C Three	
Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	
Interval Days	Interval Days	Interval Days	
Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day	
Interval 1:	Interval 1:	Interval 1:	
Interval 2:	Interval 2:	Interval 2:	
Interval 3:	Interval 3:	Interval 3:	

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obes this plan's Additional Days cost sharing vary by hospital(s) in which an notice obtains care? Yes No How many cost sharing tiers do you offer? What is your lowest cost tier? C Tier 1 C Tier 2 C Tier 3 Idditional Days Coinsurance Cost Sharing for Tier 1: Idicate the number of day intervals for Additional Days: 2 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 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: C Zero (No Coinsurance per Day) C One C Two C 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 2: End Day Interval 1: Coinsurance % Interval 2 Begin Day Interval 3: End Day Interval 3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	

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Additional Days Coinsurance Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter '989' 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? C 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) O One 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:		

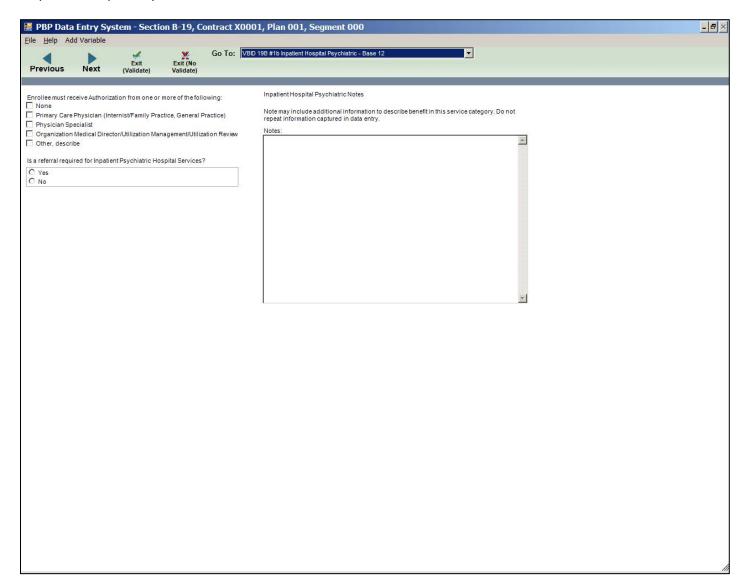


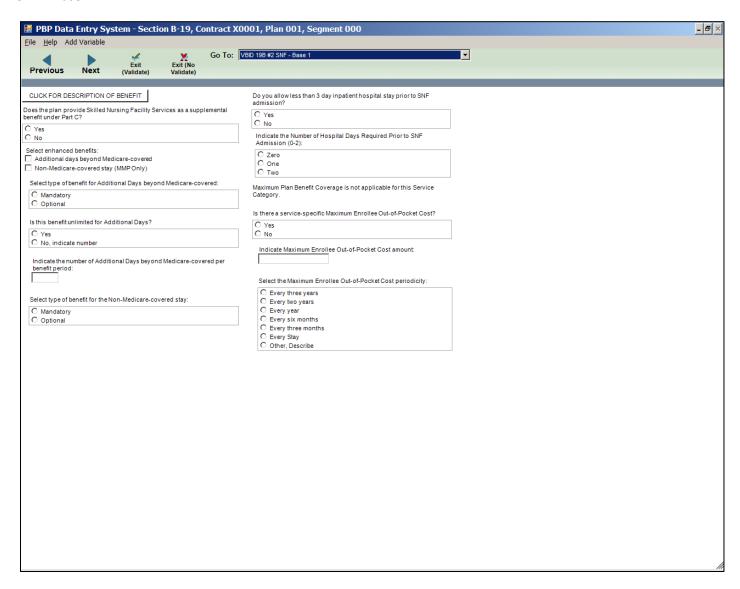
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Previous Next (Validate) Validate)		
Medicare-covered Copayment Cost Sharing for Tier 2:	Medicare-covered Copayment Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
O Yes	C Yes	
○ No	○ No	
Indicate Copayment amount for the Medicare-covered stay:	Indicate Copayment amount for the Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Copayment per Day) C One	C Zero (No Copayment per Day) C One	
C Two	C Two	
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.	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 1 Begin Day Interval 1: End Day Interval 1:	
Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	

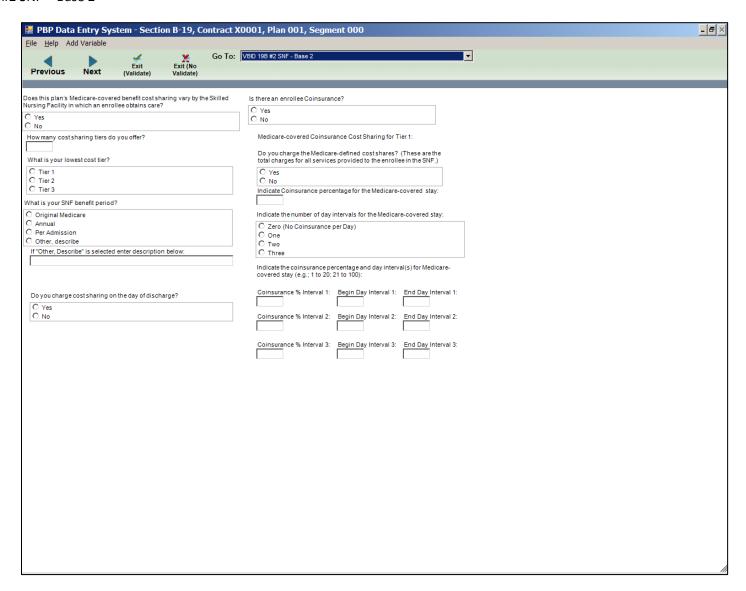
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Medicare-cove	red Lifetime Reserv	e Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3	
	mber of day interval e Reserve Days:	s for the Medicare-	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	
C Zero (No C C One C Two C Three	opayment per Day)		C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copayment per Day) C One C Two C Three	
Indicate the cop	payment amount an care-covered Lifetin	d day interval(s) ne Reserve Days	Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 50):	Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	
		Interval Days	Interval Days	Interval Days	
Сор	ay Amount Begin	Day End Day	Copay Amount Begin Day End Day	Copay Amount Begin Day End Day	
Interval 1:			Interval 1:	Interval 1:	
Interval 2:			Interval 2:	Interval 2:	
Interval 3:			Interval 3:	Interval 3:	

■ PBP Data Entry System - Section B-19, Contract 2	X0001, Plan 001, Segment 000	_ & ×
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Previous Next (Validate) Go To:		
Additional Days Copayment Cost Sharing for Tier 1:	Additional Days Copayment Cost Sharing for Tier 2:	
Indicate the number of day intervals for Additional Days:	Indicate the number of day intervals for Additional Days:	
C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copayment per Day) C One C 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):	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 1 Begin Day Interval 1: End Day Interval 1:	
Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	

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	Is the Copayment structure for the Non-Medicare-covered stay the same as	
Additional Days Copayment Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days:	the Copayment structure for the Medicare-covered stay? C Yes	
C Zero (No Copayment per Day)	C No	
O Two O Three	Indicate Copayment amount for the Non-Medicare-covered stay:	
Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):	Indicate the number of day intervals for the Non-Medicare-covered stay:	
Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	C Zero (No Copaymentper Day) C One C Two C Three	
Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	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 3 Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	
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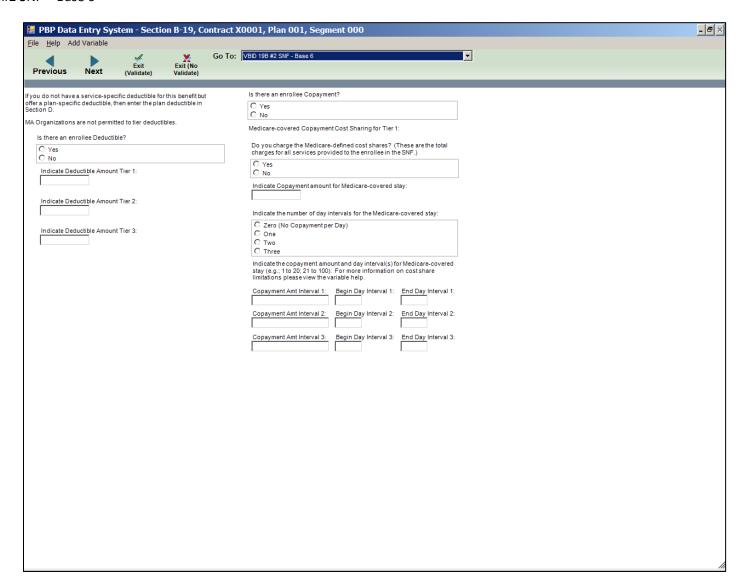




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Previ	ious Ne	xt (Validate)	Validate)	_		
Medicare-	-covered Coinsu	urance Cost Sharing fo	or Tier 2:		Medicare-covered Coinsurance Cost Sharing for Tier 3:	
		are-defined cost share			Do you charge the Medicare-defined cost shares? (These are the	
total charg	ges for all servic	es provided to the enr	rollee in the SNF.)		total charges for all services provided to the enrollee in the SNF.)	
O Yes O No					C Yes C No	
	Coinsurance per	centage for the Medica	are-covered stay:		Indicate Coinsurance percentage for the Medicare-covered stay:	
		y intervals for the Med	licare-covered stay	:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero ((No Coinsurance	e per Day)			C Zero (No Coinsurance per Day) C One	
O Two					C Two	
C Three	9				O Three	
Indicate the	he coinsurance p stay (e.g.; 1 to 20	percentage and day in 0; 21 to 100):	terval(s) for Medica	are-	Indicate the coinsurance percentage and day interval(s) for Medicare- covered stay (e.g.; 1 to 20; 21 to 100):	
Coinsurar	nce % Interval 1	: Begin Day Interval	1: End Day Inter	val 1:	Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
Coinsurar	nce % Interval 2	: Begin Day Interval	2: End Day Inter	val 2:	Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
Coinsurar	nce % Interval 3	: Begin Day Interval	3: End Day Inter	val 3:	Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
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Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care? C Yes No How many cost sharing tiers do you offer? What is your lowest cost tier? C Tier 1 C Tier 2 C Tier 3 Additional Days Coinsurance Cost Sharing for Tier 1: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurancepercentage 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 2: 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: C Zero (No Coinsurance per Day) C 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 3: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
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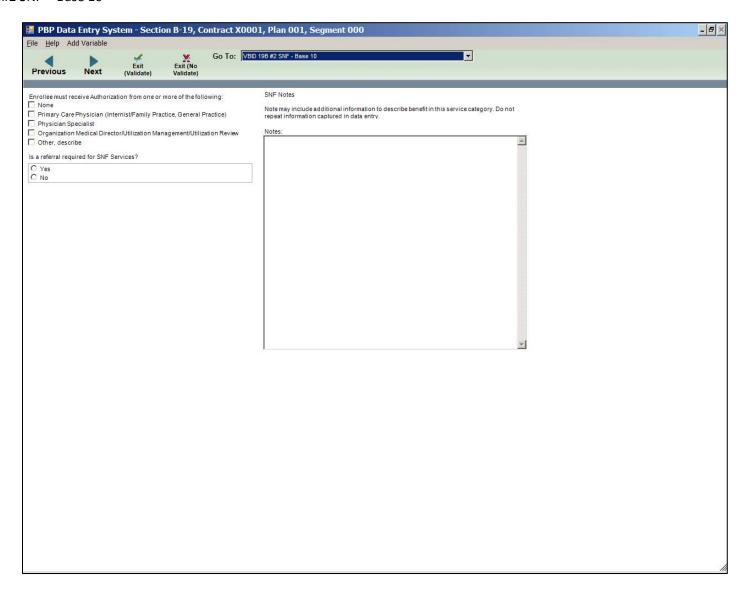
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File Help Add Variable Frevious Next (Validate) Figure 4 Figure 2 Fixed (Validate) Frevious Next (Validate)	: VBID 198 #2 SNF - Base 5	
Additional Days Coinsurance Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C 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? C Yas C No Indicate Coinsurance percentage for the Non-Medicare-covered stay: Indicate the number of day intervals for the Non-Medicare-covered stay: C Zero (No Coinsurance per Day) C One C Two C 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: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	



🔢 PBP Data Entry System - Section B-19, Contract)	X0001, Plan 001, Segment 000	_ 6 ×
File Help Add Variable	VBID 198 #2 SNF - Base 7 ▼	
Previous Next (Validate) (Validate)	VDID 190 42 SNT - DBS6 /	
(Validate) Validate)		
Medicare-covered Copayment Cost Sharing for Tier 2:	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.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	
C Yes C No	C Yes C No	
Indicate Copayment amount for Medicare-covered stay:	Indicate Copayment amount for Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Copayment per Day) C One C Two	C Zero (No Copayment per Day) C One C Two C Three	
Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g.; 1to 20; 2t to 100): For more information on cost share limitations please view the variable help.	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 1: Begin Day Interval 1: End Day Interval 1:	
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	

Elle Help Add Variable Previous Next (validate) Additional Days Copayment Cost Sharing for Tier 1: Indicate the number of day intervals for Additional Days: C zero (No Copayment per Day) C Trive Indicate the copayment amount and day interval (s) for Additional Days (c) Trive Indicate the copayment amount and day interval (s) for Additional Days (c) Trive Indicate the copayment amount and day interval (s) for Additional Days (c) Trive Indicate the copayment amount and day interval (s) for Additional Days (c) Trive Indicate the copayment amount and day interval (s) for Additional Days (enter '999' funlimited days are offered, e.g., 101 to 999); Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 2: Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3: End Day Interval 3: Copayment Amt Interval 3: End Day Interval 3: End Day Interval 3: Copayment Amt Interval 3:	PBP Data Entry System - Section B-19, Contr	ract X0001, Plan 001, Segment 000	_ & ×
Indicate the number of day intervals for Additional Days: C Zero (No Copayment per Day) C One C Two C 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 3: End Day	Exit Exit (No	o To: VBID 198 #2 SNF - Base 8	
	Additional Days Copayment Cost Sharing for Tier 1: Indicate the number of day intervals for Additional Days: C Zero (No Copayment per Day) C One C Two C Three Indicate the copayment amount and day interval(s) for Additional Day (enter '999' if unlimited days are offered; e.g., 101 to 999): Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval	Indicate the number of day intervals for Additional Days: C Zero (No Copayment per Day) One C Two C Three Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999): C Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1: C Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	

■ PBP Data Entry System - Section B-19, Contract	X0001, Plan 001, Segment 000	_ B ×
File Help Add Variable Go To: Exit Exit (No Validate) Validate)	: VBID 19B #2 SNF - Base 9	
Additional Days Copayment Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days: C Zero (No Copayment per Day) C One C Two C 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 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? C Yes C No Indicate Copayment amount for Non-Medicare-covered stay: Indicate the number of day intervals for the Non-Medicare-covered stay: C Zero (No Copayment per Day) C One C Two C 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 #3 Cardiac and Pulmonary Rehabilitation Services – Base 1

■ PBP Data Entry System - Section B-19, Contract XO	001, Plan 001, Segment 000	_ B ×
File Help Add Variable	/BID 198 #3 Cardiac and Pulmonary Rehabilitation Services - Base 1	
Exit Exit (No	BID 196 #3 Cardiac and Polinonary Renabilitation Services - Base 1	
Previous Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C? Ves No Select enhanced benefit: Additional Cardiac Rehabilitation Services Additional Intensive Cardiac Rehabilitation Services	Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services? O Yes No, indicate number Indicate number of visits for Additional Intensive Cardiac Rehabilitation Services: Select the Additional Intensive Cardiac Rehabilitation Services periodicity:	
Additional Pulmonary Rehabilitation Services Additional Pulmonary Rehabilitation Services Select type of benefit for Additional Cardiac Rehabilitation Services: C Mandatory C Optional Is this benefit unlimited for Additional Cardiac Rehabilitation Services?	C Every three years C Every two years C Every sumenths C Every sumenths C Every three months C Other, Describe	
C Yes C No, indicate number	Select type of benefit for Additional Pulmonary Rehabilitation Services:	
Indicate number of visits for Additional Cardiac Rehabilitation Services:	C Mandatory C Optional	
Select the Additional Cardiac Rehabilitation Services periodicity: C Every three years C Every two years C Every six months C Every six months C Other, Describe Select type of benefit for Additional Intensive Cardiac Rehabilitation Services: C Mandatory C Optional	Is this benefit unlimited for Additional Pulmonary Rehabilitation Services? O Yes No, indicate number Indicate number of visits for Additional Pulmonary Rehabilitation Services: Select the Additional Pulmonary Rehabilitation Services periodicity: C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	

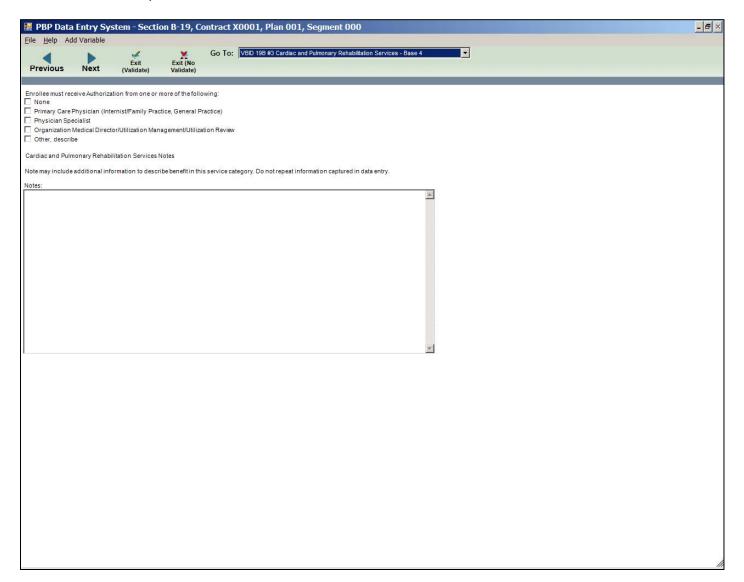
VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services – Base 2

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ile <u>H</u> elp At	uu variable	_	v	Go To:	VBID 19B #3 Cardiac and Pulmonary Rehabilitation Ser	vices - Base 2	▼	
Previous	Next	Exit (Validate)	Exit (No Validate)					
		(**************************************	,					
ximum Plan Be	nefit Coverage i	s not applicable	e for this Service	e Category.	Select which Cardiac and Pulmonary Rehabilitation	Services have a	a	
		FII O-4	- 6 D 1 1 O 1		Coinsurance (Select all that apply): Medicare-covered Cardiac Rehabilitation Service	es		
	-specific Maximu	m Enrollee Out-	of-Pocket Cost	17	Medicare-covered Intensive Cardiac Rehabilitation	on Services		
Yes No					Medicare-covered Pulmonary Rehabilitation Serv	rices		
					☐ Additional Cardiac Rehabilitation Services ☐ Additional Intensive Cardiac Rehabilitation Servi			
ndicate Maxin	num Enrollee Ou	t-of-Pocket Cos	st amount:		Additional Pulmonary Rehabilitation Services	ces		
					Additional dimonaly remainitation colvices	Minimum	Maximum	
Select Maxim	um Enrollee Out	-of-Pocket Cost	periodicity:			Coinsurance		
C Every thr	ee years				Indicate Coinsurance percentage for Medicare-			
C Every two					covered Cardiac Rehabilitation Services:			
C Every year C Every six					Indicate Coinsurance percentage for Medicare-			
C Every thr					covered Intensive Cardiac Rehabilitation Services:			
Other, De					Indicate Coinsurance percentage for Medicare- covered Pulmonary Rehabilitation Services:			
ou must includ	e total cost shar	ng to the benefi	ciary, including	any	•			
ility cost sha minimum an	ring. If you have d maximum field	a variety of cost s to reflect the lo	tsharing, pleas owest and high	e utilize est cost	Indicate Coinsurance percentage for Additional Cardiac Rehabilitation Services:			
	eneficiary may p		-					
	ollee Coinsurano	-0			Indicate Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:			
	ollee Coinsurand	e?						
O Yes O No					Indicate Coinsurance percentage for Additional Pulmonary Rehabilitation Services:			
Z NO					·, · · · · · · · · · · · · · · · ·			

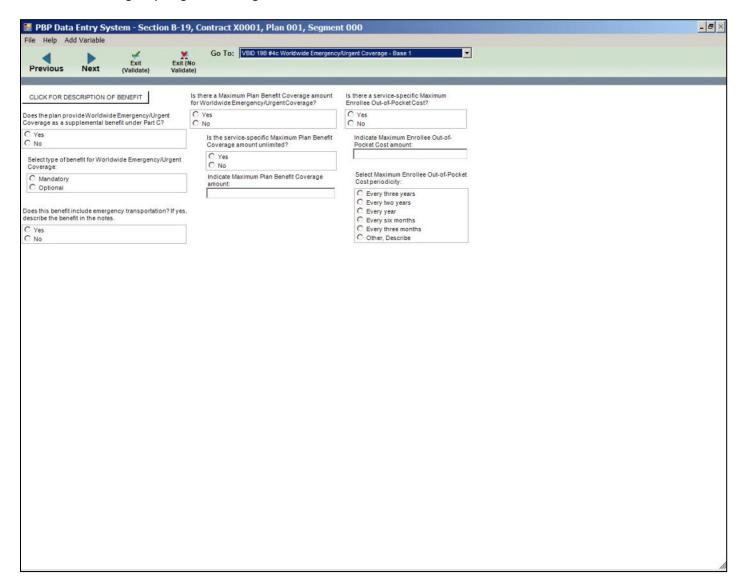
VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services – Base 3

PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000 - €					
<u>F</u> ile <u>H</u> elp Add Variable					
Exit Exit (No	Go To: VBID 19B #3 Cardiac and Pulmonary Rehability	ation Services - Base 3			
Previous Next (Validate) Validate)					
Is there an enrollee Deductible?		Minimum Copayment	Maximum Copayment		
C No	Indicate Copayment amount for Medicare- covered Cardiac Rehabilitation Services:				
Indicate Deductible Amount:	Indicate Copayment amount for Medicare- covered Intensive Cardiac Rehabilitation Services				
Is there an enrollee Copayment? C Yes C No	Indicate Copayment amount for Medicare- covered Pulmonary Rehabilitation Services:				
Select which Cardiac and Pulmonary Rehabilitation Services have	Indicate Copayment amount for Additional Cardiac Rehabilitation Services:				
a Copayment (Select all that apply): ☐ Medicare-covered Cardiac Rehabilitation Services ☐ Medicare-covered Intensive Cardiac Rehabilitation Services	Indicate Copayment amount for Additional Intensive Cardiac Rehabilitation Services:				
	Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:				
Additional Pulmonary Rehabilitation Services Additional Pulmonary Rehabilitation Services					

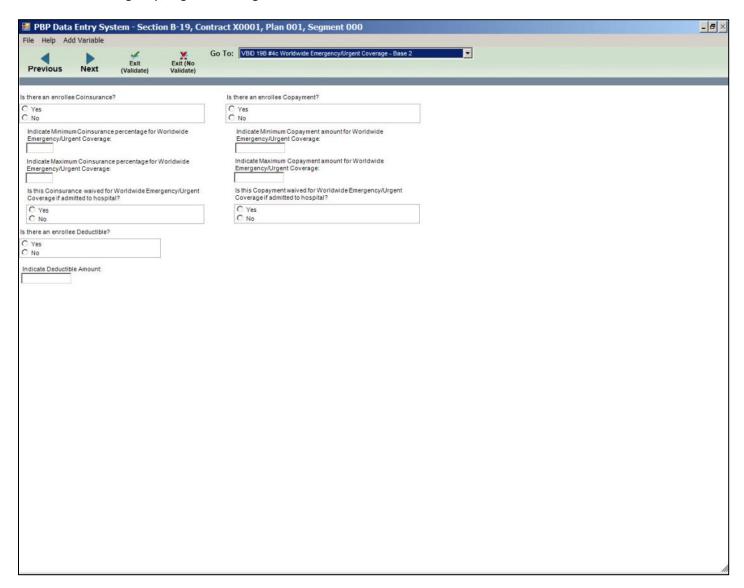
VBID 19B #3 Cardiac and Pulmonary Rehabilitation Services - Base 4



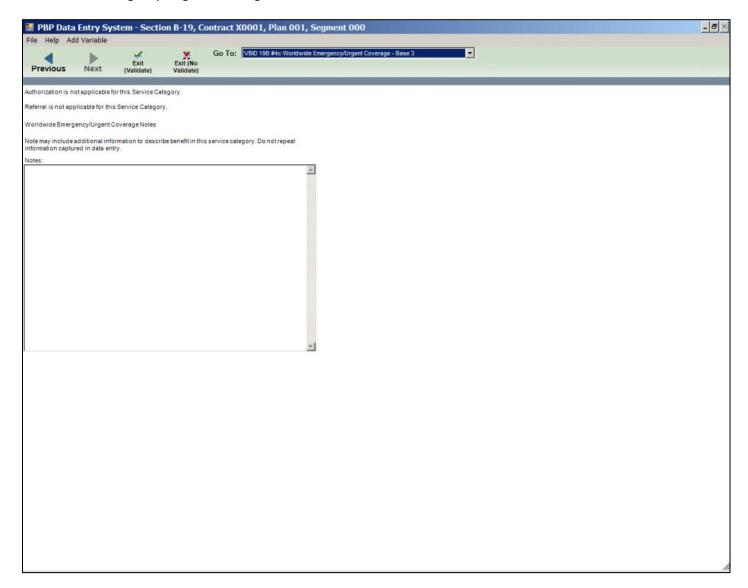
VBID 19B #4c Worldwide Emergency/Urgent Coverage – Base 1



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

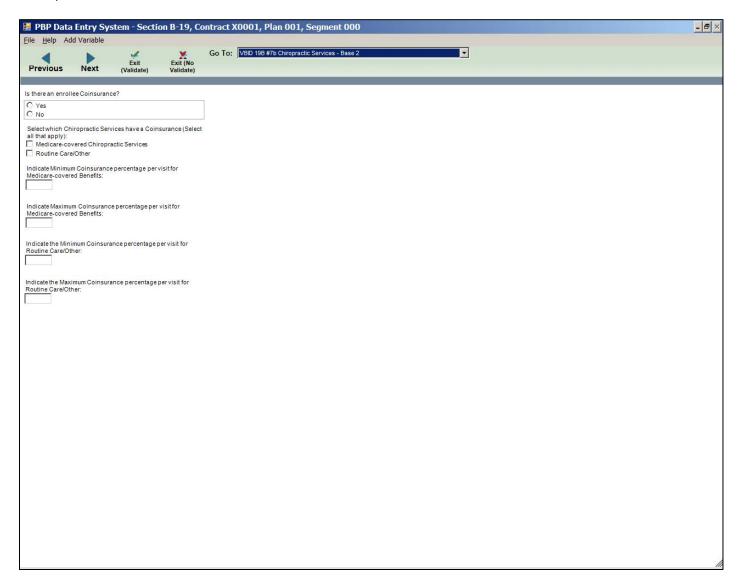


VBID 19B #4c Worldwide Emergency/Urgent Coverage - Base 3

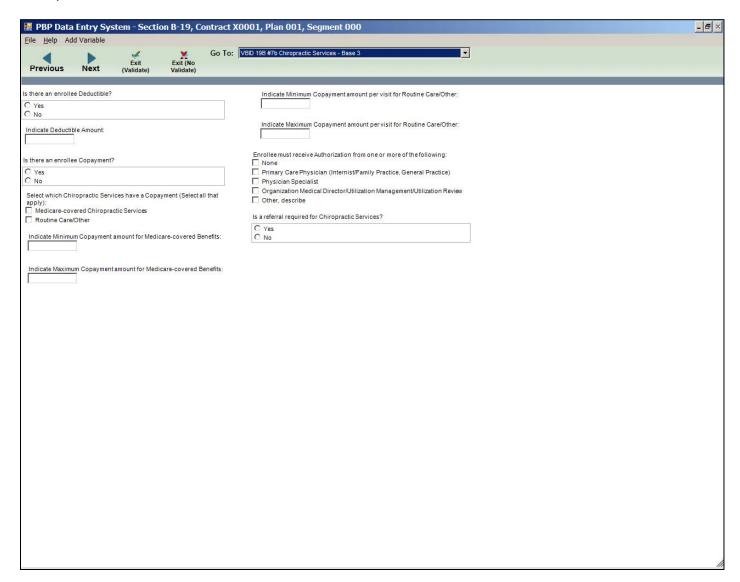


VBID 19B #7b Chiropractic Services – Base 1

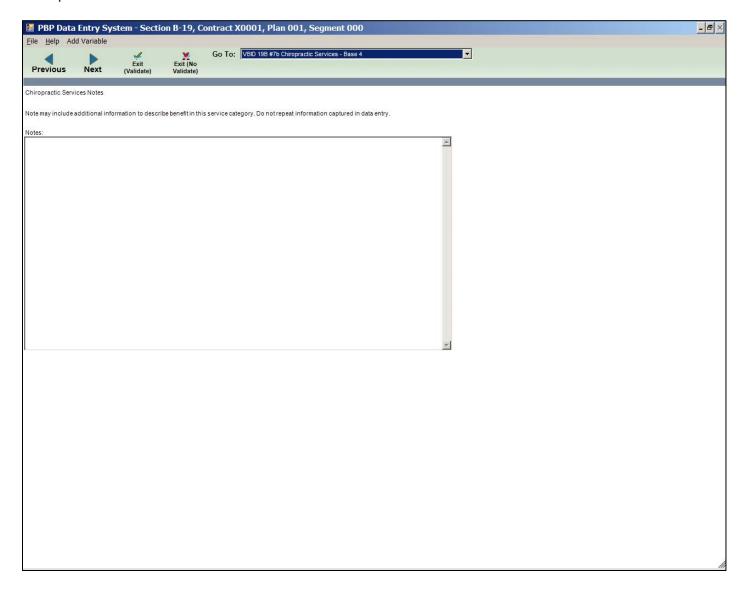
VBID 19B #7b Chiropractic Services – Base 2



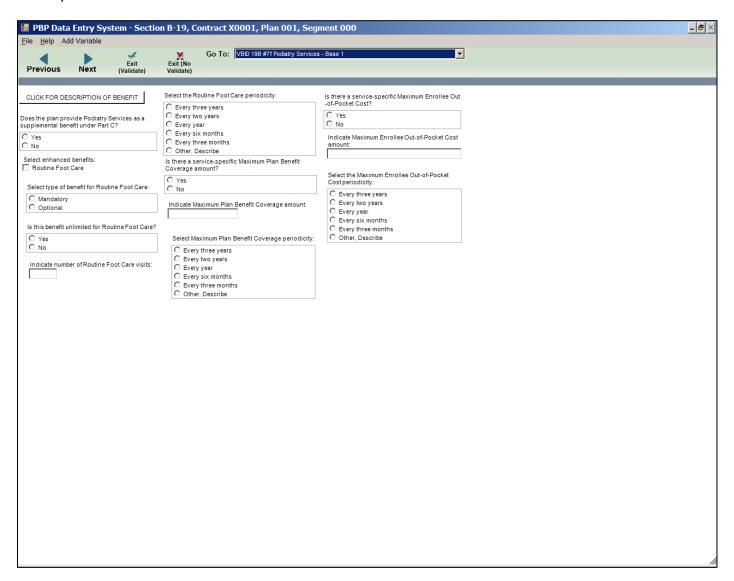
VBID 19B #7b Chiropractic Services – Base 3



VBID 19B #7b Chiropractic Services - Base 4



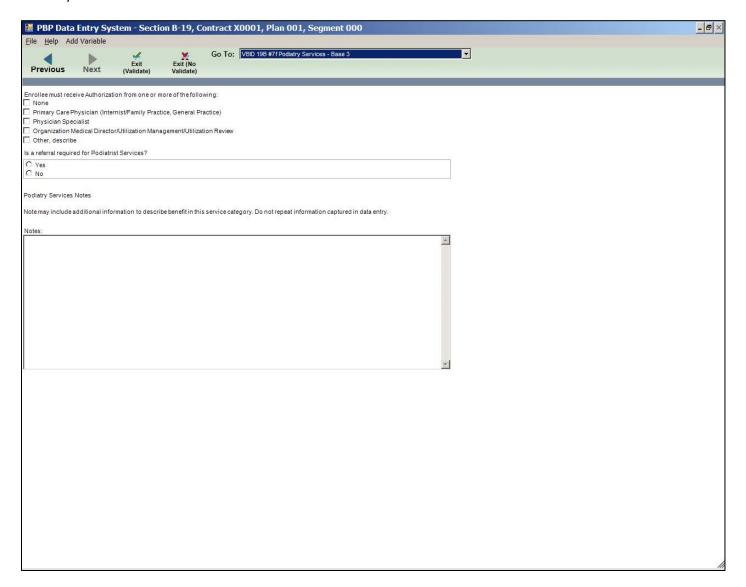
VBID 19B #7f Podiatry Services - Base 1



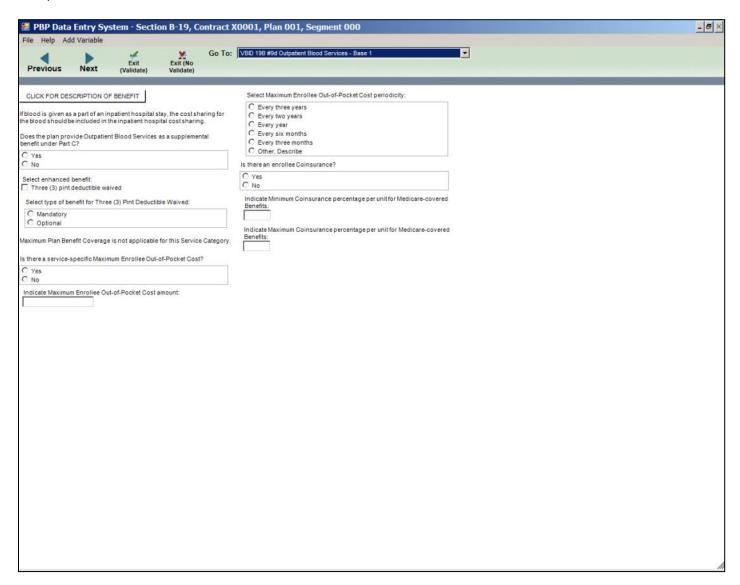
VBID 19B #7f Podiatry Services – Base 2

■ PBP Data Entry System - Section B-19, Contract 2	X0001, Plan 001, Segment 000	_ B ×
Elle Help Add Variable Frevious Next Exit Exit (No Validate) Go To:	VBID 19B #7f Podiatry Services - Base 2 ▼	
Is there an enrollee Coinsurance? C Yes No	Is there an enrollee Copayment? C Yes C No	
Select which Podiatry Services have a Coinsurance (Select all that apply): Medicare-covered Podiatry Services Routine Foot Care	Select which Podiatry Services have a Copayment (Select all that apply): Medicare-covered Podiatry Services Routine Foot Care	
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Minimum Coinsurance percentage for Routine Foot Care:	Indicate Minimum Copayment amount pervisit for Routine Foot Care:	
Indicate Maximum Coinsurance percentage for Routine Foot Care:	Indicate Maximum Copayment amount per visit for Routine Foot Care:	
Is there an enrollee Deductible? C Yes C No		
Indicate Deductible Amount:		

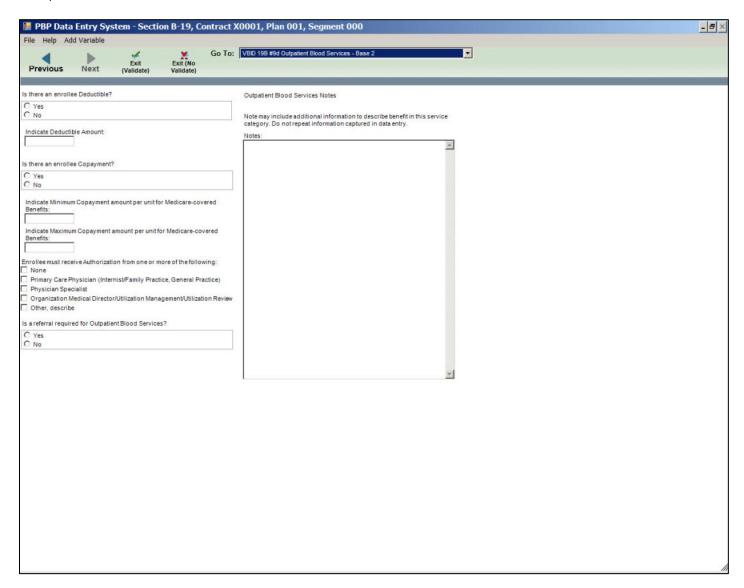
VBID 19B #7f Podiatry Services - Base 3



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



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



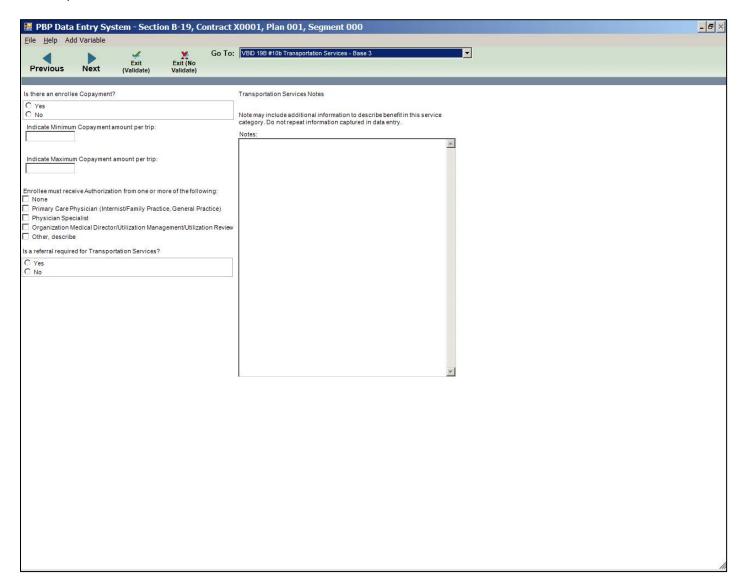
VBID 19B #10b Transportation Services – Base 1

	B-19, Contract X0001, Plan 001,	Segment 000	_ & ×
<u>File H</u> elp Add Variable	0.7		
Previous Next (Validate)	Go To: VBID 19B #10b Transport	ation Services - Base 1 ▼	
Previous Next (Validate)	Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Select Type of Transportation for Plan-approved Location:	Indicate number of trips for Any Location:	
Does the plan provide Transportation Services as a supplemental benefit under Part C? O Yes	C Round Trip C Days	Select Any Location Trips periodicity:	
O No Select enhanced benefit:	Other, describe	C Every three years Every two years Every year	
Plan-approved Location Any Location	Location:	C Every six months C Every three months Other, Describe	
Select type of benefit for Plan-approved Location: C Mandatory O Optional	approved Location: Taxi	Select Type of Transportation for Any Location: C One-way	
Is this benefit unlimited for number of trips for Plan -approved Location?	Medical Transport	C Round Trip C Days C Other, describe	
O Yes O No	Select type of benefit for Any Location:	Indicate number of days for Any Location:	
Indicate number of trips for Plan-approved Location:	C Mandatory C Optional Is this benefit unlimited for number of trips for	Select Mode of Transportation for Any Location: ☐ Taxi	
Select Plan-approved Location Trips periodicity: © Every three years	C Yes	☐ Bus/Subway ☐ Van ☐ Medical Transport	
C Every two years C Every year C Every six months C Every three months C Other, Describe	С но	Other, describe	

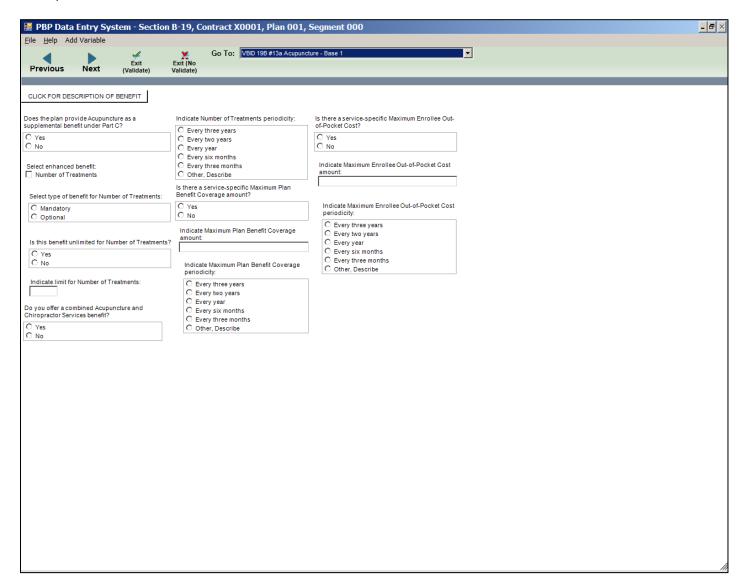
VBID 19B #10b Transportation Services – Base 2

PBP Data Entry System - Section	B-19, Contract X0001, Plan	001, Segment 000	_ - ×
<u>File Help Add Variable</u>			
Exit	Go To: VBID 19B #10b Tr	ansportation Services - Base 2	
Previous Next (Validate)	Exit (No Validate)		
Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?	
C Yes	C Yes	C Yes	
C No	C No	C No	
Indicate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of- Pocket Cost amount:	Indicate Minimum Coinsurance percentage:	
Select Maximum Plan Benefit Coverage periodicity:		Indicate Maximum Coinsurance percentage:	
C Every three years	Select Maximum Enrollee Out-of- Pocket Cost periodicity:		
C Every two years C Every year	C Every three years	Is there an enrollee Deductible?	
C Every year C Every six months	C Every two years	C Yes	
C Every three months	C Every year C Every six months		
C Other, Describe	C Every three months C Other, Describe	Indicate Deductible Amount:	
	Carlet, Bescribe		

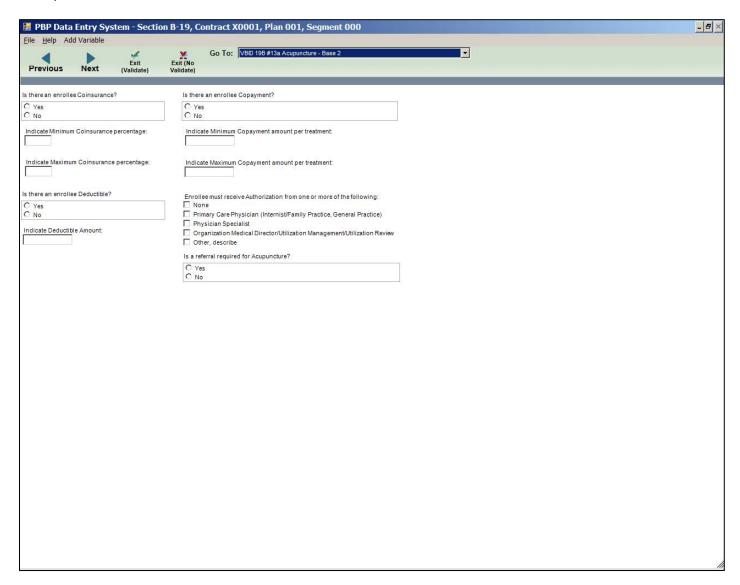
VBID 19B #10b Transportation Services - Base 3



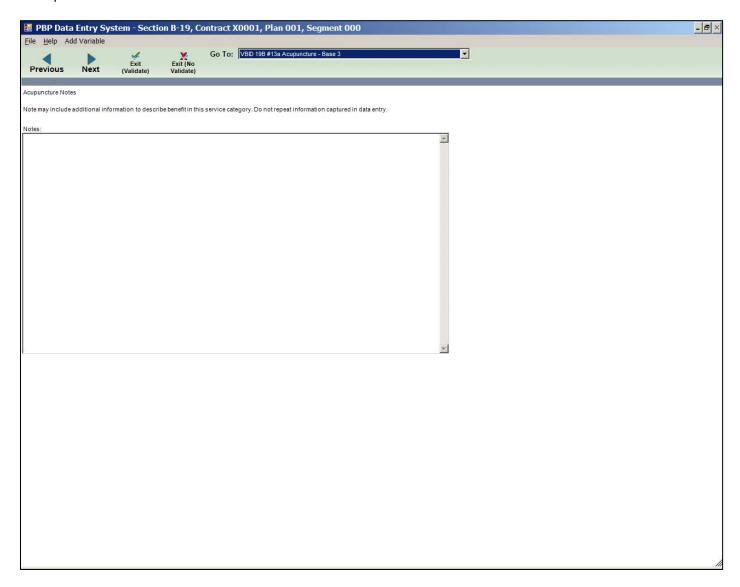
VBID 19B #13a Acupuncture - Base 1



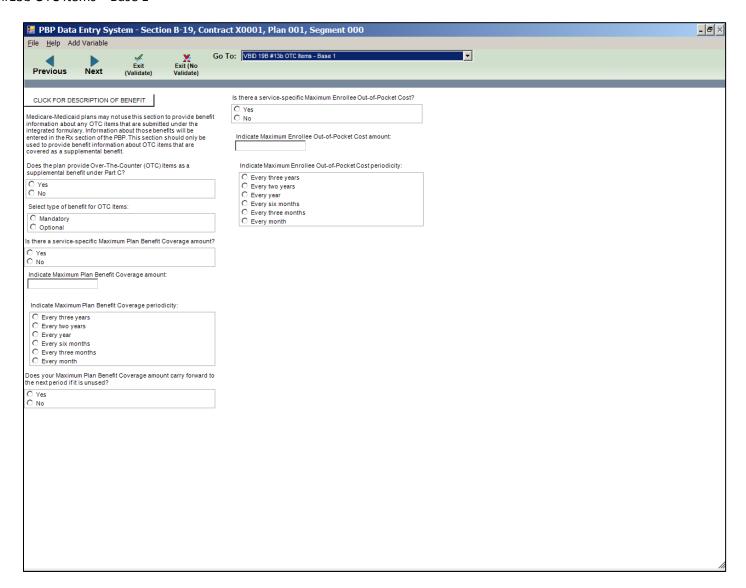
VBID 19B #13a Acupuncture - Base 2



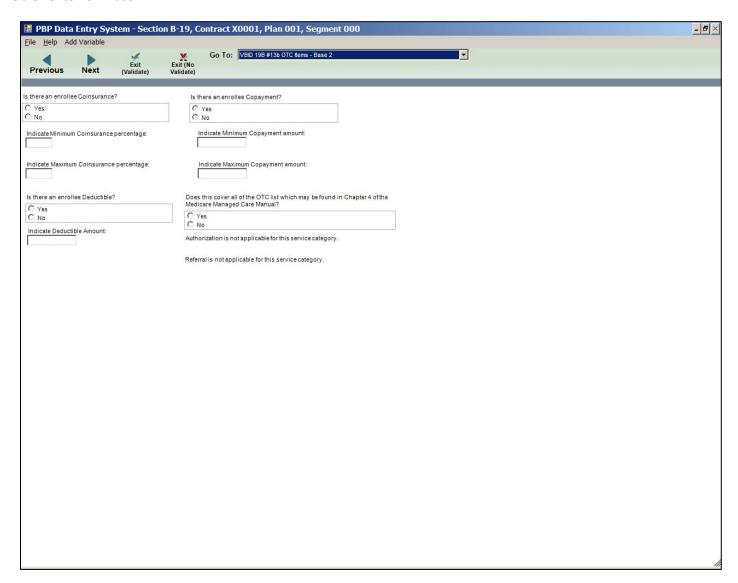
VBID 19B #13a Acupuncture - Base 3



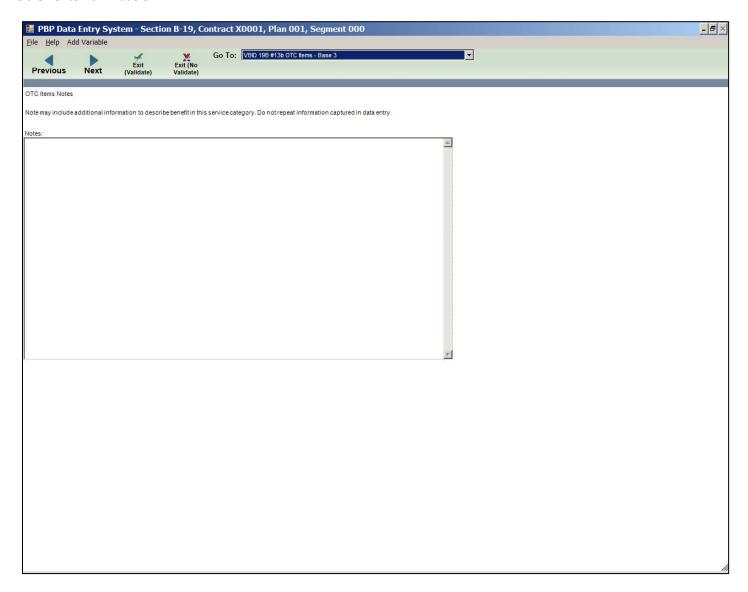
VBID 19B #13b OTC Items – Base 1



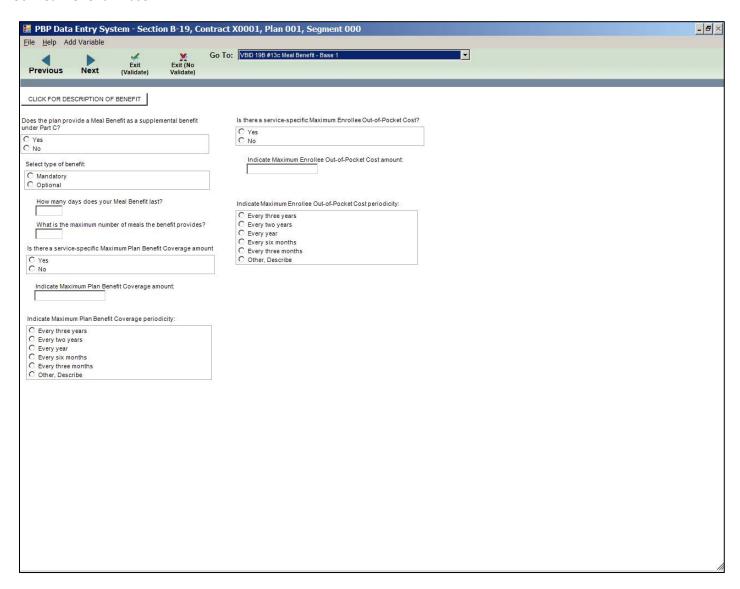
VBID 19B #13b OTC Items - Base 2



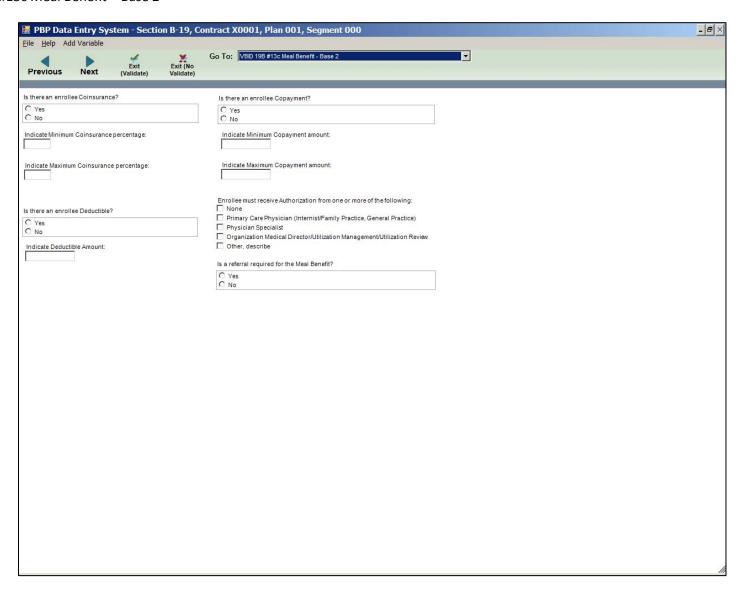
VBID 19B #13b OTC Items - Base 3



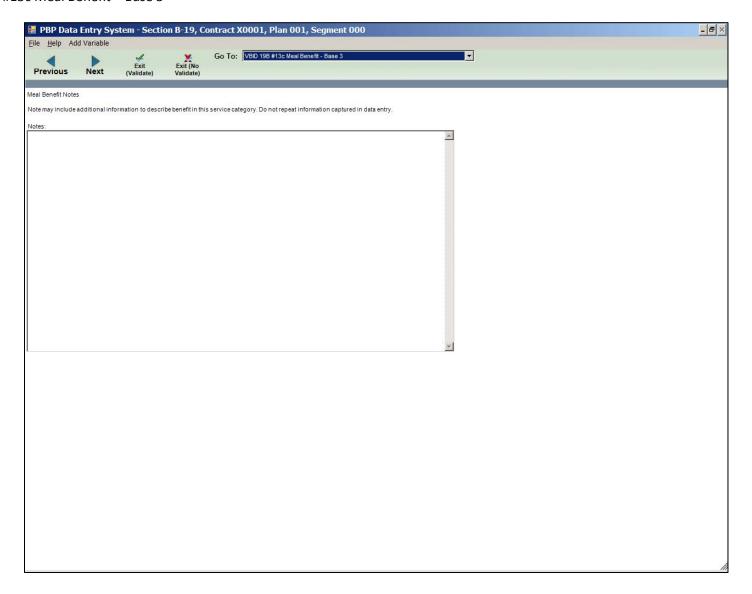
VBID 19B #13c Meal Benefit – Base 1



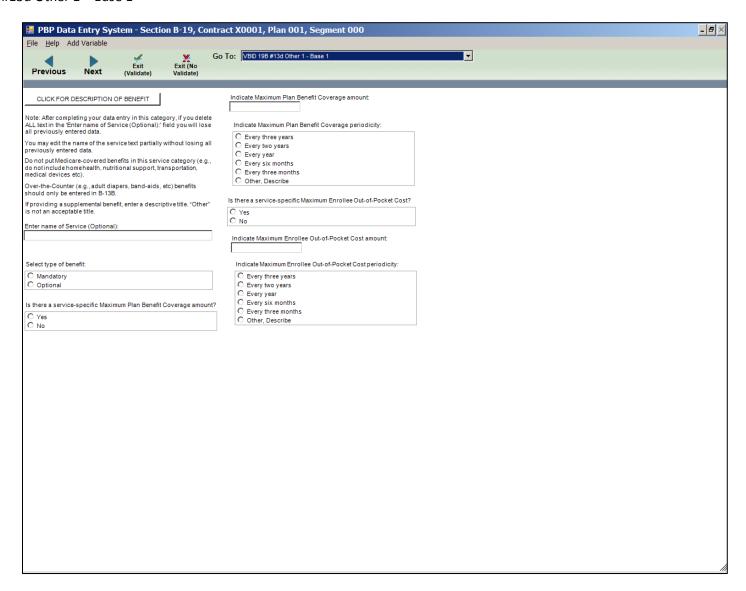
VBID 19B #13c Meal Benefit - Base 2



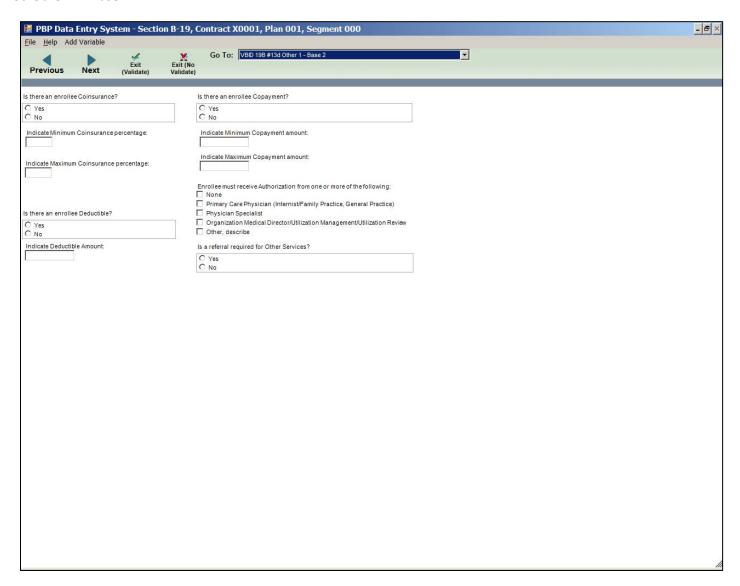
VBID 19B #13c Meal Benefit - Base 3



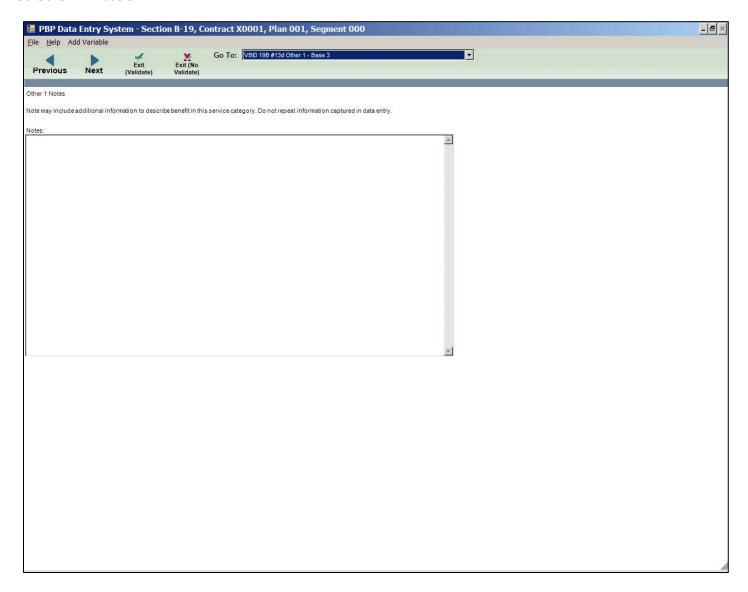
VBID 19B #13d Other 1 - Base 1



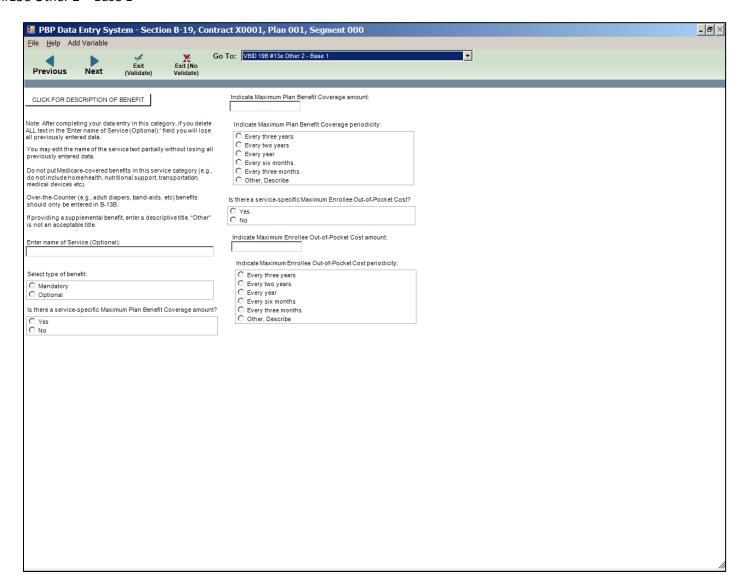
VBID 19B #13d Other 1 – Base 2



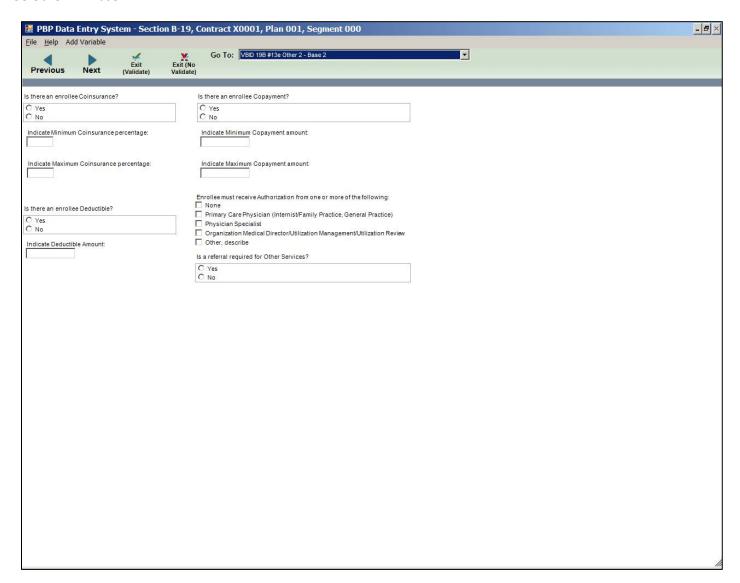
VBID 19B #13d Other 1 - Base 3



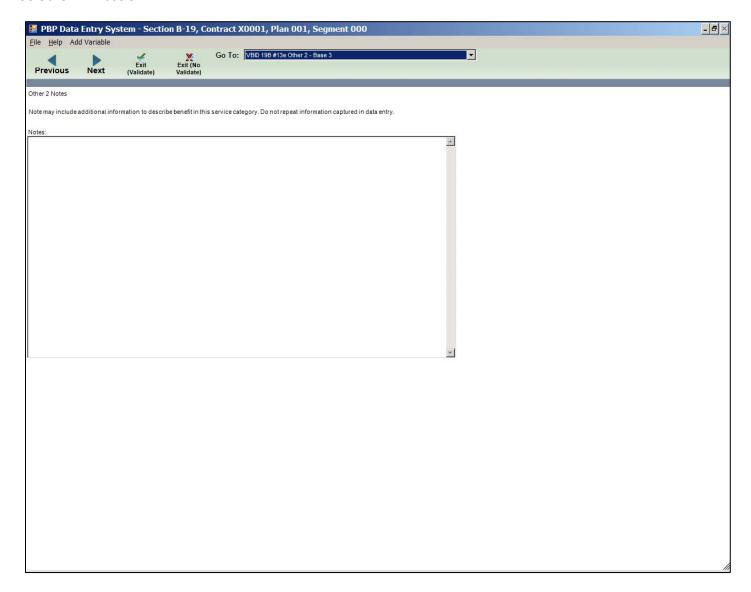
VBID 19B #13e Other 2 - Base 1



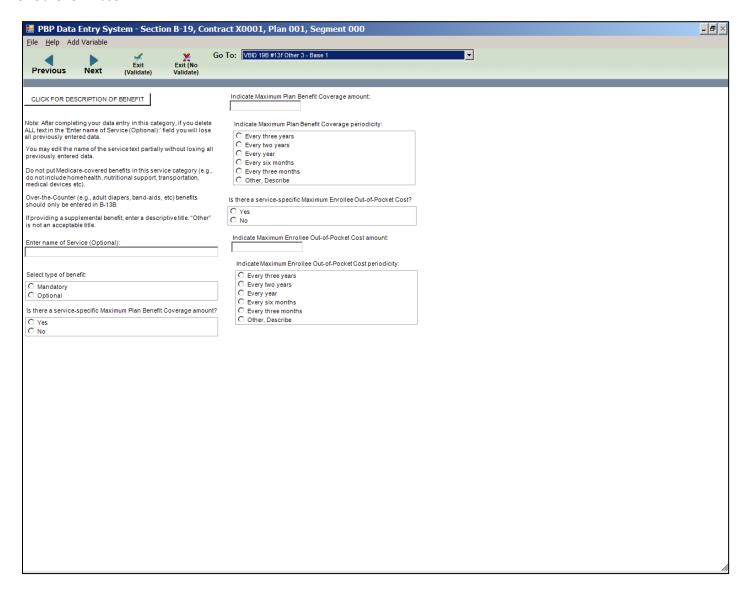
VBID 19B #13e Other 2 - Base 2



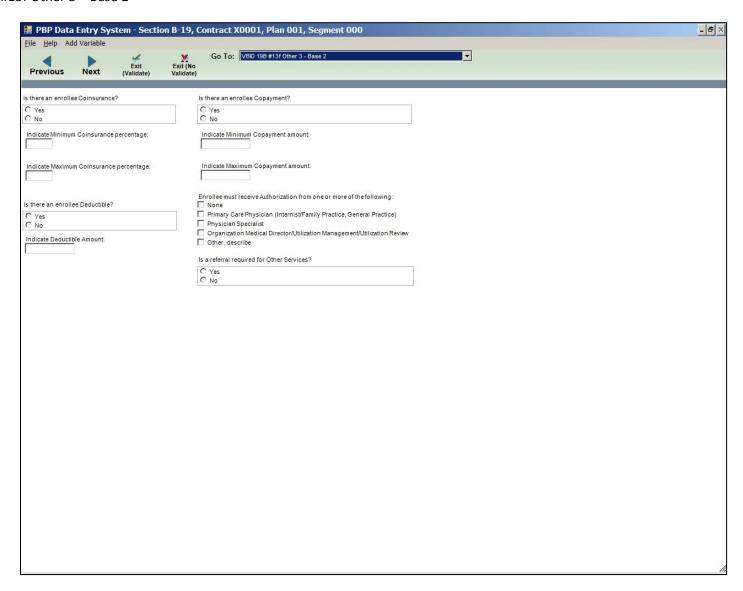
VBID 19B #13e Other 2 - Base 3



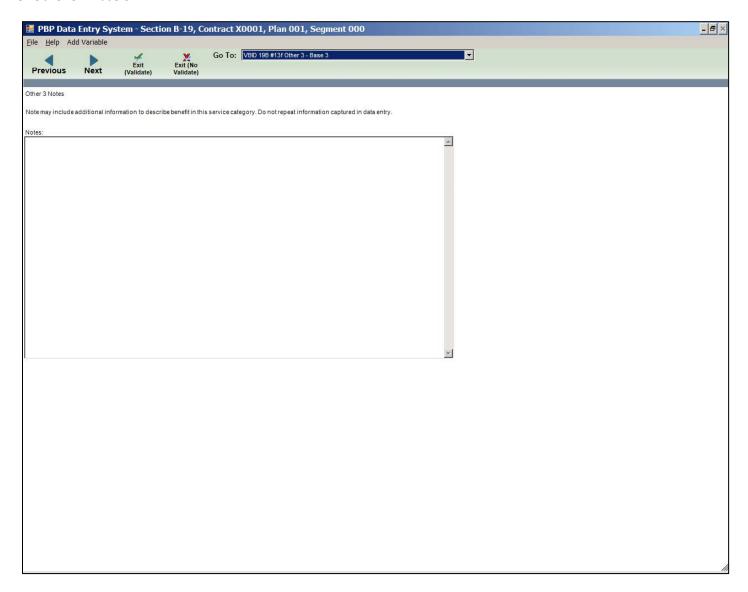
VBID 19B #13f Other 3 - Base 1



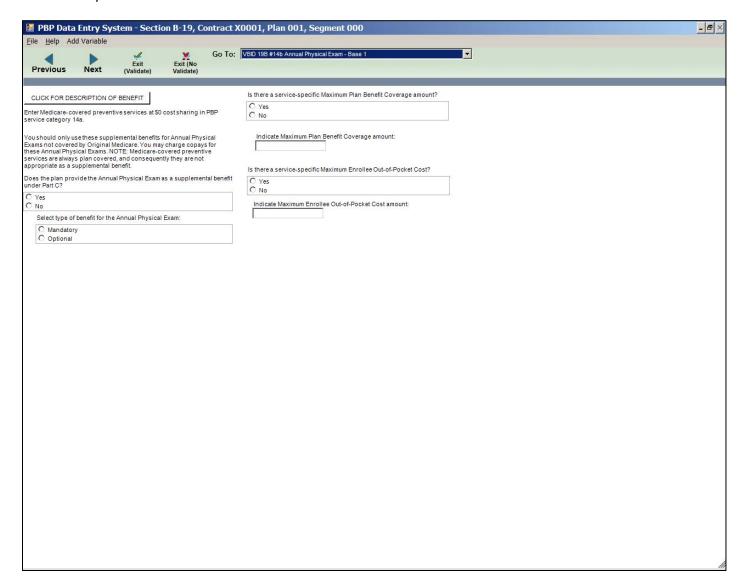
VBID 19B #13f Other 3 – Base 2



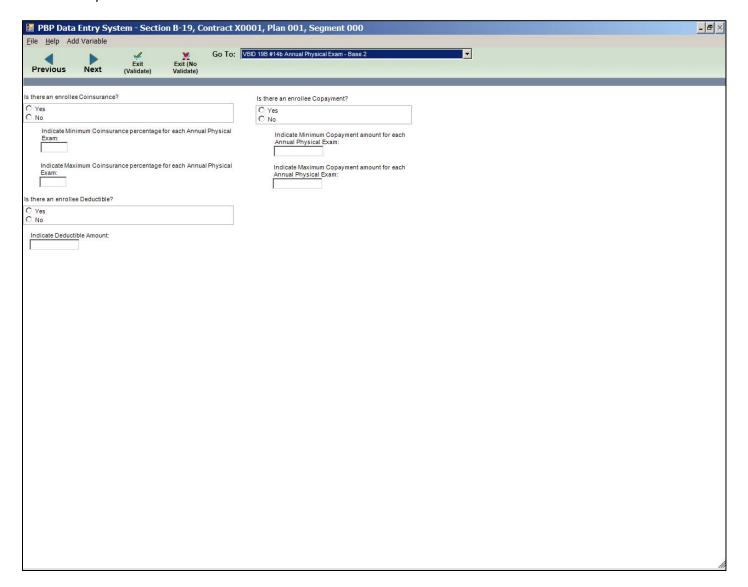
VBID 19B #13f Other 3 - Base 3



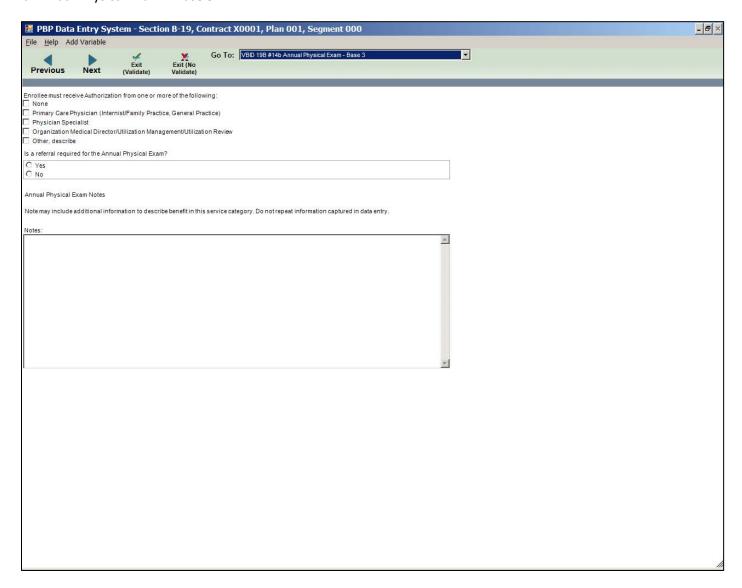
VBID 19B #14b Annual Physical Exam - Base 1



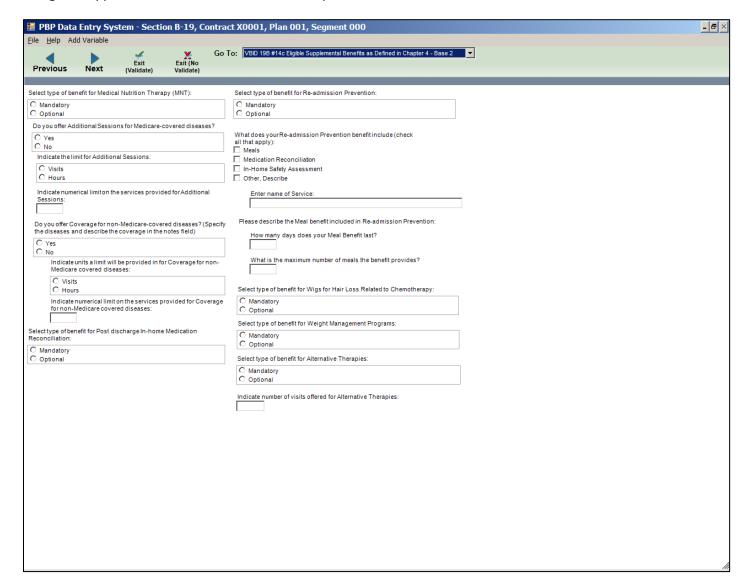
VBID 19B #14b Annual Physical Exam - Base 2



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



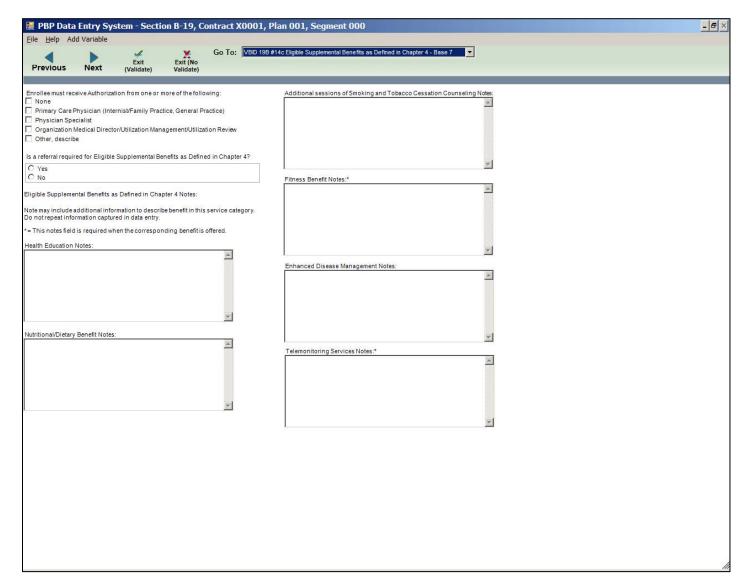
📕 PBP Data Entry System - Section B-19, Contract X0001, Pla	n 001, Segment 000		_ & ×
<u>F</u> ile <u>H</u> elp Add Variable			
	c Eligible Supplemental Benefits as Defined in Chapter 4 - Ba	se 1	
Previous Next (Validate) Validate)			
CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Health Education:	Select type of benefit for Telemonitoring Services:	
Does the plan provide Eligible Supplemental Benefits as Defined in Chapter 4 as a benefit	C Mandatory	C Mandatory	
under Part C?	C Optional	C Optional	
C Yes C No	Select type of benefit for Nutritional/Dietary Benefit:	Select type of benefit for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline):	
	C Mandatory	C Mandatory	
Select enhanced benefit (Select all that apply): Health Education	Optional	C Optional	
Nutritional/Dietary Benefit	Is this benefit unlimited for Nutritional/Dietary Benefit?	Select type of benefit for Bathroom Safety Devices:	
Additional sessions of Smoking and Tobacco Cessation Counseling Fitness Benefit*	C Yes	C Mandatory C Optional	
Enhanced Disease Management Telemonitoring Services*	C No, indicate number		
Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)*	Indicate number of visits for Nutritional/Dietary Benefit:	Select type of benefit for Counseling Services:	
Bathroom Safety Devices* Counseling Services	Borron.	C Mandatory C Optional	
In-Home Safety Assessment Personal Emergency Response System (PERS)	Indicate setting for Nutritional/Dietary Benefit:	Is this benefit unlimited for Counseling Services?	
Medical Nutrition Therapy (MNT)	O Individual Sessions	C Yes	
Post discharge In-home Medication Reconciliation Re-admission Prevention	C Group Sessions	C No, indicate number	
Wigs for Hair Loss Related to Chemotherapy Weight Management Programs*	C Both Sessions (Individual and Group)	Indicate number of visits for Counseling Services:	
Alternative Therapies*	Select type of benefit for Additional sessions of Smoking and Tobacco Cessation Counseling:		
* = A note is required when this benefit is offered.	Mandatory	Indicate setting for Counseling Services:	
	O Optional	C Individual Sessions	
	Indicate number of visits offered in addition to	Group Sessions Both Sessions (Individual and Group)	
	Medicare:	Indicate duration of sessions (in minutes):	
	Select type of benefit for Fitness Benefit:	Select type of benefit for In-Home Safety Assessment:	
	O Mandatory O Optional	C Mandatory C Optional	
	Select type of benefit for Enhanced Disease Management:	Select type of benefit for Personal Emergency Response System (PERS):	
	C Mandatory C Optional	C Mandatory C Optional	

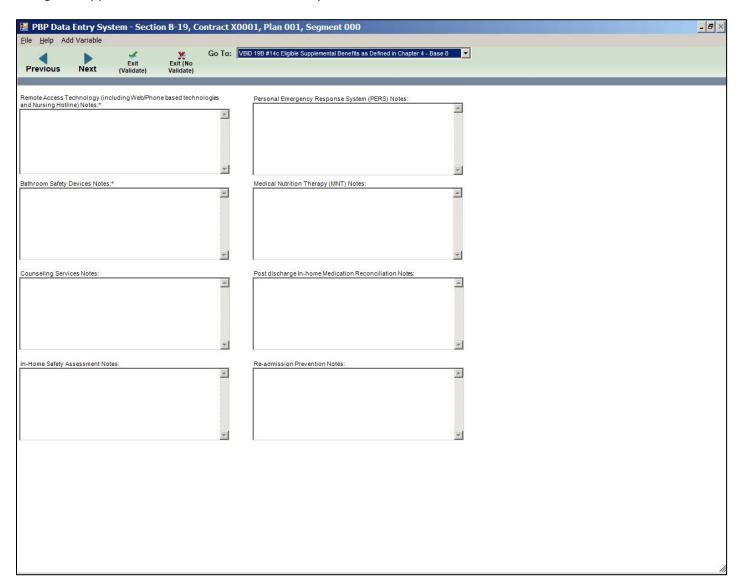


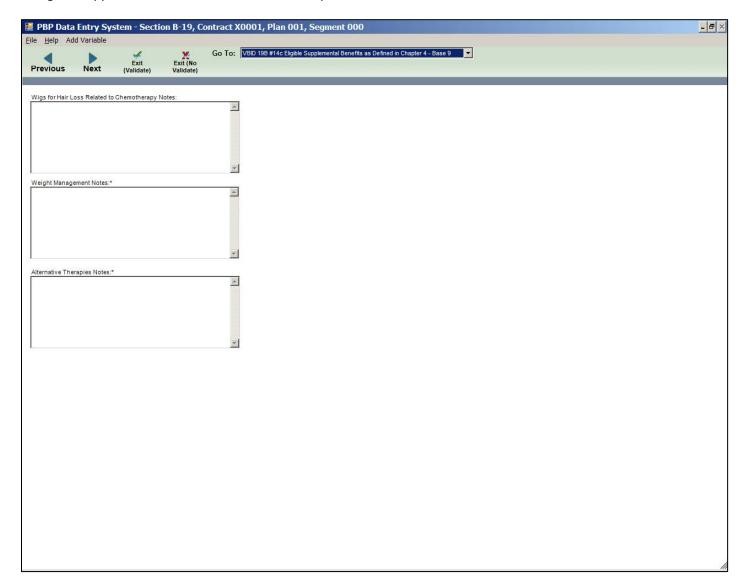
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∡ y Go	To: VBID 19B #14c Eligible Supplemental Benefits as Defined in Chapte	r 4 - Base 3 🔻	
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vious Next (Validate) Validate)			
		Indicate Maximum Plan Benefit Coverage amount for Remote	
there a service-specific Maximum Plan Benefit Coverage rount for Eligible Supplemental Benefits as Defined in	Indicate Maximum Plan Benefit Coverage amount for Additional	Access Technologies (including Web/Phone based technologies and Nursing Hotline):	
napter 4?	sessions of Smoking and Tobacco Cessation Counseling:	and Norsing Hourie).	
Yes			
·	Select Maximum Plan Benefit Coverage periodicity for Additional	Select Maximum Plan Benefit Coverage periodicity for Remote	
No	sessions of Smoking and Tobacco Cessation Counseling:	Access Technologies (including Web/Phone based technologies and Nursing Hotline):	
lect which Eligible Supplemental Benefits as Defined in	C Every three years		
napter 4 have a Maximum Plan Benefit Coverage amount	C Every two years	C Every three years	
elect all that apply):	C Every year	C Every two years	
ealth Education	C Every six months	C Every year	
utritional/Dietary Benefit	C Every three months	C Every six months	
dditional sessions of Smoking and Tobacco Cessation Counseli	O Other, Describe	C Every three months	
ness Benefit Ihanced Disease Management		O Other, Describe	
Inanced Disease Management Ilemonitoring Services	Indicate Maximum Plan Benefit Coverage amount for Fitness	Indicate Maximum Plan Benefit Coverage amount for Bathroom	
emote Access Technologies (including Web/Phone based techn	Benefit:	Safety Devices:	
athroom Safety Devices			
ounseling Services	Select Maximum Plan Benefit Coverage periodicity for Fitness	Select Maximum Plan Benefit Coverage periodicity for Bathroom	
Home Safety Assessment	Benefit:	Safety Devices:	
rsonal Emergency Response System (PERS)	C Every three years		
edical Nutrition Therapy (MNT)	C Every two years	C Every three years	
st discharge In-home Medication Reconciliation	C Every year	C Every two years	
admission Prevention	C Every year C Every six months	C Every year	
igs for Hair Loss Related to Chemotherapy eight Management Programs	C Every six months C Every three months	C Every six months	
aight Management Programs	O Every three months O Monthly	C Every three months	
dicate Maximum Plan Benefit Coverage amount for Health		C Other, Describe	
lucation:	O Other, Describe	Indicate Maximum Plan Benefit Coverage amount for Counseling	
	Indicate Maximum Plan Benefit Coverage amount for Enhanced	Services:	
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lect Maximum Plan Benefit Coverage periodicity for Health lucation:		Colort Manieuro Blas Basseft Courses a saintielts for	
	Select Maximum Plan Benefit Coverage periodicity for Enhanced	Select Maximum Plan Benefit Coverage periodicity for Counseling Services:	
Every three years	Disease Management:		
Every two years	C Every three years	C Every three years	
Every year	C Every two years	C Every two years	
Every six months	C Every two years C Every vear	C Every year	
Every three months	C Every year C Every six months	C Every six months	
Other, Describe		C Every three months	
dicate Maximum Plan Benefit Coverage amount for	C Every three months	C Other, Describe	
dicate Maximum Plan Benefit Coverage amount for stritional/Dietary Benefit:	O Other, Describe	Indicate Maximum Plan Benefit Coverage amount for In-Home	
, contain	Indicate Maximum Plan Benefit Coverage amount for Telemonitoring Services:	Safety Assessment:	
	Totalianitaling Services.		
lect Maximum Plan Benefit Coverage periodicity for			
tritional/Dietary Benefit:	Select Maximum Plan Benefit Coverage periodicity for	Select Maximum Plan Benefit Coverage periodicity for In-Home	
Every three years	Telemonitoring Services:	Safety Assessment:	
Every two years	C Every three years	C Every three years	
Every year	C Every two years	C Every two years	
Every six months	C Every year	C Every year	
Every three months	C Every six months	C Every six months	
Other, Describe	C Every three months	C Every three months	
20.0, 2020.00	Other, Describe	O Other, Describe	

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

■ PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000			
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Previous Next (Validate) Validate)			
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Is there an enrollee Coinsurance?			
O Yes	Indicate Minimum Coinsurance percentage for Fitness Benefit:	Indicate Minimum Coinsurance percentage for In- Home Safety Assessment:	Indicate Minimum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy:
C No Select which Eligible Supplemental Benefits as Defined in Chapter 4 have a Coinsurance (Select all that apply):	Indicate Maximum Coinsurance percentage for Fitness Benefit:	Indicate Maximum Coinsurance percentage for In- Home Safety Assessment:	Indicate Maximum Coinsurance percentage for Wigs for
Health Education Nutritional/Dietary Benefit	Indicate Minimum Coinsurance percentage for Enhanced Disease Management:	Tionic Salety Assessment.	Hair Loss Related to Chemotherapy:
Additional sessions of Smoking and Tobacco Cessation Counseli Fitness Benefit Enhanced Disease Management		Indicate Minimum Coinsurance percentage for Personal Emergency Response System (PERS):	Indicate Minimum Coinsurance percentage for Weight Management Programs:
Telemonitoring Services Remote Access Technologies (including Web/Phone based techn	Indicate Maximum Coinsurance percentage for Enhanced Disease Management:	Indicate Maximum Coinsurance percentage for	Indicate Maximum Coinsurance percentage for Weight
Bathroom Safety Devices Counseling Services In-Home Safety Assessment	Indicate Minimum Coinsurance percentage for Telemonitoring Services:	Personal Emergency Response System (PERS):	Management Programs:
Personal Emergency Response System (PERS) Medical Nutrition Therapy (MNT)	Indicate Maximum Coinsurance percentage for Telemonitoring	Indicate Minimum Coinsurance percentage for Medical Nutrition Therapy (MNT):	Indicate Minimum Coinsurance percentage for Alternative Therapies:
Post discharge In-home Medication Reconciliation Re-admission Prevention Wigs for Hair Loss Related to Chemotherapy	Services:	Indicate Maximum Coinsurance percentage for Medical Nutrition Therapy (MNT):	Indicate Maximum Coinsurance percentage for
Indicate Minimum Coinsurance percentage for Health Education:	Indicate Minimum Coinsurance percentage for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline):	Indicate Minimum Coinsurance percentage for Post	Alternative Therapies:
Indicate Maximum Coinsurance percentage for Health	Indicate Maximum Coinsurance percentage for Remote Access	discharge In-home Medication Reconciliation:	You must include total cost sharing to the beneficiary,
Education:	Technologies (including Web/Phone based technologies and Nursing Hotline):	Indicate Maximum Coinsurance percentage for Post discharge In-home Medication Reconciliation:	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
Indicate Minimum Coinsurance percentage for Nutritional/Dietary Benefit:	Indicate Minimum Coinsurance percentage for Bathroom Safety Devices:	Indicate Minimum Coinsurance percentage for Re- admission Prevention:	sharing that a beneficiary may pay.
Indicate Maximum Coinsurance percentage for Nutritional/Dietary Benefit:	Indicate Maximum Coinsurance percentage for Bathroom Safety Devices:	Indicate Maximum Coinsurance percentage for Re- admission Prevention:	
Indicate Minimum Coinsurance percentage for Additional	Indicate Minimum Coinsurance percentage for Counseling Services:		
sessions of Smoking and Tobacco Cessation Counseling:	Indicate Maximum Coinsurance percentage for Counseling Services:	:	
Indicate Maximum Coinsurance percentage for Additional sessions of Smoking and Tobacco Cessation Counseling:			
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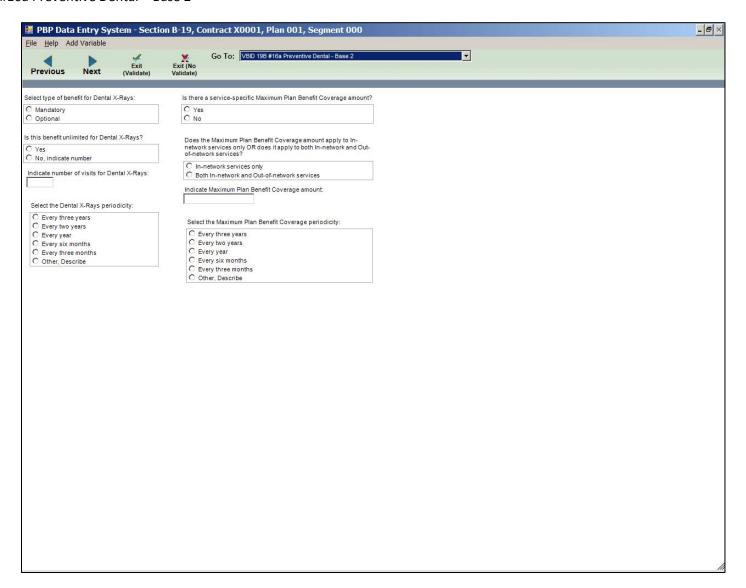




VBID 19B #16a Preventive Dental – Base 1

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Previous Next (Validate)	Validate)			
CLICK FOR DESCRIPTION OF BENEFIT	· ·	Select type of benefit for Fluoride Treatment:		
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	C Every year	C Mandatory C Optional Is this benefit unlimited for Fluoride Treatment?		
C No	C Every three months C Other, Describe	C Yes C No, indicate number		
Select enhanced benefits: Oral Exams	Selecttype of benefit for Prophylaxis (Cleaning):	Indicate number of visits for Fluoride Treatment:		
☐ Prophylaxis (Cleaning) ☐ Fluoride Treatment ☐ Dental X-Rays	C Mandatory C Optional			
Select type of benefit for Oral Exams:	Is this benefitunlimited for Prophylaxis (Cleaning)?	Select the Fluoride Treatment periodicity: C Every three years C Every two years		
C Optional	C No, indicate number	C Every year C Every six months		
Is this benefit unlimited for Oral Exams? O Yes O No indicate number	Select the Prophylaxis (Cleaning) periodicity:	C Every three months C Other, Describe		
C No, indicate number Indicate number of visits for Oral Exams:	Select the Prophylaxis (Cleaning) periodicity: C Every three years C Every year C Every year C Every six months C Every three months C Other, Describe			

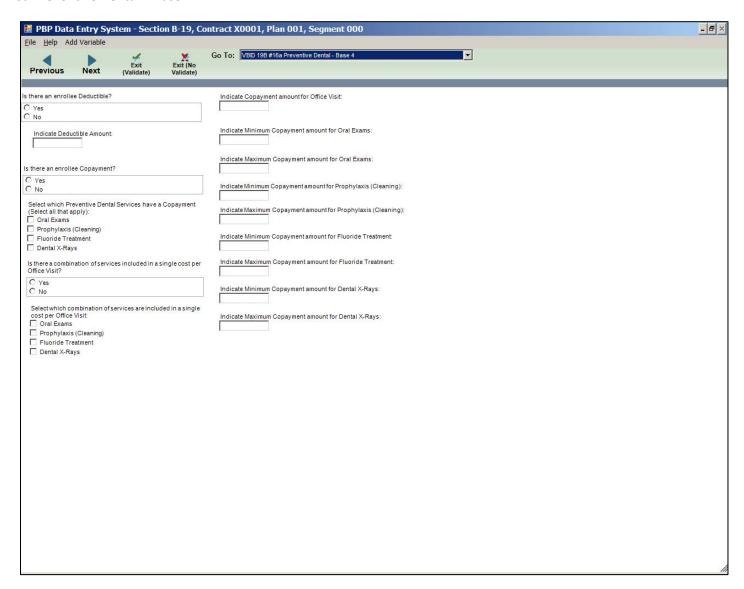
VBID 19B #16a Preventive Dental – Base 2



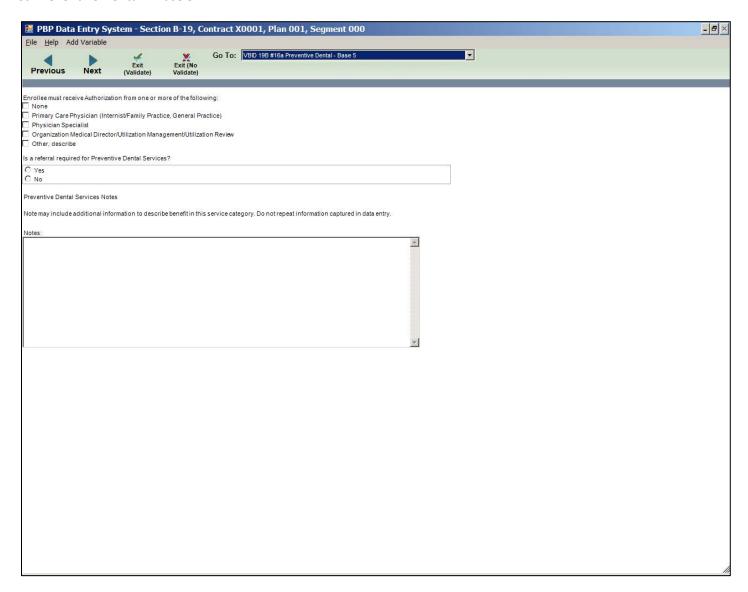
VBID 19B #16a Preventive Dental – Base 3

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Is there a service-specific Yes No Indicate Maximum E Select the Maximum C Every three ye C Every the year C Every two service year C Every six mon C every three one Other Cescrit Is there an enrollee C Yes No Select which Prev (Select all that app Oral Exams Prophylaxis (C Fluoride Treatr Dental X-Rays	Enrollee Out-of- m Enrollee Out- rars rs ths onths oe Coinsurance? entive Dental Se leaning)	Pocket Cost a	st periodicity:	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 Dental X-Rays: Indicate Maximum Coinsurance percentage for Dental X-Rays:	

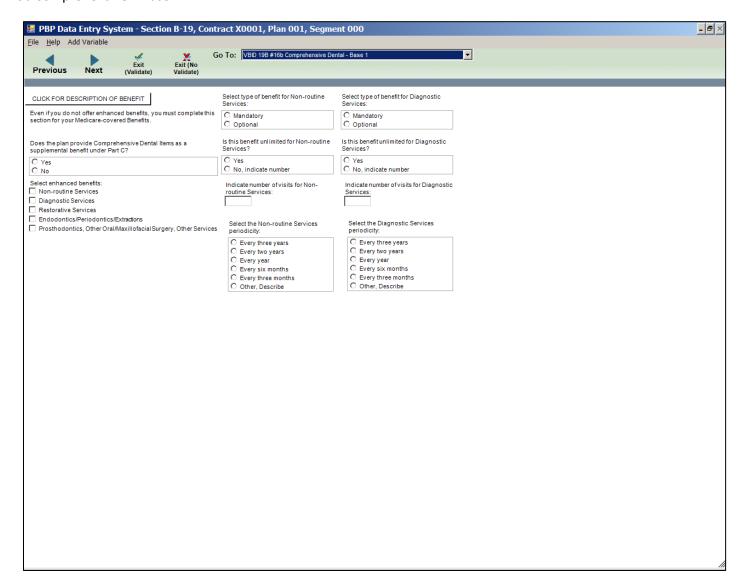
VBID 19B #16a Preventive Dental - Base 4



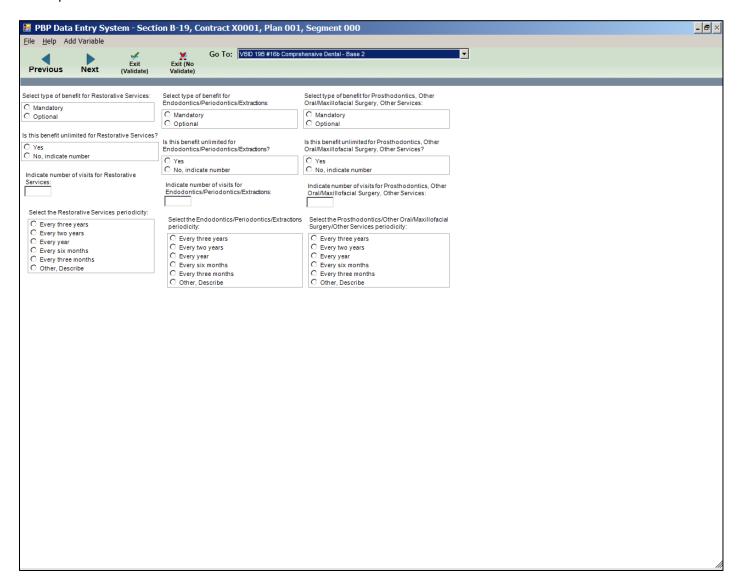
VBID 19B #16a Preventive Dental - Base 5



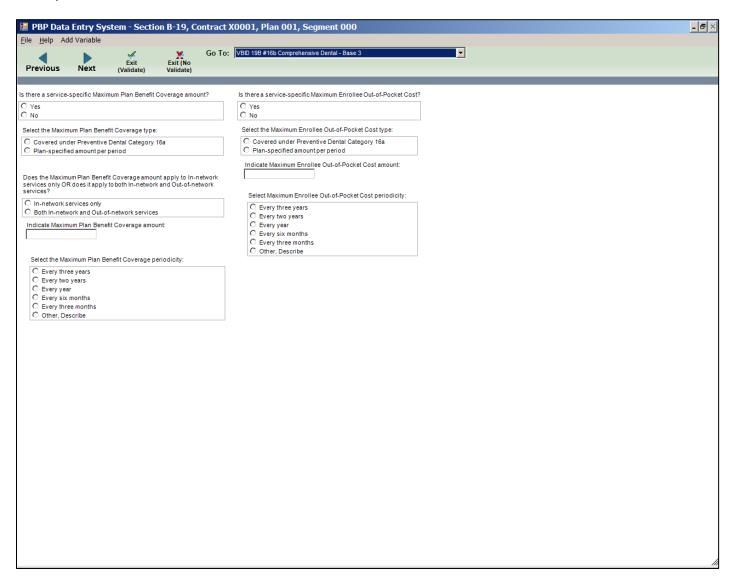
VBID 19B #16b Comprehensive - Base 1



VBID 19B #16b Comprehensive - Base 2



VBID 19B #16b Comprehensive - Base 3



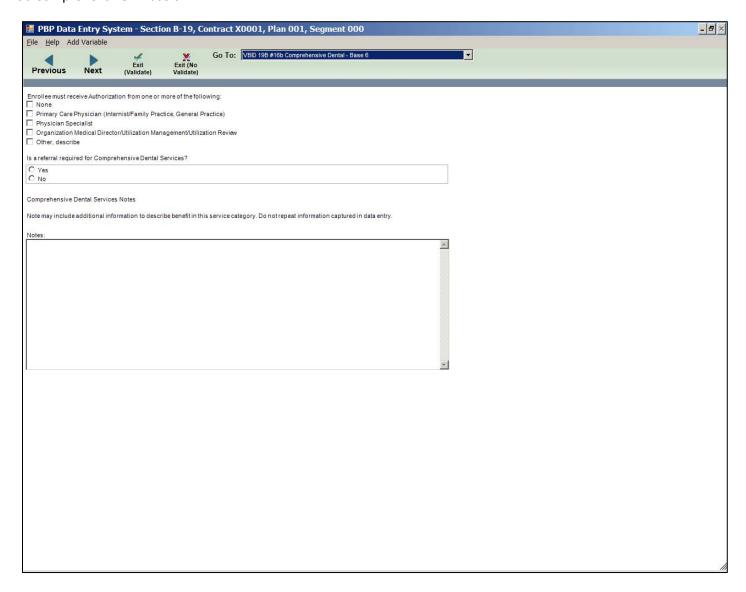
VBID 19B #16b Comprehensive – Base 4

■ PBP Data Entry System - Section B-19, Contract XO	0001, Plan 001, Segment 000	_ & ×
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Exit Exit (No	VBID 19B #16b Comprehensive Dental - Base 4 ▼	
Previous Next (Validate) Validate)		
Is there an enrollee Coinsurance?	Indicate Minimum Coinsurance percentage for Restorative Services:	
C No		
Select which Comprehensive Dental Services have a Coinsurance (Select all that apply): Medicare-covered Benefits	Indicate Maximum Coinsurance percentage for Restorative Services:	
□ Non-routine Services □ Diagnostic Services □ Restorative Services	Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions:	
☐ Endodontics/Periodontics/Extractions		
☐ Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Indicate the Minimum Coinsurance percentage for Medicare-covered	Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:	
Benefits:		
Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Minimum Coinsurance percentage for Non-routine Services:		
	Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Maximum Coinsurance percentage for Non-routine Services:		
	Is there an enrollee Deductible?	
Indicate Minimum Coinsurance percentage for Diagnostic Services:	C Yes	
Indicate Maximum Coinsurance percentage for Diagnostic Services:	Indicate Deductible Amount:	

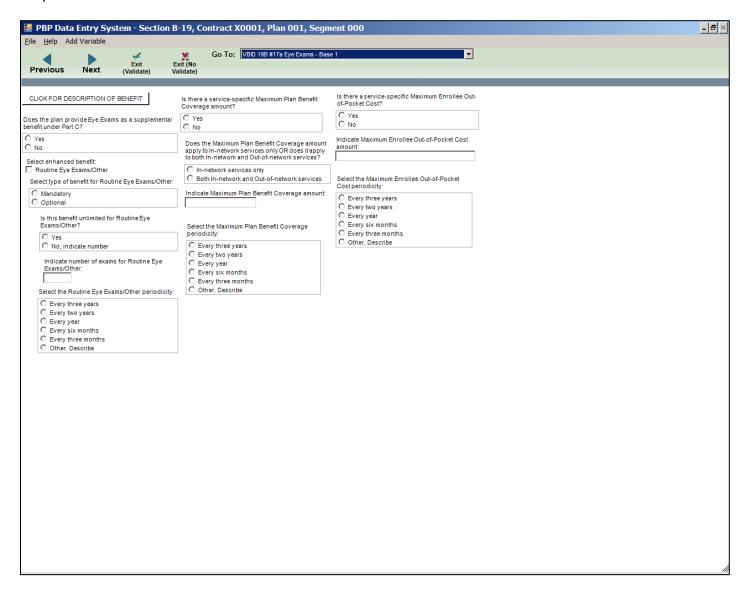
VBID 19B #16b Comprehensive – Base 5

■ PBP Data Entry System - Section B-1	.9, Contract X0001, Plan 001, Segment 000	_ & ×
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Exit Exit	Go To: VBID 198 #16b Comprehensive Dental - Base 5	
Previous Next (Validate) Valid	iate)	
Is there an enrollee Copayment?	Indicate Maximum Copayment amount for Diagnostic Services:	
C No		
Select which Comprehensive Dental Services		
have a Copayment (Select all that apply): Medicare-covered Benefits	Indicate Minimum Copayment amount for Restorative Services:	
Non-routine Services	Control of the Contro	
☐ Diagnostic Services		
Restorative Services	Indicate Maximum Copayment amount for Restorative	
☐ Endodontics/Periodontics/Extractions	Services:	
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services		
Indicate Minimum Copayment amount for Medicare- covered Benefits:	Indicate Minimum Copayment amount for	
COVERED BOTTOMS.	Endodontics/Periodontics/Extractions:	
Indicate Maximum Copayment amount for Medicare-		
covered Benefits:	Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions:	
Indicate Minimum Copayment amount for Non-routine Services:	Indicate Minimum Copayment amount for Prosthodontics,	
CONTINUES.	Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Maximum Consument amount for Non-routine		
Indicate Maximum Copayment amount for Non-routine Services:		
	Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	
Indicate Minimum Copayment amount for Diagnostic		
Services:		
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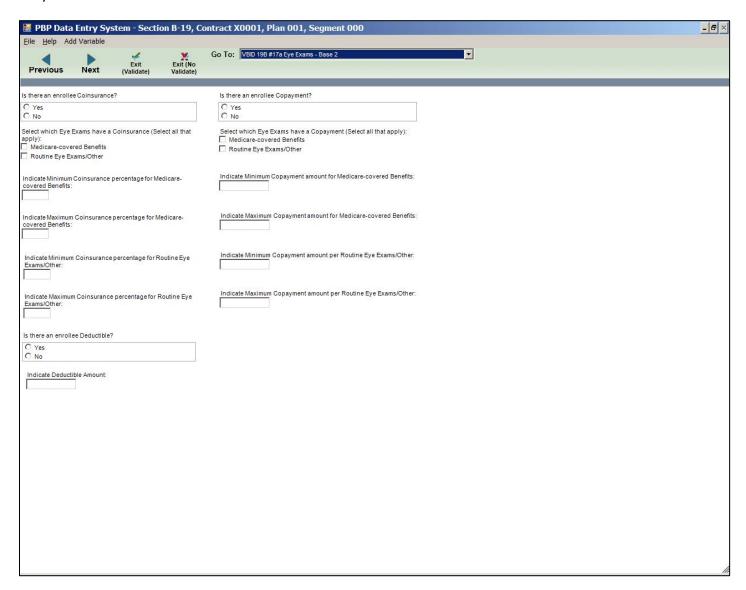
VBID 19B #16b Comprehensive - Base 6



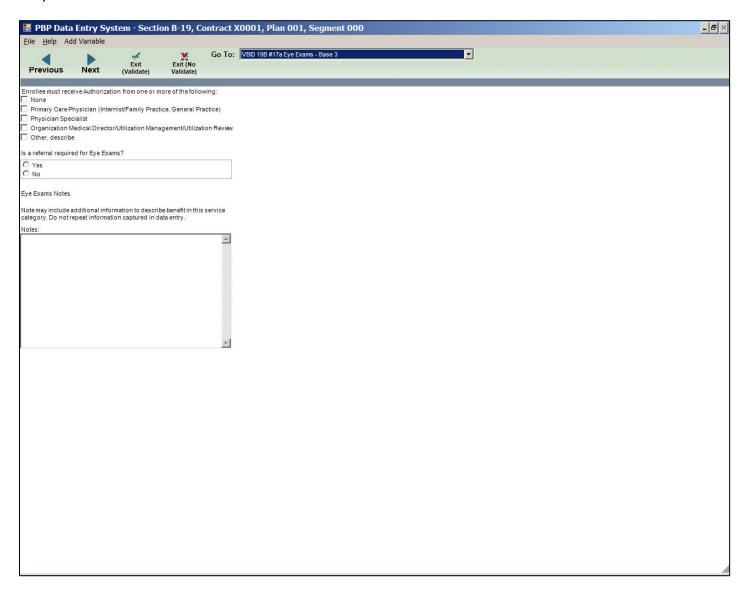
VBID 19B #17a Eye Exams - Base 1



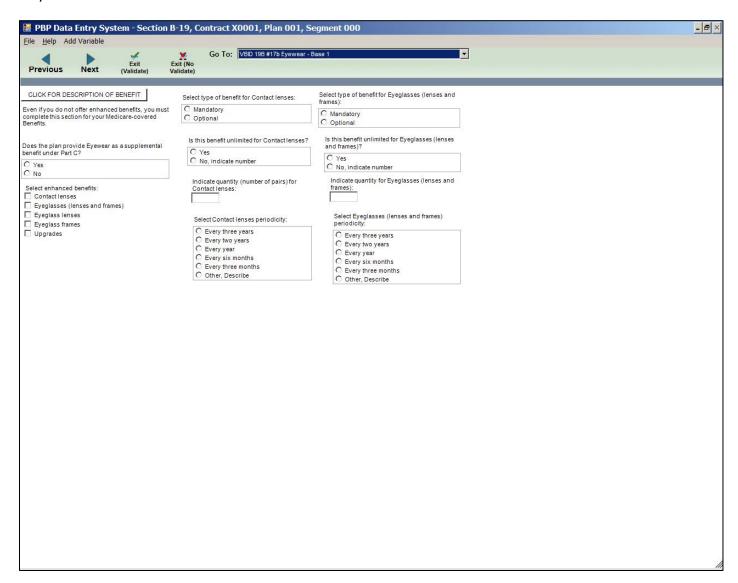
VBID 19B #17a Eye Exams - Base 2



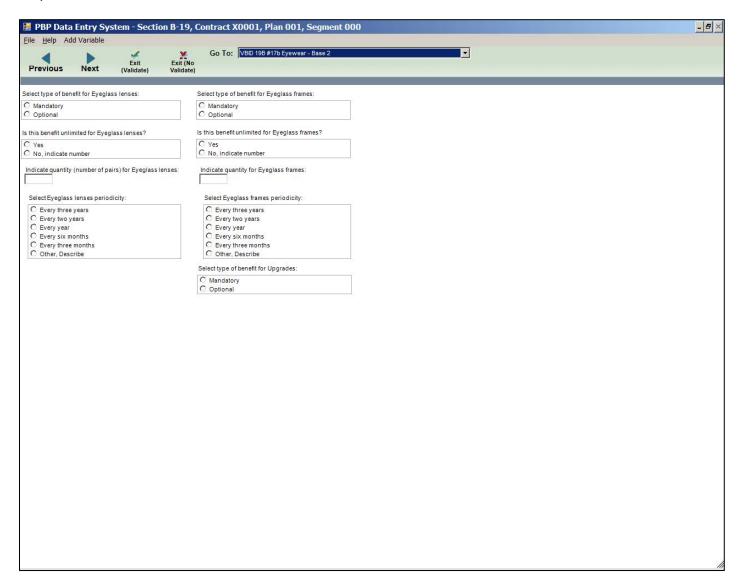
VBID 19B #17a Eye Exams - Base 3



VBID 19B #17b Eyewear - Base 1



VBID 19B #17b Eyewear - Base 2



VBID 19B #17b Eyewear – Base 3

Select the Maximum Plan Benefit Coverage amount for Eyeglasses (lenses and fames): C eyer of Coverage of Coverage amount for Eyeglasses (lenses and fames): C eyer of Coverage of Coverage amount for Eyeglasses (lenses and fames): C eyer of Coverage of Cove	File Help Add Variable	Section B-19, Contract X0001,	- tan-oot/ ocginene oo		_
Benefit Coverage amount? Select the Maximum Plan Benefit Coverage type: Coverd under Eye Exams Courtage type: Coverd under Eye Exams Courtage Amount per period Des the Maximum Plan Benefit Coverage amount per period Des the Maximum Plan Benefit Coverage amount per period Des the Maximum Plan Benefit Coverage amount per period Des the Maximum Plan Benefit Coverage amount apply to In-network services? Contact lenses: Courtage amount apply to In-network services? Connect lenses Courtage amount apply to In-network and Out-of-network services? Courtage amount for Eyeglasses (lenses and frames): Courtage amount for Eyeglasse (lenses and frames): Courtage amount for Eyeglasse frames: Courtage amount for Eyeglasse fram	Exi	t Exit (No	#17b Eyewear - Base 3	<u> </u>	
Both In-network and Out-of-network services Do you offer a Combined Max Plan Benefit Coverage amount for Contact lenses: Indicate Max Plan Benefit Coverage amount for Eyeglass lenses: Indicate Max Plan Benefit Coverage amount for Upgrades:	Benefit Coverage amount? C Yes C No Select the Maximum Plan Benefit Coverage type: C Covered under Eye Exams Category 17a C Plan-specified amount per period Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it Rapply to both In	Benefit Coverage periodicity: C Every three years C Every two years C Every year C Every six months C Every three months Other, Describe Select the type of Eyewear with Individual Max Plan Benefit Coverage amount: Contact lenses Eyeglasses (lenses and frames)	amount for Eyeglasses (lenses and frames): Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglasses (lenses and frames): C Every three years C Every two years C Every year C Every syst months C Every three months	amount for Eyeglass frames: Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglass frames: C Every three years C Every two years C Every two years C Every stamonths C Every three months	
Benefit Coverage Amount for all Eyewear? C Yes C No Indicate Combined Maximum Plan Benefit Coverage amount: C Every three years C Every two years C Every year C Every six months C Every six months C Every three months C Every three months C Every three months C Other, Describe Select the Individual Maximum Plan Benefit Coverage periodicity for Upgrades: For Upgrades: C Every three years C Every three years C Every two years C Every two years C Every year C Every six months C Every six months C Every three months C Other, Describe	Both In-network and Out-of-network	☐ Eyeglass frames ☐ Upgrades Indicate Max Plan Benefit Coverage	Indicate Max Plan Benefit Coverage	Indicate Max Plan Benefit Coverage	
C Every six months C Every three months C Every three months	Benefit Coverage Amount for all Eyewear? C Yes C No	Benefit Coverage periodicity for Contact lenses: C Every three years C Every two years	Benefit Coverage periodicity for Eyeglass lenses: C Every three years C Every two years C Every year C Every six months	Plan Benefit Coverage periodicity for Upgrades: © Every three years © Every two years © Every year © Every year	
	benefit Goverage amount.	C Every six months C Every three months			

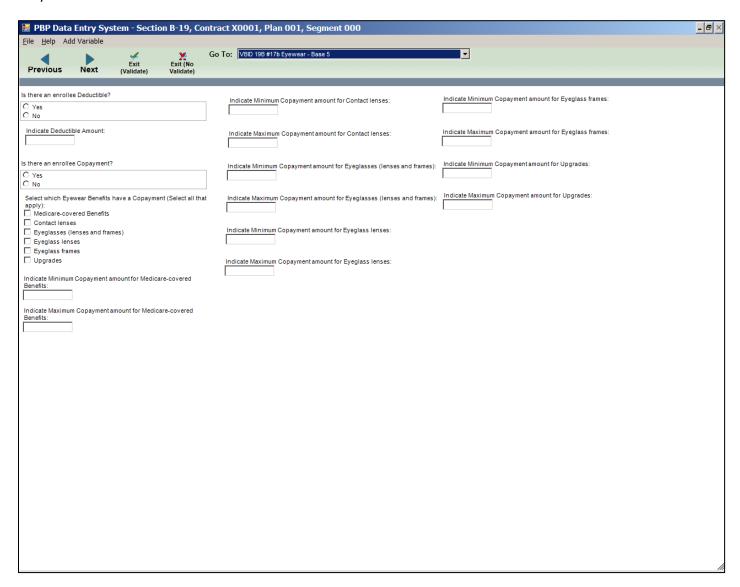
CY 2017 PBP Data Entry System Screens

VBID 19B #17b Eyewear – Base 4

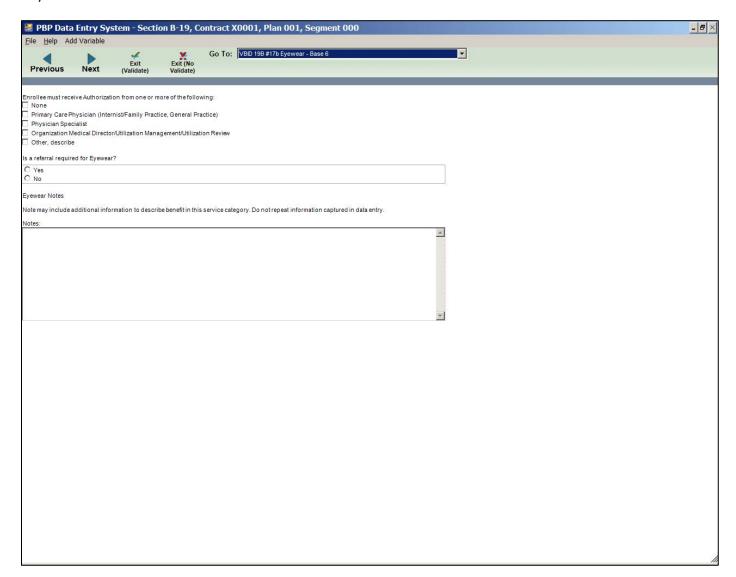
■ PBP Data Entry System - Section B-19, Con	tract X0001, Plan 001, Segment 000		_ & ×
Elle Help Add Variable Previous Next Exit Exit (No Validate)	Go To: VBD 198 #17b Eyewear - Base 4		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes No	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	Indicate Minimum Coinsurance percentage for Eyeglass frames:	
Select the Maximum Enrollee Out-of-Pocket Cost type: C Covered under Eye Exams Category 17a C Plan-specified amount per period	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Indicate Maximum Coinsurance percentage for Eyeglass frames:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Minimum Coinsurance percentage for Contact lenses:	Indicate Minimum Coinsurance percentage for Upgrades:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity: © Every three years © Every two years © Every year	Indicate Maximum Coinsurance percentage for Contact lenses:	Indicate Maximum Coinsurance percentage for Upgrades:	
C Every six months C Every three months C Other, Describe	Indicate Minimum Coinsurance percentage for Eyeglasses (lenses and frames):		
Is there an enrollee Coinsurance? C Yes C No	Indicate Maximum Coinsurance percentage for Eyeglasses (lenses and frames):		
Select which Eyewear Benefits have a Coinsurance (Select all that apply): Medicare-covered Benefits Contact lenses	Indicate Minimum Coinsurance percentage for Eyeglass lenses:		
Eyeglasses (lenses and frames) Eyeglass lenses Eyeglass frames Upgrades	Indicate Maximum Coinsurance percentage for Eyeglass lenses:		
			//

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

PBP Data Entry System - Section B-19, C	ontract X0001, Plan 001, Segment 000	_ B ×
Eile Help Add Variable Previous Next Exit (No Validate) Exit (No Validate)	Go To: VBID 19B #18a Hearing Exams - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Even if you do not offer enhanced benefits, you must complete	Select Routine Hearing Exams periodicity: C Every three years C Every two years	
this section for your Medicare-covered Benefits.	C Every year C Every six months C Every three months C Other, Describe	
Does the plan provide Hearing Exams as a supplemental benefit under Part C? C Yes	Select type of benefit for Fitting/Evaluation for Hearing Aid:	
C Yes	C Mandatory C Optional	
Select enhanced benefits: Routine Hearing Exams Fitting/Evaluation for Hearing Aid	Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	
Select type of benefit for Routine Hearing Exams:	C Yes C No, indicate number	
C Mandatory C Optional	Indicate number for Fitting/Evaluation for Hearing. Aid:	
Is this benefit unlimited for Routine Hearing Exams?		
C Yes C No, indicate number	Select Fitting/Evaluation for Hearing Aid periodicity: C Every three years	
Indicate number for Routine Hearing Exams:	C Every two years C Every year C Every six months C Every three months C Other, Describe	

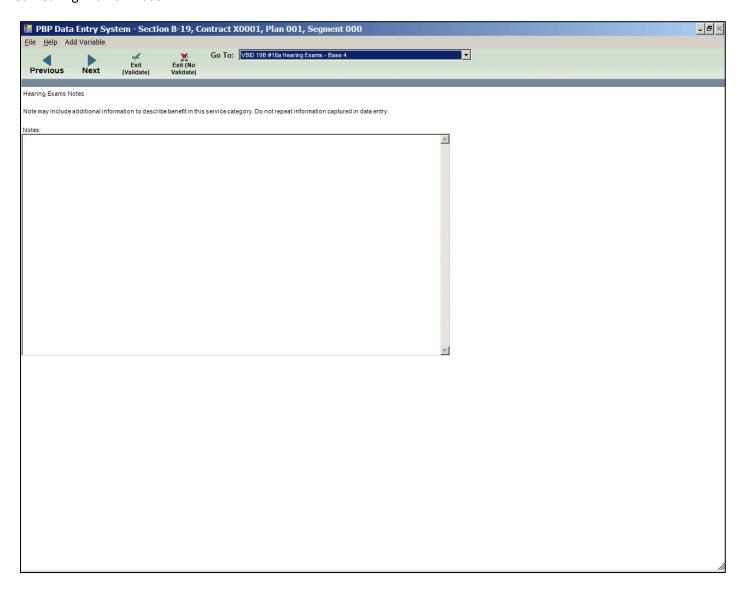
VBID 19B #18a Hearing Exams – Base 2

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Coverage amou		mum Plan Benefit	Is there Enrollee	a service-specific Out-of-Pocket Co	Maximum st?	Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	
O Yes O No			C No				
apply to In-netw	work services or	it Coverage amount nly OR does it apply network services?	Cost a	e Maximum Enroll mount:	ee Out-of-Pocket	Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	
O In-network	services only		1				
		f-network services		t Maximum Enrolle periodicity:	e Out-of-Pocket	Indicate Minimum Coinsurance percentage for Routine Hearing Exams:	
Indicate Maxim	num Plan Benefi	t Coverage amount:	O E	very three years very two years very year		Todaller realing Exams.	
periodicity:	ximum Plan Ben	efit Coverage	O E	very six months very three months ther, Describe		Indicate Maximum Coinsurance percentage for Routine Hearing Exams:	
C Every thre C Every two	years			enrollee Coinsur	ance?	Indicate Minimum Coinsurance percentage for	
C Every year	months		C Yes C No			Fitting/Evaluation for Hearing Aid:	
C Every thre C Other, Des			Coinsurar	ich Hearing Exam nce (Select all that	apply):		
	ollee Deductible	e?	Routin	are-covered Benef e Hearing Exams		Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:	
C Yes C No			Fitting	/Evaluation for He	aring Aid		
Indicate De	eductible Amou	nt:					

VBID 19B #18a Hearing Exams – Base 3

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Trevious	IVEX	(Validate)	validate)		
C Yes	ee Copayment	?	7	Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	
Select which Hea all that apply): Medicare-cov Routine Heari	ered Benefits ng Exams		payment (Select	Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	
Indicate Minimur Benefits:			care-covered	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	
Indicate Maximu Benefits:	m Copayment	amount for Med	icare-covered	Other, describe Is a referral required for Hearing Exams?	
Indicate Minimur Exams:	m Copayment	amount for Rout	ine Hearing	C Yes C No	
Indicate Maximu Exams:	m Copayment	amountfor Rou	tine Hearing		
					,

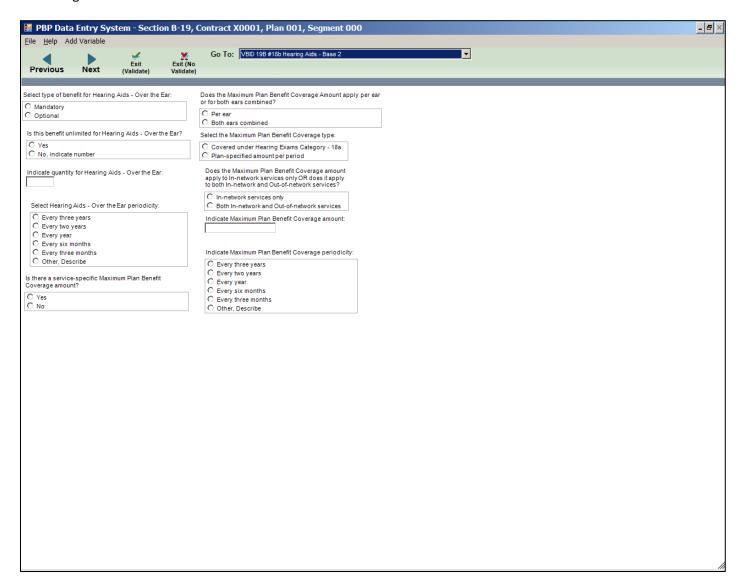
VBID 19B #18a Hearing Exams - Base 4



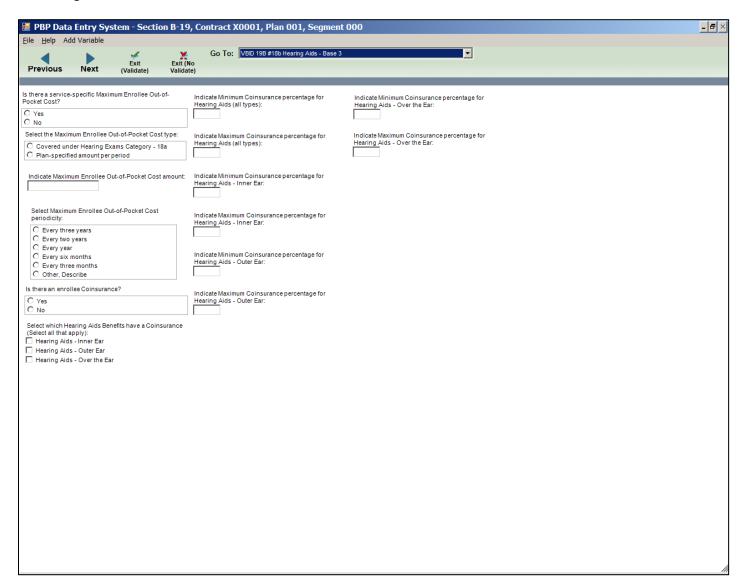
VBID 19B #18b Hearing Aids – Base 1

CUCK FOR DESCRIPTION OF BENEFIT Does the plan provide Having Aids is a supplemental benefit under Part OF Next C Yes No No No Select Hearing Aids - Manage (all types) Exit No C Every three years C Every three years C Every three months C Manadory C Optional S this benefit unlimited for Hearing Aids - Outer Ear: Indicate quantity for Hearing Aids (all types): Indicate quantity for Hearing Aids (all	PBP Data Entry System - Section	on B-19, Contract X0001, Plan	001, Segment 000	_ B ×
Does the plan provide Hearing Aids as a supplemental benefit under Part C? C Yes C Every two years C Every six months C Every six months C Other, Describe Select hanned benefits: Hearing Aids - Outer Ear Hearing Aids - Outer Ear Hearing Aids - Outer Ear Hearing Aids - Over the Ear Select type of benefit for Hearing Aids Inner Ear: C Mandatory C Optional Is this benefit unlimited for Hearing Aids and supplement Is this benefit unlimited for Hearing Aids and supplement Indicate quantity for Hearing Aids (all types): Indicate quantity for Hearing Aids (all types): Indicate quantity for Hearing Aids (all types): Indicate quantity for Hearing Aids (all types): Indicate quantity for Hearing Aids (all types): Indicate quantity for Hearing Aids (all types): Indicate quantity for Hearing Aids (all types): Indicate quantity for Hearing Aids (all types): Select type of benefit for Hearing Aids - Outer Ear: Select type of benefit unlimited for Hearing Aids - Outer Ear: Select type of benefit unlimited for Hearing Aids - Outer Ear: Select type of benefit unlimited for Hearing Aids - Outer Ear: Select type of benefit unlimited for Hearing Aids - Outer Ear: Select type of benefit unlimited for Hearing Aids - Outer Ear: Select type of benefit unlimited for Hearing Aids - Outer Ear: Select Hearing Aids - Out	Exit	Exit (No	earing Aids - Base 1	
	Eile Help Add Variable Previous Next (Validate) CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Hearing Aids as a supplemental benefit under Part C? C Yes C No Select enhanced benefits: Hearing Aids (all types) Hearing Aids - Outer Ear Hearing Aids - Outer the Ear Select type of benefit for Hearing Aids (all types): C Mandatory Optional Is this benefit unlimited for Hearing Aids (all types)? C Yes C No, indicate number	Go To: VBID 198 #18b H Exit (No Validate) Select Hearing Alds (all types) periodicity C Every three years C Every year C Every year C Every year C Every year C Every three months C Other, Describe Select type of benefit for Hearing Alds - Inner Ear: C Mandatory C Optional Is this benefit unlimited for Hearing Alds - Inner Ear? C Yes No, indicate number	Select Hearing Aids - Inner Ear periodicity: C Every three years C Every two years C Every six months C Other, Describe Select type of benefit for Hearing Aids - Outer Ear: C Mandatory C Optional Is this benefit unlimited for Hearing Aids - Outer Ear? C Yes No, indicate number Indicate quantity for Hearing Aids - Outer Ear: Select Hearing Aids - Outer Ear: C Every two years C Every two years C Every two years C Every six months C Every three months C Every three months	

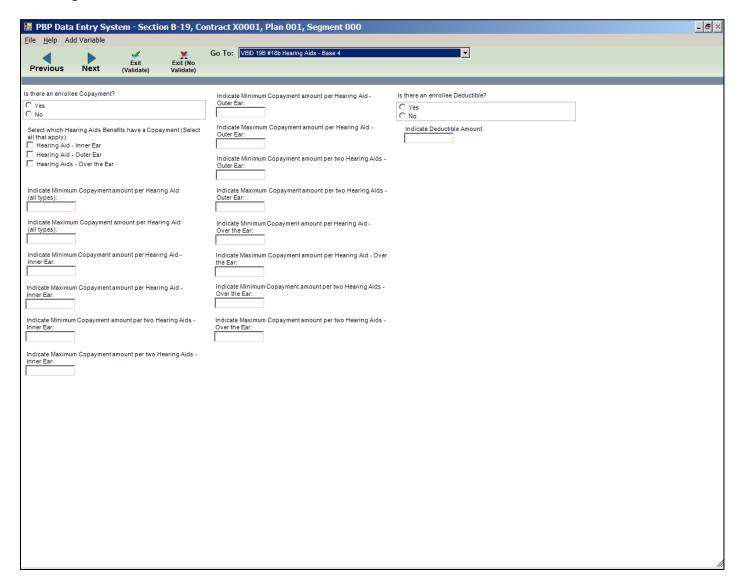
VBID 19B #18b Hearing Aids - Base 2



VBID 19B #18b Hearing Aids - Base 3



VBID 19B #18b Hearing Aids - Base 4



VBID 19B #18b Hearing Aids – Base 5

