CY 2018 PBP Data Entry System Screens

#1a Inpatient Hospital-Acute – Base 1

#1a Inpatient Hospital-Acute – Base 2

CY 2018 PBP Data Entry System Screens

#1a Inpatient Hospital-Acute – Base 3

File   Help   Add Variable

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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.)

○ Yes
○ No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

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

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

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

Medicare-covered Coinsurance Cost Sharing for Tier 3:

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

○ Yes
○ No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

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

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

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

#1a Inpatient Hospital-Acute – Base 4

#1a Inpatient Hospital-Acute – Base 5

#1a Inpatient Hospital-Acute – Base 6

#1a Inpatient Hospital-Acute – Base 7

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

File   Help   Add Variable

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

MA Organizations are not permitted to tier deductibles.

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount for Tier 1:

Indicate Deductible Amount for Tier 2:

Indicate Deductible Amount for Tier 3:

Is there an enrollee Copayment?
○ Yes
○ No

Medicare-covered Copayment Cost Sharing for Tier 1:

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

Indicate Copayment amount for the Medicare-covered stay:

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

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

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

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

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

#1a Inpatient Hospital-Acute – Base 8

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

File   Help   Add Variable

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Medicare-covered Copayment Cost Sharing for Tier 2:

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

○ Yes
○ No

Indicate Copayment amount for the Medicare-covered stay:

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

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

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

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

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

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

Medicare-covered Copayment Cost Sharing for Tier 3:

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

○ Yes
○ No

Indicate Copayment amount for the Medicare-covered stay:

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

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

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

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

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

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

#1a Inpatient Hospital-Acute – Base 9

#1a Inpatient Hospital-Acute – Base 10

#1a Inpatient Hospital-Acute – Base 11

#1a Inpatient Hospital-Acute – Base 12

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

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CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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

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

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

#1b Inpatient Hospital Psychiatric – Base 1

#1b Inpatient Hospital Psychiatric – Base 2

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

File   Help   Add Variable

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

How many cost sharing tiers do you offer?
[   ]

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

Is there an enrollee Coinsurance?
○ Yes
○ No

Medicare-covered Coinsurance Cost Sharing for Tier 1:

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

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

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

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

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

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

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

#1b Inpatient Hospital Psychiatric – Base 3

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

File   Help   Add Variable

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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.)
○ Yes
○ No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

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

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

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

Medicare-covered Coinsurance Cost Sharing for Tier 3:

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

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

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

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

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

#1b Inpatient Hospital Psychiatric – Base 4

#1b Inpatient Hospital Psychiatric – Base 5

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

File   Help   Add Variable

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

○ Yes
○ No

How many cost sharing tiers do you offer?

[ ]

What is your lowest cost tier?

○ Tier 1
○ Tier 2
○ Tier 3

Additional Days Coinsurance Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:

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

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

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

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

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

Additional Days Coinsurance Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:

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

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

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

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

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

#1b Inpatient Hospital Psychiatric – Base 6

#1b Inpatient Hospital Psychiatric – Base 7

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

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

MA Organizations are not permitted to tier deductibles.

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

Indicate Deductible Amount for Tier 1:

Indicate Deductible Amount for Tier 2:

Indicate Deductible Amount for Tier 3:

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

Medicare-covered Copayment Cost Sharing for Tier 1:

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

Indicate Copayment amount for the Medicare-covered stay:

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

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

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

#1b Inpatient Hospital Psychiatric – Base 8

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

File   Help   Add Variable

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Medicare-covered Copayment Cost Sharing for Tier 2:

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

Indicate Copayment amount for the Medicare-covered stay:

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

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

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

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

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

Medicare-covered Copayment Cost Sharing for Tier 3:

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

Indicate Copayment amount for the Medicare-covered stay:

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

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

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

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

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

#1b Inpatient Hospital Psychiatric – Base 9

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#1b Inpatient Hospital Psychiatric – Base 10

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#1b Inpatient Hospital Psychiatric – Base 11

#1b Inpatient Hospital Psychiatric – Base 12

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

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

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

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

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

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

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Inpatient Hospital Psychiatric Notes

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

Notes:

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Medicare-covered Coinsurance Cost Sharing for Tier 2:

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

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

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

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

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

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

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

Medicare-covered Coinsurance Cost Sharing for Tier 3:

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

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

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

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

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

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

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

#2 SNF – Base 4

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

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

- Yes
- No

How many cost sharing tiers do you offer?

What is your lowest cost tier?

- Tier 1
- Tier 2
- Tier 3

Additional Days Coinsurance Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:

- Zero (No Coinsurance per Day)
- One
- Two
- Three

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

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

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

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

Additional Days Coinsurance Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:

- Zero (No Coinsurance per Day)
- One
- Two
- Three

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

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

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

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

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#2 SNF – Base 5

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

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Additional Days Coinsurance Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

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

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

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

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

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

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

○ Yes
○ No

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

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

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

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

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

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

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

#2 SNF – Base 6

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

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

MA Organizations are not permitted to tier deductibles.

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

Indicate Deductible Amount Tier 1:

Indicate Deductible Amount Tier 2:

Indicate Deductible Amount Tier 3:

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

Medicare-covered Copayment Cost Sharing for Tier 1:

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

Indicate Copayment amount for Medicare-covered stay:

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

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

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

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

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

#2 SNF – Base 7

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

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◄ Previous   ► Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: #2 SNF - Base 7

Medicare-covered Copayment Cost Sharing for Tier 2:

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

Indicate Copayment amount for Medicare-covered stay:
[____]

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

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

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

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

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

Medicare-covered Copayment Cost Sharing for Tier 3:

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

Indicate Copayment amount for Medicare-covered stay:
[____]

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

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

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

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

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

#2 SNF – Base 8

#2 SNF – Base 9

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

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Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

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

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

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

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

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

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

○ Yes
○ No

Indicate Copayment amount for Non-Medicare-covered stay:

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

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

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

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

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

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

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#2 SNF (B Only) – Base 1

#2 SNF (B Only) – Base 2

#2 SNF (B Only) – Base 3

#2 SNF (B Only) – Base 4

#3 Cardiac and Pulmonary Rehabilitation Services – Base 1

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#3 Cardiac and Pulmonary Rehabilitation Services – Base 2

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

File Help Add Variable

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

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

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

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

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

#3 Cardiac and Pulmonary Rehabilitation Services – Base 3

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

File   Help   Add Variable

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

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

Indicate Deductible Amount:

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

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

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

#3 Cardiac and Pulmonary Rehabilitation Services – Base 4

#4a Emergency Care – Base 1

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

File   Help   Add Variable

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: #4a Emergency Care - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Cost sharing cannot be greater than the amount established by CMS in the Final Call Letter for Medicare-covered Emergency Care.

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

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate the maximum per visit amount:

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

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

Enter number of Days or Hours:

#4a Emergency Care – Base 2

#4b Urgently Needed Services – Base 1

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

File   Help   Add Variable

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

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

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Select the Maximum Enrollee Out-of-Pocket Cost type:
○ Covered under Emergency Care Service Category 4a
○ Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:
[   ]

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

Cost sharing cannot be greater than the amount established by CMS in the Final Call Letter for Medicare-covered Urgently Needed Services.

Is there an enrollee Coinsurance?
○ Yes
○ No

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

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

Indicate the maximum per visit amount:
[   ]

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

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

Enter number of Days or Hours:
[   ]

#4b Urgently Needed Services – Base 2

#4b Urgently Needed Services – Base 3

#4c Worldwide Emergency/Urgent Coverage – Base 1

#4c Worldwide Emergency/Urgent Coverage – Base 2

#4c Worldwide Emergency/Urgent Coverage – Base 3

#5 Partial Hospitalization – Base 1

#5 Partial Hospitalization – Base 2

#6 Home Health Services – Base 1

#6 Home Health Services – Base 2

#6 Home Health Services – Base 3

#6 Home Health Services – MMP – Base 1

#6 Home Health Services – MMP – Base 2

#6 Home Health Services – MMP – Base 3

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

File   Help   Add Variable

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

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

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

Indicate copayment amount for one or more of the following s

	Minimum Copayment	Maximum Copayment
Additional Hours of Care:		
Personal Care Services:		
Other 1:		
Other 2:		

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

Select which service requires qualification for and enrollment in a state-operated waiver program:
- ☐ Additional Hours of Care
- ☐ Personal Care Services
- ☐ Other 1
- ☐ Other 2

Is authorization required?
- ○ Yes
- ○ No

Is a referral required for Services?
- ○ Yes
- ○ No

Home Health Services MMP Notes

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

Notes:

#7a Primary Care Physician Services – Base 1

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#7a Primary Care Physician Services – Base 2

#7b Chiropractic Services – Base 1

#7b Chiropractic Services – Base 2

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

File   Help   Add Variable

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

Is there an enrollee Coinsurance?
○ Yes
○ No

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

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

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

Indicate the Minimum Coinsurance percentage per visit for Routine Care:

Indicate the Maximum Coinsurance percentage per visit for Routine Care:

Indicate the Minimum Coinsurance percentage per visit for Other Service:

Indicate the Maximum Coinsurance percentage per visit for Other Service:

Is there an enrollee Copayment?
○ Yes
○ No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount per visit for Routine Care:

Indicate Maximum Copayment amount per visit for Routine Care:

Indicate Minimum Copayment amount per visit for Other Service:

Indicate Maximum Copayment amount per visit for Other Service:

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount:

Is authorization required?
○ Yes
○ No

Is a referral required for Chiropractic Services?
○ Yes
○ No

#7b Chiropractic Services – Base 3

CY2018 PBP – Section B
11/30/2016

#7c Occupational Therapy Services – Base 1

#7c Occupational Therapy Services – Base 2

#7c Occupational Therapy Services – MMP – Base 1

#7c Occupational Therapy Services – MMP – Base 2

#7d Physician Specialist Services – Base 1

#7d Physician Specialist Services – Base 2

#7e Mental Health Specialty Services – Base 1

#7e Mental Health Specialty Services – Base 2

#7e Mental Health Specialty Services – Base 3

#7f Podiatry Services – Base 1

#7f Podiatry Services – Base 2

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

File Help Add Variable

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

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

Select which Podiatry Services have a Coinsurance (Select all that apply):
- ☐ Medicare-covered Podiatry Services
- ☐ Routine Foot Care

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Foot Care:

Indicate Maximum Coinsurance percentage for Routine Foot Care:

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

Indicate Deductible Amount:

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

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

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

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

Indicate Minimum Copayment amount per visit for Routine Foot Care:

Indicate Maximum Copayment amount per visit for Routine Foot Care:

#7f Podiatry Services – Base 3

#7g Other Health Care Professional – Base 1

#7g Other Health Care Professional – Base 2

#7h Psychiatric Services – Base 1

11/30/2016
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#7h Psychiatric Services – Base 2

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

File   Help   Add Variable

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

Is there an enrollee Coinsurance?
○ Yes
○ No

Select which Psychiatric Services have a Coinsurance (Select all that apply):
☐ Medicare-covered Individual Sessions
☐ Medicare-covered Group Sessions
Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate Maximum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate Minimum Coinsurance percentage for Medicare-covered Group Sessions:

Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions:

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
○ Yes
○ No

Select which Psychiatric Services have a Copayment (Select all that apply):
☐ Medicare-covered Individual Sessions
☐ Medicare-covered Group Sessions
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for Medicare-covered Group Sessions:

#7h Psychiatric Services – Base 3

#7i PT and SP Services – Base 1

CY 2018 PBP Data Entry System Screens

#7i PT and SP Services – Base 2

#7i PT and ST – MMP – Base 1

#7i PT and ST – MMP – Base 2

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

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

File   Help   Add Variable

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

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

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

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

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

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

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

#9a Outpatient Hospital Services – Base 1

#9a Outpatient Hospital Services – Base 2

#9a Outpatient Hospital Services – Base 3

#9b ASC Services – Base 1

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

File   Help   Add Variable

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

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

○ Yes
○ No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

Is there an enrollee Coinsurance?

○ Yes
○ No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

#9b ASC Services – Base 2

#9b ASC Services – Base 3

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

File   Help   Add Variable

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

ASC Services Notes

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

Notes:

#9c Outpatient Substance Abuse – Base 1

#9c Outpatient Substance Abuse – Base 2

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

File   Help   Add Variable

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

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

Is there an enrollee Coinsurance?
○ Yes
○ No

Select which Outpatient Substance Abuse Services have a Coinsurance (Select all that apply):
☐ Medicare-covered Individual Sessions
☐ Medicare-covered Group Sessions

Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate Maximum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate Minimum Coinsurance percentage for Medicare-covered Group Sessions:

Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions:

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
○ Yes
○ No

Select which Outpatient Substance Abuse Services have a Copayment (Select all that apply):
☐ Medicare-covered Individual Sessions
☐ Medicare-covered Group Sessions

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for Medicare-covered Group Sessions:

#9c Outpatient Substance Abuse – Base 3

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

File   Help   Add Variable

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

Is authorization required?
- ○ Yes
- ○ No

Is a referral required for Outpatient Substance Abuse Services?
- ○ Yes
- ○ No

Outpatient Substance Abuse Notes

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

Notes:

#9d Outpatient Blood Services – Base 1

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

File   Help   Add Variable

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

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Select enhanced benefit:
- ☐ Three (3) pint deductible waived

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

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

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

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

CY 2018 PBP Data Entry System Screens

#9d Outpatient Blood Services – Base 2

#10a Ambulance Services – Base 1

#10a Ambulance Services – Base 2

#10b Transportation Services – Base 1

#10b Transportation Services – Base 2

#10b Transportation Services – Base 3

#11a DME – Base 1

#11a DME – Base 2

CY 2018 PBP Data Entry System Screens

#11a DME – MMP – Base 1

#11a DME – MMP – Base 2

#11b Prosthetics/Medical Supplies – Base 1

#11b Prosthetics/Medical Supplies – Base 2

#11b Prosthetics/Medical Supplies – Base 3

#11b Prosthetics/Medical Supplies – MMP – Base 1

#11c Diabetic Supplies and Services – Base 1

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#11c Diabetic Supplies and Services – Base 2

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

File   Help   Add Variable

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #11c Diabetic Supplies and Services - Base 2

Is there an enrollee Copayment?
○ Yes
○ No

Select which Diabetic Supplies and Services have a Copayment (Select all that apply):
☐ Medicare-covered Diabetes Supplies
☐ Medicare-covered Diabetic Therapeutic Shoes or Inserts

Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:

Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:

Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Do you limit Diabetic Supplies and Services to those from specified manufacturers?
○ Yes
○ No

Is authorization required?
○ Yes
○ No

Referral is not applicable for this Service Category.

Diabetic Supplies and Services Notes

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

#12 Dialysis Services – Base 1

#12 Dialysis Services – Base 2

#13a Acupuncture – Base 1

#13a Acupuncture – Base 2

#13a Acupuncture – Base 3

#13b OTC Items – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✖ Exit (No Validate)   Go To: #13b OTC Items - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Medicare-Medicaid plans may not use this section to provide benefit information about any OTC items that are submitted under the integrated formulary. Information about those benefits will be entered in the Rx section of the PBP. This section should only be used to provide benefit information about OTC items that are covered as a supplemental benefit.

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?
- ○ Yes
- ○ No

Select type of benefit for OTC Items:
- ○ Mandatory
- ○ Optional

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

Indicate Maximum Plan Benefit Coverage amount:
[   ]

Indicate Maximum Plan Benefit Coverage periodicity:
- ○ Every three years
- ○ Every two years
- ○ Every year
- ○ Every six months
- ○ Every three months
- ○ Every month

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?
- ○ Yes
- ○ No

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:
[   ]

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:
- ○ Every three years
- ○ Every two years
- ○ Every year
- ○ Every six months
- ○ Every three months
- ○ Every month

#13b OTC Items – Base 2

#13b OTC Items – Base 3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13b OTC Items - Base 3

OTC Items Notes

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

Notes:

#13c Meal Benefit – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13c Meal Benefit - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

Select type of benefit for Meals:
- ○ Mandatory
- ○ Optional

How many days does your Meal Benefit last?

What is the maximum number of meals the benefit provides?

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

#13c Meal Benefit – Base 2

#13c Meal Benefit – Base 3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13c Meal Benefit - Base 3

Meal Benefit Notes

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

Notes:

#13d Other 1 – Base 1

#13d Other 1 – Base 2

#13d Other 1 – Base 3

#13e Other 2 – Base 1

#13e Other 2 – Base 2

#13e Other 2 – Base 3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13e Other 2 - Base 3

Other 2 Notes

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

Notes:

#13f Other 3 – Base 1

#13f Other 3 – Base 2

#13f Other 3 – Base 3

#13g Dual Eligible SNPs with Highly Integrated Services – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Plans only fill out this section if they have received written notification from CMS that they qualify for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services.

Dual Eligible SNPs with Highly Integrated Services Benefit Attestation

☐ I attest that I have received written notification from CMS that this individual SNP plan qualifies for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services for CY 2016. I further attest that the additional supplemental benefit(s) that the SNP describes in this section of the PBP do not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside.

You may edit the name of the service text partially without losing all previously entered data.

If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.

Enter name of Service (Optional):

Select type of benefit for Dual Eligible SNPs with Highly Integrated Services:
○ Mandatory
○ Optional

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

#13g Dual Eligible SNPs with Highly Integrated Services – Base 2

#13g Dual Eligible SNPs with Highly Integrated Services – Base 3

#13h Additional Services – Base 1

#13h Additional Services – Base 2

#13h Additional Services – Base 3

#13h Additional Services – Base 4

#13h Additional Services – Base 5

#13h Additional Services – Base 6

#13h Additional Services – Base 7

#13h Additional Services – Base 8

#13h Additional Services – Base 9

#13h Additional Services – Base 10

#13h Additional Services – Base 11

#13h Additional Services – Base 12

#13h Additional Services – Base 13

#13h Additional Services – Base 14

#13h Additional Services – Base 15

#13h Additional Services – Base 16

#13h Additional Services – Base 17

#13h Additional Services – Base 18

#13h Additional Services – Base 19

#13h Additional Services – Base 20

#13h Additional Services – Base 21

#13h Additional Services – Base 22

#13h Additional Services – Base 23

#13h Additional Services – Base 24

#13h Additional Services – Base 25

#13h Additional Services – Base 26

#13h Additional Services – Base 27

#13h Additional Services – Base 28

#13h Additional Services – Base 29

#13h Additional Services – Base 30

#14a Medicare-covered Zero Dollar Preventive Services

#14b Annual Physical Exam – Base 1

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#14b Annual Physical Exam – Base 2

#14b Annual Physical Exam – Base 3

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

◀ Previous   ▶ Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   **Go To:** #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Eligible Supplemental Benefits as Defined in Chapter 4 as a benefit under Part C?

○ Yes
○ No

Select enhanced benefit (Select all that apply):

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

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

Select type of benefit for Health Education:
○ Mandatory
○ Optional

Select type of benefit for Nutritional/Dietary Benefit:
○ Mandatory
○ Optional

Is this benefit unlimited for Nutritional/Dietary Benefit?
○ Yes
○ No, indicate number

Indicate number of visits for Nutritional/Dietary Benefit:
[   ]

Indicate setting for Nutritional/Dietary Benefit:
○ Individual Sessions
○ Group Sessions
○ Both Sessions (Individual and Group)

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

Indicate number of visits offered in addition to Medicare:
[   ]

Select type of benefit for Fitness Benefit:
○ Mandatory
○ Optional

Select type of benefit for Enhanced Disease Management:
○ Mandatory
○ Optional

Select type of benefit for Telemonitoring Services:
○ Mandatory
○ Optional

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

Select the type of Remote Access Technologies offered (Select all that apply):
☐ Web/Phone based technologies
☐ Nursing Hotline

Select type of benefit for Bathroom Safety Devices:
○ Mandatory
○ Optional

Select type of benefit for Counseling Services:
○ Mandatory
○ Optional

Is this benefit unlimited for Counseling Services?
○ Yes
○ No, indicate number

Indicate number of visits for Counseling Services:
[   ]

Indicate setting for Counseling Services:
○ Individual Sessions
○ Group Sessions
○ Both Sessions (Individual and Group)

Indicate duration of sessions (in minutes):
[   ]

Select type of benefit for In-Home Safety Assessment:
○ Mandatory
○ Optional

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

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

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

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

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

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

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Is there an enrollee Coinsurance?
○ Yes
○ No

Select which Eligible Supplemental Benefits as Defined in Chapter 4 have a Coinsurance (Select all that apply):

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

Indicate Minimum Coinsurance percentage for Health Education:

Indicate Maximum Coinsurance percentage for Health Education:

Indicate Minimum Coinsurance percentage for Nutritional/Dietary Benefit:

Indicate Maximum Coinsurance percentage for Nutritional/Dietary Benefit:

Indicate Minimum Coinsurance percentage for Additional sessions of Smoking and Tobacco Cessation Counseling:

Indicate Maximum Coinsurance percentage for Additional sessions of Smoking and Tobacco Cessation Counseling:

Indicate Minimum Coinsurance percentage for Fitness Benefit:

Indicate Maximum Coinsurance percentage for Fitness Benefit:

Indicate Minimum Coinsurance percentage for Enhanced Disease Management:

Indicate Maximum Coinsurance percentage for Enhanced Disease Management:

Indicate Minimum Coinsurance percentage for Telemonitoring Services:

Indicate Maximum Coinsurance percentage for Telemonitoring Services:

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

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

Indicate Minimum Coinsurance percentage for Bathroom Safety Devices:

Indicate Maximum Coinsurance percentage for Bathroom Safety Devices:

Indicate Minimum Coinsurance percentage for Counseling Services:

Indicate Maximum Coinsurance percentage for Counseling Services:

Indicate Minimum Coinsurance percentage for In-Home Safety Assessment:

Indicate Maximum Coinsurance percentage for In-Home Safety Assessment:

Indicate Minimum Coinsurance percentage for Personal Emergency Response System (PERS):

Indicate Maximum Coinsurance percentage for Personal Emergency Response System (PERS):

Indicate Minimum Coinsurance percentage for Medical Nutrition Therapy (MNT):

Indicate Maximum Coinsurance percentage for Medical Nutrition Therapy (MNT):

Indicate Minimum Coinsurance percentage for Post discharge In-home Medication Reconciliation:

Indicate Maximum Coinsurance percentage for Post discharge In-home Medication Reconciliation:

Indicate Minimum Coinsurance percentage for Re-admission Prevention:

Indicate Maximum Coinsurance percentage for Re-admission Prevention:

Indicate Minimum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy:

Indicate Maximum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy:

Indicate Minimum Coinsurance percentage for Weight Management Programs:

Indicate Maximum Coinsurance percentage for Weight Management Programs:

Indicate Minimum Coinsurance percentage for Alternative Therapies:

Indicate Maximum Coinsurance percentage for Alternative Therapies:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.
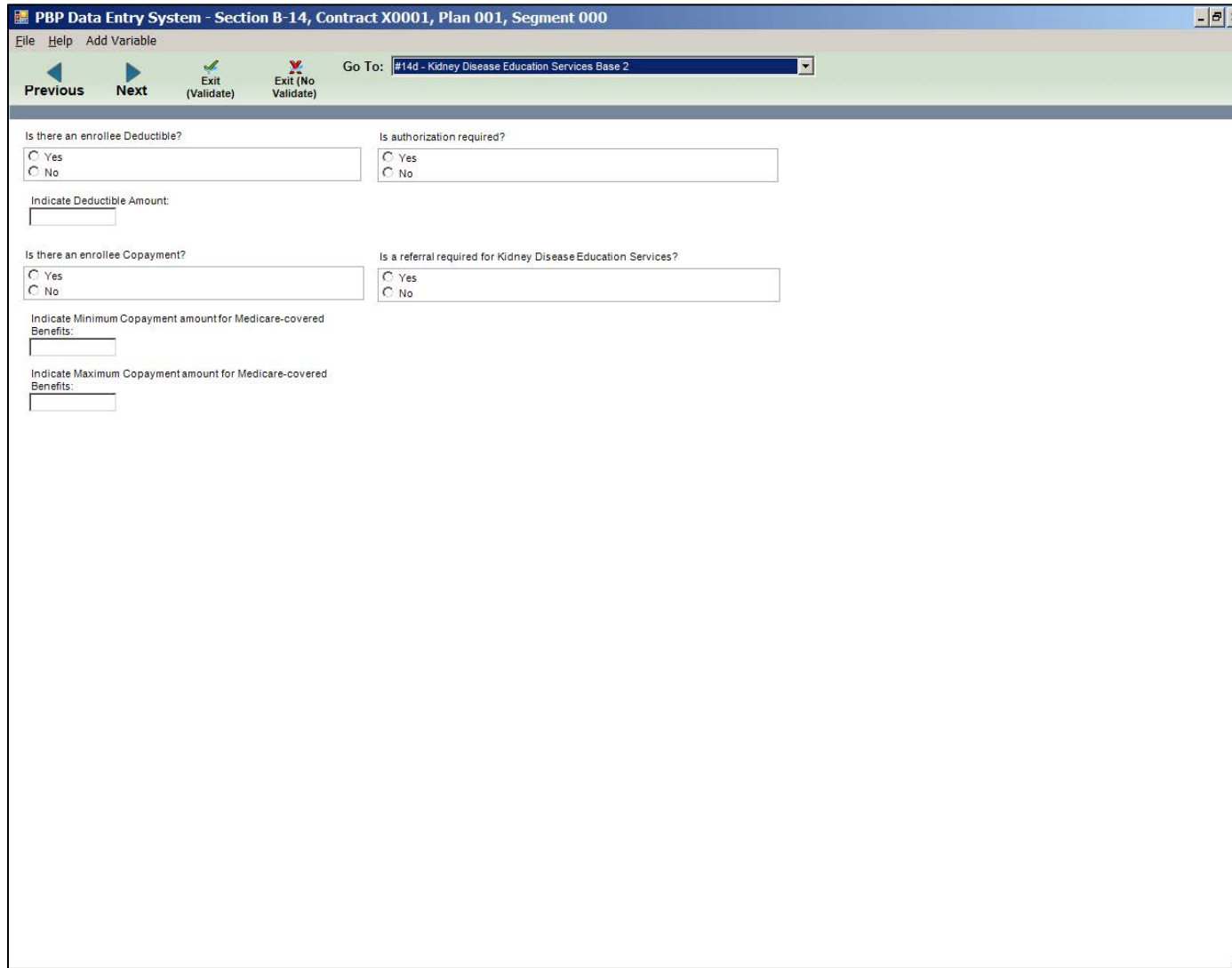
#14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 8

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

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File Help Add Variable

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Is authorization required?
○ Yes
○ No

Is a referral required for Eligible Supplemental Benefits as Defined in Chapter 4?
○ Yes
○ No

Eligible Supplemental Benefits as Defined in Chapter 4 Notes:

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

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

Health Education Notes:

Nutritional/Dietary Benefit Notes:

Additional sessions of Smoking and Tobacco Cessation Counseling Notes:

Fitness Benefit Notes:*

Enhanced Disease Management Notes:

Telemonitoring Services Notes:*

#14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 10

#14c Eligible Supplemental Benefits as Defined in Chapter 4 – Base 11

CY 2018 PBP Data Entry System Screens

#14d Kidney Disease Education Services – Base 1

#14d Kidney Disease Education Services – Base 2

#14d Kidney Disease Education Services – Base 3

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

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Kidney Disease Education Services Notes

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

Notes:

#14e Other Medicare-covered Preventive Services – Base 1

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

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CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

Glaucoma screening, diabetes self-management training, and Other Medicare-covered preventive services are Medicare-covered preventive services for which data entry must be completed in this section. See the Benefit Description for more guidance.

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?
- ○ Yes
- ○ No

Select which Services have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply):
- ☐ Medicare-covered Glaucoma Screening
- ☐ Medicare-covered Diabetes Self-Management Training
- ☐ Other Medicare-covered Preventive Services

Indicate Medicare-covered Glaucoma Screening Maximum Enrollee Out-of-Pocket Cost amount:

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

Indicate Medicare-covered Diabetes Self-Management Training Maximum Enrollee Out-of-Pocket Cost amount:

Select the Medicare-covered Diabetes Self-Management Training Maximum Enrollee Out-of-Pocket Cost periodicity:
- ○ Every three years
- ○ Every two years
- ○ Every year
- ○ Every six months
- ○ Every three months
- ○ Other, Describe

Indicate Other Medicare-covered Preventive Services Maximum Enrollee Out-of-Pocket Cost amount:

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

#14e Other Medicare-covered Preventive Services – Base 2

#14e Other Medicare-covered Preventive Services – Base 3

#14e Other Medicare-covered Preventive Services – Base 4

#15 Medicare Part B Rx Drugs – Base 1

#15 Medicare Part B Rx Drugs – Base 2

#15 Medicare Part B Rx Drugs – Notes

#15 Home Infusion Bundled Services

PBP Data Entry System - Section B-15, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

◀ **Previous**   ▶ **Next**   ✔ **Exit (Validate)**   ✘ **Exit (No Validate)**   **Go To:** #15 Home Infusion Bundled Services

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?

○ Yes
○ No

If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 10, 2016 at 11:59am Eastern Time.

You must also ensure that your benefit includes not only the home infusion drug, but any services and supplies associated with the home infusion drug's administration.

If your organization elects to provide Part D home infusion drugs as part of a supplemental bundled service then those services must be provided at $0 cost sharing. As described in the CY 2010 Call Letter this waiver is conditioned on the application of zero cost sharing for the bundle of home infusion services provided under a supplemental benefit.

Does the plan pay for Part D drug home infusion services and supplies as a Medicaid benefit?

○ Yes
○ No

#16a Preventive Dental – Base 1

#16a Preventive Dental – Base 2

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

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Select type of benefit for Dental X-Rays:
- ○ Mandatory
- ○ Optional

Is this benefit unlimited for Dental X-Rays?
- ○ Yes
- ○ No, indicate number

Indicate number of visits for Dental X-Rays:
[   ]

Select the Dental X-Rays periodicity:
- ○ Every three years
- ○ Every two years
- ○ Every year
- ○ Every six months
- ○ Every three months
- ○ Other, Describe

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

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?
- ○ In-network services only
- ○ Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:
[   ]

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

#16a Preventive Dental – Base 3

#16a Preventive Dental – Base 4

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#16a Preventive Dental – Base 5

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#16b Comprehensive Dental – Base 1

#16b Comprehensive Dental – Base 2

CY 2018 PBP Data Entry System Screens

#16b Comprehensive Dental – Base 3

#16b Comprehensive Dental – Base 4

#16b Comprehensive Dental – Base 5

#16b Comprehensive Dental – Base 6

#17a Eye Exams – Base 1

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#17a Eye Exams – Base 2

#17a Eye Exams – Base 3

#17b Eyewear – Base 1

#17b Eyewear – Base 2

#17b Eyewear – Base 3

#17b Eyewear – Base 4

#17b Eyewear – Base 5

#17b Eyewear – Base 6

#18a Hearing Exams – Base 1

#18a Hearing Exams – Base 2

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

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

Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?
- In-network services only
- Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

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

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?
- Yes
- No

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

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Hearing Exams:

Indicate Maximum Coinsurance percentage for Routine Hearing Exams:

Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

#18a Hearing Exams – Base 3

#18a Hearing Exams – Base 4

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #18a Hearing Exams - Base 4

Hearing Exams Notes

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

Notes:

#18b Hearing Aids – Base 1

#18b Hearing Aids – Base 2

11/30/2016
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

CY 2018 PBP Data Entry System Screens

#18b Hearing Aids – Base 3

#18b Hearing Aids – Base 4

#18b Hearing Aids – Base 5

#20 Outpatient Drugs – Base 1

#20 Outpatient Drugs – Base 2

#20 Outpatient Drugs – Base 3

#20 Outpatient Drugs – Base 4

#20 Outpatient Drugs – Notes

#20 Outpatient Drugs – Group 1 – Base 1

CY 2018 PBP Data Entry System Screens

#20 Outpatient Drugs – Group 1 – Base 2

#20 Outpatient Drugs – Group 2 – Base 1

11/30/2016
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#20 Outpatient Drugs – Group 2 – Base 2

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

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Select from where Group 2 Drugs can be acquired
☐ Designated Retail Pharmacy
☐ HMO-Owned Pharmacy
☐ Mail Order
☐ Other, Describe

Is there an enrollee Coinsurance for Group 2?
○ Yes
○ No

Is there an enrollee Copayment for Group 2?
○ Yes
○ No

Indicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy:

Indicate Copayment amount for Group 2 Designated Retail Pharmacy:

Up to a _____ day supply covered for Group 2 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 2 for HMO-Owned Pharmacy:

Indicate Copayment amount for Group 2 HMO-Owned Pharmacy:

Up to a _____ day supply covered for Group 2 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 2 for Mail Order:

Indicate Copayment amount for Group 2 Mail Order:

Up to a _____ day supply covered for Group 2 Mail Order:

Indicate Coinsurance percentage for Group 2 for Other:

Indicate Copayment amount for Group 2 Other:

Up to a _____ day supply covered for Group 2 Other:

#20 Outpatient Drugs – Group 3 – Base 1

CY 2018 PBP Data Entry System Screens

#20 Outpatient Drugs – Group 3 – Base 2

Select from where Group 3 Drugs can be acquired:
☐ Designated Retail Pharmacy
☐ HMO-Owned Pharmacy
☐ Mail Order
☐ Other, Describe

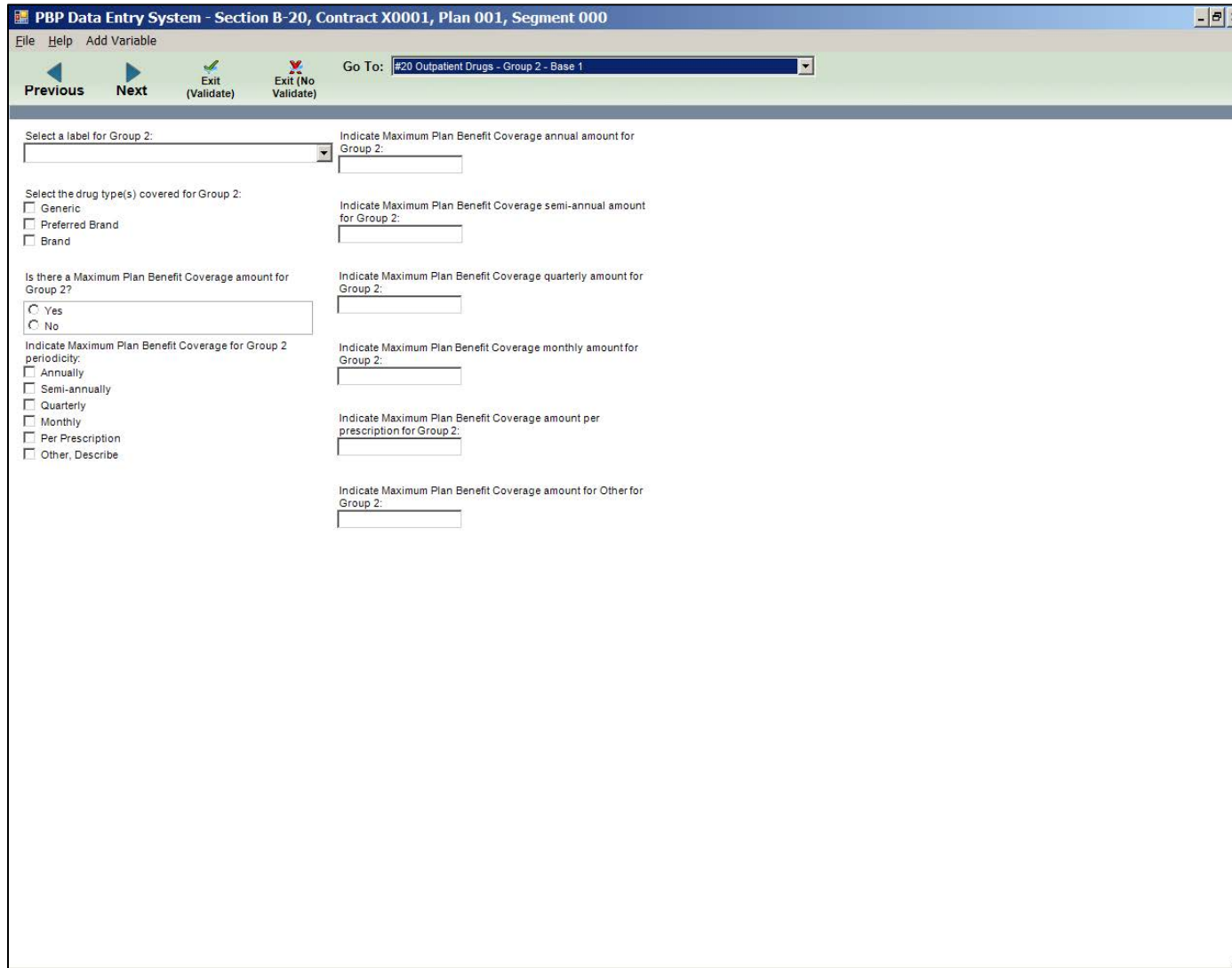Is there an enrollee Coinsurance for Group 3?
○ Yes
○ No

Is there an enrollee Copayment for Group 3?
○ Yes
○ No

Indicate Coinsurance percentage for Group 3 Designated Retail Pharmacy:

Indicate Copayment amount for Group 3 Designated Retail Pharmacy:

Up to a _____ day supply covered for Group 3 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 3 HMO-Owned Pharmacy:

Indicate Copayment amount for Group 3 HMO-Owned Pharmacy:

Up to a _____ day supply covered for Group 3 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 3 Mail Order:

Indicate Copayment amount for Group 3 Mail Order:

Up to a _____ day supply covered for Group 3 Mail Order:

Indicate Coinsurance percentage for Group 3 Other:

Indicate Copayment amount for Group 3 Other:

Up to a _____ day supply covered for Group 3 Other:

#20 Outpatient Drugs – Group 4 – Base 1

CY 2018 PBP Data Entry System Screens

#20 Outpatient Drugs – Group 4 – Base 2

#20 Outpatient Drugs – Group 5 – Base 1

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

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Select a label for Group 5:

Select the drug type(s) covered for Group 5:
☐ Generic
☐ Preferred Brand
☐ Brand

Is there a Maximum Plan Benefit Coverage amount for Group 5?
○ Yes
○ No

Indicate Maximum Plan Benefit Coverage for Group 5 periodicity:
☐ Annually
☐ Semi-annually
☐ Quarterly
☐ Monthly
☐ Per Prescription
☐ Other, Describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 5:

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 5:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 5:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 5:

#20 Outpatient Drugs – Group 5 – Base 2

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File   Help   Add Variable

Go To: #20 Outpatient Drugs - Group 5 - Base 2

Previous   Next   Exit (Validate)   Exit (No Validate)

Select from where Group 5 Drugs can be acquired:
☐ Designated Retail Pharmacy
☐ HMO-Owned Pharmacy
☐ Mail Order
☐ Other, Describe

Is there an enrollee Coinsurance for Group 5?
○ Yes
○ No

Is there an enrollee Copayment for Group 5?
○ Yes
○ No

Indicate Coinsurance percentage for Group 5 Designated Retail Pharmacy:

Indicate Copayment amount for Group 5 Designated Retail Pharmacy:

Up to a _____ day supply covered for Group 5 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 5 HMO-Owned Pharmacy:

Indicate Copayment amount for Group 5 HMO-Owned Pharmacy:

Up to a _____ day supply covered for Group 5 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 5 Mail Ord

Indicate Copayment amount for Group 5 Mail Order:

Up to a _____ day supply covered for Group 5 Mail Order:

Indicate Coinsurance percentage for Group 5 Other:

Indicate Copayment amount for Group 5 Other:

Up to a _____ day supply covered for Group 5 Other:

#20 Home Infusion Bundled Services

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING