Help	tract X0001, Plan 001, Segment 000	
	To: #1a Inpatient Hospital-Acute - Base 1	
evious Next (Validate) Validate)		
LICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Non-Medicare-covered stay:	
es the plan provide Inpatient Hospital-Acute Services as a plemental benefit under Part C?	C Mandatory C Optional	
Yes No	Select type of benefit for Upgrades:	
ect enhanced benefits: Additional Days	C Mandatory C Optional	
Non-Medicare-covered Stay Upgrades		
elect type of benefit for Additional Days:		
Mandatory Optional		
this benefit unlimited for Additional Days?		
Yes No, indicate number		
ndicate number of Additional Days per benefit period:		
Tucate number of Additional Days per benefic period.		

BP Data Entry System - Section B-1, Contract . Help		
Go To: 🖉	1a Inpatient Hospital-Acute - Base 2	
vious Next (Validate) Validate)		
imum Plan Benefit Coverage is not applicable for this Service Category.	Is there an enrollee Coinsurance?	
	C Yes	
nere a service-specific Maximum Enrollee Out-of-Pocket Cost?	C No	
Yes	Medicare-covered Coinsurance Cost Sharing for Tier 1:	
No		
dicate the Maximum Enrollee Out-of-Pocket Cost amount:	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	C Yes C No	
C Every three years		
O Every two years	Indicate Coinsurance percentage for the Medicare-covered stay:	
C Every year		
C Every six months	Indicate the number of day intervals for the Medicare-covered stay:	
© Every three months © Every Benefit Period	C Zero (No Coinsurance per Day)	
C Every Stay	O One	
O Other, Describe	C Two	
s this plan's Medicare-covered benefit costsharing vary by hospital(s) in	C Three	
h an enrollee obtains care?	Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):	
Yes		
No	Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
How many cost sharing tiers do you offer?		
	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
What is your lowest cost tier?		
C Tier 1	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
O Tier 2 O Tier 3		
O Her3		

elp				
		Exit	Exit (No	#1a Inpatient Hospital-Acute - Base 3
vious	Next	(Validate)	Validate)	
care-covere	ed Coinsurance	ce Cost Sharing fo	r Tier 2:	Medicare-covered Coinsurance Cost Sharing for Tier 3:
ou charge th	ne Medicare-o	lefined cost share	s? (These are the total	Do you charge the Medicare-defined cost shares? (These are the total
ges tor all se (es	ervices provid	ed to the enrollee i	in the inpatient facility.)	charges for all services provided to the enrollee in the inpatient facility.) Ves
lo				C No
Indicate Coi	insurance per	centage for the Me	edicare-covered stay:	Indicate Coinsurance percentage for the Medicare-covered stay:
			Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:
O One	o Coinsuranc	e per Day)		○ Zero (No Coinsurance per Day) ○ One
C Two C Three				C Two C Three
Indicate the		percentage and da e.g., 1 to 30; 31 to 9	ay interval(s) for the 90):	Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30, 31 to 90):
Coinsurance	e % Interval 1	Begin Day Inter	val 1 End Day Interval 1:	Coinsurance % Interval 1 Begin Day Interval 1 End Day Interval 1:
Coinsurance	e % Interval 2	Begin Day Interv	val 2 End Day Interval 2:	Coinsurance % Interval 2 Begin Day Interval 2 End Day Interval 2:
Coinsuranc	e % Interval 3	Begin Day Inter	val 3 End Day Interval 3:	Coinsurance % Interval 3 Begin Day Interval 3 End Day Interval 3:

Elle Help Previous Next Exit (No Validate) Go To: F1a Inpatient Hospital-Acute - Base 4 Medicare-covered Lifetime Reserve Days Tier 1 Medicare-covered Lifetime Reserve Days Tier 2 Medicare-covered Lifetime Reserve Days Tier 3	
Previous Next (Validate) Medicare-covered Lifetime Reserve Days Tier 1 Medicare-covered Lifetime Reserve Days Tier 2 Medicare-covered Lifetime Reserve Days Tier 3	
Indicate the number of day intervals for the Indicate the number of day intervals for the Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: Medicare-covered Lifetime Reserve Days:	
Medicale-Corete Linemie (testere Day) Medicale-Corete Linemie (testere Day) Imedicale-Corete Linemie (testere Day) C Zero (No Coinsurance per Day) C Zero (No Coinsurance per Day) C Zero (No Coinsurance per Day) C No C No C No C Two C Two C Two C Tree C Three C Three	
Indicate the coinsurance percentage and day Indicate the coinsurance percentage and day Indicate the coinsurance percentage and day Interval(s) for the 60 Medicare-covered Lifetime Interval(s) for the 60 Medicare-covered Lifetime Interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Reserve Days (i.e., 1 - 60): Reserve Days (i.e., 1 - 60):	
Interval Days Interval Days	
Coinsurance % Begin Day End Day Coinsurance % Begin Day End Day Coinsurance % Begin Day End Day	
Interval 1: Interv	
Interval 3: Interval 3	

PBP Data Entry System - Section B-1, Contract X	(0001, Plan 001, Segment 000	_ 8
e Help Go To: #10 Exit Exit (No	a Inpatient Hospital-Acute - Base 5	
Previous Next (Validate) Validate)		
Does this plan's Additional Days cost sharing vary by hospital(s) in which an	Additional Days Coinsurance Cost Sharing for Tier 2:	
enrollee obtains care?	Indicate the number of day intervals for Additional Days:	
C Yes C No	C Zero (No Coinsurance per Day)	
How many cost sharing tiers do you offer?	C One O Two	
What is your lowest cost tier?		
C Tier 1 C Tier 2	Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):	
C Tier 3	Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
Additional Days Coinsurance Cost Sharing for Tier 1:		
ndicate the number of day intervals for Additional Days:	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
C Zero (No Coinsurance per Day) C One		
O Two O Three	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
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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vious	Next	Exit (Validate)	Exit (No Validate)	To: #1a Inpatient Hospital-Acute - Base 6	
	Colorea	ce Cost Sharing for 1	Fine 2:	Is the Coinsurance structure for the Non-Medicare-covered stay the Is the Coinsurance structure for Upgrade	
		intervals for Addition		same as the Coinsurance structure for the Medicare-covered stay? Coinsurance structure for the Medicare-covered stay?	overed stay?
	pinsurance		lai Days.	C Yes C No C No	
ne vo hree				Indicate Coinsurance percentage for the Non-Medicare-covered stay:	or Upgrades:
		percentage and day i ted days are offered;	nterval(s) for Addition e.g., 91 to 999):	 al Indicate the number of day intervals for the Non-Medicare-covered stay:	
surance	6 Interval 1	Begin Day Interval	1: End Day Interval 1	O Two	
surances	6 Interval 2	Begin Day Interval :	2: End Day Interval 2	C Three Indicate the coinsurance percentage and day interval(s) for the Non- Medicare-covered stay (enter "999" ifunlimited days are offered; e.g.; 1 to 999):	
surance?	6 Interval 3	Begin Day Interval	3: End Day Interval 3		
				Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
				Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	

BP Data Entry System - Section B-1, Cor	ntract X0001, Plan 001, Segment 000	_ 5
Help	o To: ≢1a Inpatient Hospital-Acute - Base 7	
evious Next (Validate) Ge		
ou do not have a service-specific deductible for this benefit but er a plan-specific deductible, then enter the plan deductible in ction D.	Medicare-covered Copayment Cost Sharing for Tier 1: Do you charge the Medicare-defined cost shares? (These are the total charges	
Organizations are not permitted to tier deductibles.	for all services provided to the enrolleein the inpatient facility.) C Yes	
here an enrollee Deductible? Yes	O No	
No	Indicate Copayment amount for the Medicare-covered stay:	
ndicate Deductible Amount for Tier 1:	Indicate the number of day intervals for the Medicare-covered stay:	
	C Zero (No Copayment per Day) C One	
ndicate Deductible Amount for Tier 2:	C Two	
	C Three	
dicate Deductible Amount for Tier 3:	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.	
nere an enrollee Copayment?	Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	
Yes No	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	

		1		C - T		
evious	Next	Exit (Validate)	Exit (No Validate)	Go 10:	#1a Inpatient Hospital-Acute - Base 8	
		nt Cost Sharing for			Medicare-covered Copayment Cost Sharing for Tier 3:	
arges for all s	the Medicare- ervices provid	defined cost share ded to the enrollee	es? (These are in the inpatien	the total (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.)	
Yes No					O Yes O No	
		t for the Medicare- ervals for the Med		stav:	Indicate Copayment amount for the Medicare-covered stay:	
	opaymentper			July.	C Zero (No Copayment per Day) C One C Two	
Three					Ö Three	
ered stay (e	.a., 1 to 30; 31	nt and day interva to 90): For more i the variable help.	l(s) for the Mec nformation on	licare- cost	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.	
		Begin Day Interval			Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	
ayment Am	t Interval 2 E	Begin Day Interval	2: End Day	nterval 2:	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
oayment Am	t Interval 3 E	Begin Day Interval	3: End Day I	nterval 3:	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	

BP Data Entry System - Section B Help	-1, Contract X0001, Plan 001, Segme	nt UUU	_ 8
evious Next (Validate) Valida	Go To: #1a Inpatient Hospital-Acute - Base 9 Io te)		
dicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3	
icate the number of day intervals for the Medicare- vered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	
Zero (No Copayment per Day) One Two Three	C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copaymentper Day) C One C Two C Three	
icate the copayment amount and day interval(s) the 60 Medicare-covered Lifetime Reserve Days ., 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	
erval 1:	Interval 1:	Interval 1:	
erval 2:	Interval 2:	Interval 2:	
erval 3:	Interval 3:	Interval 3:	

PBP Data Entry System - Section B-1, Contract	t X0001, Plan 001, Segment 000	_ 8 3
jie Help	#1a Inpatient Hospital-Acute - Base 10	
Exit Exit (No Previous Next (Validate) Validate)		
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 Copaymentper 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 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:	

PBP Data Entry System - Section B-1, Contrac	ct X0001, Plan 001, Segment 000
ile Help Exit Exit No	#1a Inpatient Hospital-Acute - Base 11
Previous Next Exit Exit (No (Validate) Validate)	
Additional Days Copayment Cost Sharing for Tier 3:	Is the Copayment structure for the Non-Medicare-covered stay the same as
Indicate the number of day intervals for Additional Days:	the Copayment structure for the Medicare-covered stay?
C Zero (No Copayment per Day) C One	C Yes C No
C Two C 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:
	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:
	Copayment Amt Interval 3: End Day Interval 3: End Day Interval 3:

PBP Data Entry System - Section B-1, Contra	act X0001, Plan 001, Segment 000	_ 8
Exit Exit (No	o: #1a Inpatient Hospital-Acute - Base 12	
Previous Next (Validate) Validate)		
Is the Copayment structure for Upgrades the same as the Copayment structure for the Medicare-covered stay?	Inpatient Hospital-Acute Notes Note may include additional information to describe benefit in this service category. Do not repeat	
C Yes C No	Information captured in data entry. Notes:	
Indicate Copayment amount for Upgrades per stay:	Notes:	
Indicate Copayment amount for Upgrades per day:		
What is your Inpatient Hospital-Acute benefit period?		
O Original Medicare O Annual		
C Per Admission or Per Stay C Other, Describe		
If "Other, Describe" is selected enter description below:		
Do you charge cost sharing on the day of discharge?		
C Yes C No		
Is authorization required?		
C Yes C No		
s a referral required for Inpatient Hospital-Acute Services?		
C No		

vious Next (Validate)	So To: #1a Inpatient Hospital-Acute (B Only) - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount?	
you offer Inpatient Hospital-Acute Services as a benefit? Yes	C Yes C No	
No	Indicate Maximum Plan Benefit Coverage amount:	
ect type of benefit for Inpatient Hospital-Acute Services: Mandatory		
Optional	Select Maximum Plan Benefit Coverage periodicity:	
es this benefit have unlimited days?	C Every three years C Every two years	
Yes No, indicate number	C Every year C Every six months	
dicate number of days per period:	C Every three months C Every Benefit Period C Every Stay	
	C Other, Describe	
Select the days periodicity:	1	
C Every three years C Every two years		
C Every year C Every six months		
C Every six months		
C Every Benefit Period		
C Every Stay C Other, Describe		
Conten, Describe		

BP Data Entry System - Section B-1, Contra Help		
	: #1a Inpatient Hospital-Acute (8 Only) - Base 2	
evious Next (Validate) Validate)		
there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the number of day intervals for the stay:	
Yes	C Zero (No Coinsurance per Day)	
No	C One C Two	
dicate the Maximum Enrollee Out-of-Pocket Cost amount:	C Three	
	Indicate the coinsurance percentage and day interval(s) for the stay	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	(enter "999" if unlimited days are offered; e.g., 1 to 999):	
C Every three years	Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
C Every two years		
O Every year		
C Every six months C Every three months	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
C Every Benefit Period		
C Every Stay	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
C Other, Describe		
here an enrollee Coinsurance?		
Yes No		

revious Next (Validate) Go To): ≢1a Inpatient Hospital-Acute (B Only) - Base 3		
there an enrollee Deductible? Yes No Indicate Deductible Amount: Yes No Indicate Copayment? Yes No Indicate Copayment amount per stay: C Zero (No Copayment per Day) C One C Two C Three	Indicate the copayment amount and day interval(s) for the stay (enter '999' if unlimited days are offered; e.g., 1 to 999): Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 2: Copayment Amt Interval 2 Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3: Do you charge cost sharing on the day of discharge? C Yes C No	Is authorization required? Yes Is a referral required for InpatientHospital-Acute Services? Yes No	

	Acute Notes	Exit (No Validate)				
may include : s:	additional information to de	escribe benefit in this s	service category. Do not repeat info	rmation captured in data entry.		
					<u>×</u>	
					y	

Violus Violus Violus Violus Violus Violus Violus Violus Violus Violus Violus Violus Violus Violus Violus Violus Violus <th><u>telp</u></th> <th></th> <th></th>	<u>telp</u>		
ICK FOR DESCRIPTION OF BENEFIT Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes No io Select the Maximum Enrollee Out-of-Pocket Cost type: C Covered under inpatient Hospital Services Category 1a C Yes Non-Medicare-covered Stay Indicate Maximum Enrollee Out-of-Pocket Cost amount: Mandatory Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: No, indicate number C Yery Users Idicate number C Every three years C Every three period C Every three months C Every Benefit for Non-Medicare-covered stay: C Every Stay	Exit Exit (No	Fo: #1b Inpatient Hospital Psychiatric - Base 1	
Bendan provide inpatient Hospital Psychiatric Services as a plemental benefit under Part C? Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No No Select the Maximum Enrollee Out-of-Pocket Cost type: C evered under inpatient Hospital Services Category 1a Select the Maximum Enrollee Out-of-Pocket Cost type: Additional Days C evered under inpatient Hospital Services Category 1a Non-Medicare-covered Stay Indicate Maximum Enrollee Out-of-Pocket Cost amount: Mandatory Optional Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years C very six months Every three months Every three months Every three months Every berefit for Non-Medicare-covered stay: Other, Describe	(Validate) Validate)		
plemental benefit under Part C? Yes No ledet enhanced benefit: Additional Days Non-Medicare-covered Stay elect type of benefit for Additional Days: Mandatory Optional Select the Maximum Enrollee Out-of-Pocket Cost period Indicate number ndicate number ndicate number ndicate number ndicate number of Additional Days per benefit period: Every three months C Every Stay O other, Describe	LICK FOR DESCRIPTION OF BENEFIT	Maximum Plan Benefit Coverage is not applicable for this Service Category.	
lede thanced benefit: Covered under Inpatient Hospital Services Category 1a Non-Medicare-covered Stay Indicate Maximum Enrollee Out-of-Pocket Cost amount: Iman-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Mandatory Optional Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Covery three years Vers Covery three years No, indicate number Covery three years Covery six months Covery six months Covery six months Covery six months Covery Stay Covery Stay elect type of benefit for Non-Medicare-covered stay: Other, Describe	olemental benefit under Part C? Yes No	C Yes C No	
Content for Solution to	Additional Days	C Covered under Inpatient Hospital Services Category 1a	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Select the Maximum Enrollee Out-of-Pocket Cost periodicity: No, indicate number No, indicate number Additional Days per benefit period: C Every three months C Every three months C Every Senset Very Stary elect type of benefit for Non-Medicare-covered stay:	Mandatory	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
	this benefit unlimited for Additional Days? Yes No, indicate number ndicate number of Additional Days per benefit period: elect type of benefit for Non-Medicare-covered stay: Mandatory	C Every three years C Every two years C Every year C Every six months C Every three months C Every Benefit Period C Every Stay	

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vious Next (Validate) Go To:	#1b Inpatient Hospital Psychiatric - Base 2	
s this plan's Medicare-covered benefit costsharing vary by hospital(s) in than enrollee obtains care?	in Medicare-covered Coinsurance Cost Sharing for Tier 1:	
Yes No	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	
rmany cost sharing tiers do you offer?	C Yes	
	C No	
at is your lowest cost tier?	Indicate Coinsurance percentage for the Medicare-covered stay:	
Tier 1 Tier 2	Indicate the number of day intervals for the Medicare-covered stay:	
Tier 3	C Zero (No Coinsurance per Day)	
ere an enrollee Coinsurance?	C One C Two	
Yes	C Three	
No	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: Coinsurance % Interval 3 Begin Day Interval 3: Coinsurance % Interval 3 End Day Interval 3: Coinsurance % Interval 3 End Day Interval 3:	

elp				
vious Next	Exit	Exit (No	#1b Inpatient Hospital Psychiatric - Base 3	
VIOUS NEXT	(Validate)	Validate)		
care-covered Coinsur	ance Cost Sharing for	Tier 2:	Medicare-covered Coinsurance Cost Sharing for Tier 3:	
ou charge the Medicar	e-defined cost shares	? (These are the total	Do you charge the Medicare-defined cost shares? (These are the total	
ges for all services pro	vided to the enrollee in	the inpatient facility.)	charges for all services provided to the enrollee in the inpatient facility.)	
'es Io			C Yes C No	
ndicate Coinsurance	percentage for the Med	dicare-covered stay:	Indicate Coinsurance percentage for the Medicare-covered stay:	
ndicate the number of	day intervals for the N	fedicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Coinsura		iculture-covered stay.	C Zero (No Coinsurance per Day)	
O One			C One C Two	
C Two C Three			O Two	
Indicate the coinsuran Medicare-covered sta	ce percentage and day y (e.g., 1 to 30; 31 to 9	y interval(s) for the 0):	Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30, 31 to 90):	
Coinsurance % Interva	I 1 Begin Day Interv	al 1: End Day Interval 1	1: Coinsurance% Interval 1 Begin Day Interval 1: End Day Interval 1:	
Coinsurance % Interva	I 2 Begin Day Interv	al 2: End Day Interval 2	2: Coinsurance% Interval 2: End Day Interval 2: End Day Interval 2:	
Coinsurance % Interva	13 Begin Day Interv	al 3: End Day Interval 3	3: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	

PBP Data Entry System - Section B- Help	L, Contract X0001, Plan 001, Segn		
Exit Exit (N	Go To: #1b Inpatient Hospital Psychiatric - Bas	e 4 🔽	
evious Next (Validate) Validate	e)		_
dicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3	
licate the number of day intervals for the dicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	
Zero (No Coinsurance per Day) One Two Three	C Zero (No Coinsurance per Day) C One C Two C Three	C Zero (No Coinsurance per Day) C One C Two C Three	
licate the coinsurance percentage and day erval(s) for the 60 Medicare-covered Lifetime serve 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	
erval 1:	Interval 1:	Interval 1:	
rval 2:	Interval 2:	Interval 2:	
erval 3:	Interval 3:	Interval 3:	

PBP Data Entry System - Section B-1, Contract 2	X0001, Plan 001, Segment 000	
Help Go To:	Ib Inpatient Hospital Psychiatric - Base 5	
revious Next (Validate) Go To: #		
oes this plan's Additional Days cost sharing vary by hospital(s) in which an nrollee obtains care?	Additional Days Coinsurance Cost Sharing for Tier 2:	
) Yes	Indicate the number of day intervals for Additional Days:	
No How many cost sharing tiers do you offer?	C Zero (No Coinsurance per Day) C One	
	C Two C Three	
What is your lowest cost tier?	Indicate the coinsurance percentage and day interval(s) for Additional	
O Tier 1 O Tier 2	Days (enter "999" if unlimited days are offered; e.g., 91 to 999):	
O Tier 3	Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
ditional Days Coinsurance Cost Sharing for Tier 1:		
icate the number of day intervals for Additional Days:	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
Zero (No Coinsurance per Day) One		
Two Three	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
dicate the coinsurance percentage and day interval(s) for Additional		
ys (enter "999" if unlimited days are offered; e.g., 91 to 999):		
oinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:		
binsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:		
pinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:		

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∢ vious	Next	Exit (Validate)	Exit (No Validate)	To: ≢1b Inpatient Hospital Psychiatric - Base 6	
itional Days	Coinsuran	ce Cost Sharing for 1	Tier 3:	Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay?	
		ntervals for Addition	al Days:	C Yes	
Zero (No Co One	insurance (ber Day)		C No	
Two Three				Indicate Coinsurance percentage for the Non-Medicare-covered stay:	
licate the coi ys (enter "99	nsurance p 19" if unlimit	ercentage and day in ed days are offered;	nterval(s) for Additiona e.g., 91 to 999):	Indicate the number of day intervals for the Non-Medicare-covered stay:	
insurance %	Interval 1	Begin Day Interval	I: End Day Interval 1:	C Zero (No Coinsurance per Day) C One	
				C Two C Three	
insurance%	Interval 2	Begin Day Interval 2	2: End Day Interval 2:	Indicate the coinsurance percentage and day interval(s) for the Non- Medicare-covered stay (enter "999" ifunlimited days are offered; e.g.; 1 to 999):	
insurance%	Interval 3	Begin Day Interval 3	3: End Day Interval 3:	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:	

BP Data Entry System - Section B-1, Cor	ntract X0001, Plan 001, Segment 000	_
jelp	io To: #1b Inpatient Hospital Psychiatric - Base 7	
Vious Next (Validate)		
(validate) validate)		
u do not have a service-specific deductible for this benefit but	Medicare-covered Copayment Cost Sharing for Tier 1:	
r a plan-specific deductible, then enter the plan deductible in tion D.	Do you charge the Medicare-defined cost shares? (These are the total charges	
Organizations are not permitted to tier deductibles.	for all services provided to the enrollee in the inpatient facility.)	
nere an enrollee Deductible?	C Yes C No	
Yes	Indicate Copayment amount for the Medicare-covered stay:	
No		
dicate Deductible Amount for Tier 1:	Indicate the number of day intervals for the Medicare-covered stay:	
	C Zero (No Copayment per Day) C One	
dicate Deductible Amount for Tier 2:	C Two	
dicate Deductible Amount for Tier 3:	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.	
there an enrollee Copayment?	Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	
Yes No		
10	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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e <u>H</u> elp Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#1b Inpatient Hospital Psychiatric - Base 8	
Medicare-cove	red Copaymer	nt Cost Sharing for T	ier 2:		Medicare-covered Copayment Cost Sharing for Tier 3:	
Do you charge	the Medicare-	defined cost shares	? (These are		Do you charge the Medicare-defined cost shares? (These are the total charges	
Charges for all s	services provi	ded to the enrollee in	the inpatien	t facility.)	for all services provided to the enrollee in the inpatient facility.) C Yes	
C No					C No	
		nt for the Medicare-co			Indicate Copayment amount for the Medicare-covered stay:	
C Zero (No C		tervals for the Medic	are-covered	stay:	Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Copayment per Day)	
C One	opayment per	Duy/			O One	
C Two C Three					C Two C Three	
covered stay (e	e.g., 1 to 30; 31	int and day interval(s to 90): For more inf the variable help.			Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30, 31 to 30). For more information on cost share limitations please view the variable help.	
Copayment Am	nt Interval 1	Begin Day Interval 1:	End Day	Interval 1:	Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	
Copayment Am	nt Interval 2	Begin Day Interval 2:	End Day	Interval 2:	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
Copayment Am	nt Interval 3	Begin Day Interval 3:	End Day	Interval 3:	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	
1						

PBP Data Entry System - Section B	-1, Contract X0001, Plan 001, Seyme		
	Go To: #1b Inpatient Hospital Psychiatric - Base 9		
revious Next (Validate) Valida	lo je)		
dicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3	
dicate the number of day intervals for the Medicare- vered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	
Zero (No Copayment per Day)	C Zero (No Copayment per Day)	C Zero (No Copayment per Day)	
One Two	O One O Two	C One C Two	
Three	C Three	O Three	
dicate the copayment amount and day interval(s) the 60 Medicare-covered Lifetime Reserve Days 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 Medicate-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	
erval 1:	Interval 1:	Interval 1:	
erval 2:	Interval 2:	Interval 2:	
terval 3:	Interval 3:	Interval 3:	

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evious Next	Exit I (Validate) V	¥ Go To: Exit (No ∕alidate)	#1b Inpatient Hospital Psychiatric - Base 10	
ditional Days Copaymer	nt Cost Sharing for Tier 1	:	Additional Days Copayment Cost Sharing for Tier 2:	
dicate the number of day			Indicate the number of day intervals for Additional Days:	
C Zero (No Copaymentp C One C Two C Three	per Day)		C Zero (No Copaymentper Day) C One C Two C Three	
ndicate the copayment am enter "999" if unlimited da	nount and day interval(s) lys are offered; e.g., 91 to	for Additional Days 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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Additional Days Copayment Cost Sharing for Tier 3:	Is the Copayment structure for the Non-Medicare-covered stay the same as	
Indicate the number of day intervals for Additional Days:	the Copayment structure for the Medicare-covered stay?	
O Zero (No Copaymentper Day) O One O Two	C No Indicate Copayment amount for the Non-Medicare-covered stay:	
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);	Indicate the number of day intervals for the Non-Medicare-covered stay:	
Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	O Two	
Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	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 3 Begin Day Interval 3: End Day Interval 3:	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:	

evious exit evious exit for To: for To: original Medicare Original Medicare Annual Per Admission or Per Stay Other, Describe'' is selected enter description below:	PBP Data Entry System - Section B-1, Contra	act X0001, Plan 001, Segment 000
evicus Next Validate) Instain Validate) Note: Instain Validate) Instain Validate	Help	e#1b Inpatient Hospital Psychiatric - Base 12
Original Medicare Anual Per Admission or Per Stay Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Voter, Describe Notes: If "Other, Describe" is selected enter description below: Image: Comparison of the day of discharge? you charge cost sharing on the day of discharge? Image: Comparison of the day of discharge? Yes No nuthorization required? Image: Comparison of the day of lischarge? Yes No neterral required for Inpatient Psychiatric Hospital Services? Image: Comparison of the day of lischarge? Yes Yes	Previous Next (Validate) Validate)	
Annual information captured in data entry. Per Admission or Per Stay Notes: Other, Describe" is selected enter description below: Notes: You charge cost sharing on the day of discharge? Image: Comparison of the day of discharge? Yes No No Image: Comparison of the day of discharge? Yes No Interral required for Inpatient Psychiatric Hospital Services? Yes Yes	Vhat is your Inpatient Hospital Psychiatric benefit period?	Inpatient Hospital Psychiatric Notes
If "Other, Describe" is selected enter description below: you charge cost sharing on the day of discharge? Yes No authorization required? Yes No areferral required for Inpatient Psychiatric Hospital Services? Yes	○ Original Medicare ○ Annual ○ Per Admission or Per Stay ○ Other, Describe	information captured in data entry. Notes:
Yes No authorization required? Yes No areferral required for Inpatient Psychiatric Hospital Services? Yes	If "Other, Describe" is selected enter description below:	
No authorization required? Yes No areferral required for Inpatient Psychiatric Hospital Services? Yes	o you charge cost sharing on the day of discharge?	
Yes No Inferral required for Inpatient Psychiatric Hospital Services? Yes	Yes No	
No referral required for Inpatient Psychiatric Hospital Services? Yes	authorization required?	
Yes	No	
	a referral required for Inpatient Psychiatric Hospital Services? Yes	
	No	¥

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WOUS Next (Validate) Validate) CLICK FOR DESCRIPTION OF BENEFIT Is there a service-specific Maximum Plan Benefit Coverage amount? Yes Is there a service-specific Maximum Plan Benefit Coverage amount? Yes No alect type of benefit for Inpatient Psychiatric Hospital Services: Select the Maximum Plan Benefit Coverage type: Mandatory Covered under Inpatient Hospital Services: Mandatory Indicate number C Yes Indicate number Indicate number Select the days per period: C Every three years C Every three years C Every three years C Every three years C Every three months C Every three months C Every three months C	
you offer Inpatient Psychiatric Hospital Services as a benefit? Yes No Select type of benefit for Inpatient Psychiatric Hospital Services: Mandatory Optional Does this benefit have unlimited days? C Yes No Select the days per period: Indicate number of days per period: Select the days periodicitly: C Every three years C Every three months C Every three mo	
you offer Inpatient Psychiatric Hospital Services as a benefit? Yes No elect type of benefit for Inpatient Psychiatric Hospital Services: Mandatory Optional Does this benefit have unlimited days? Yes No Select the days per period: Indicate number of days per period: Select the days periodicity: C Every three years C Every three months C Every three mont	
you offer Inpatient Psychiatric Hospital Services as a benefit? Yes No elect type of benefit for Inpatient Psychiatric Hospital Services: Mandatory Optional Does this benefit have unlimited days? C Yes C Yes Indicate number Indicate number Select the days per period: Select the days per period: C Every three years C Every three months C	
No Select the Maximum Plan Benefit Coverage type: Indicatory Optional Does this benefit have unlimited days? Covered under Inpatient Hospital Services Category 1a O Yes Indicate number No Select the Maximum Plan Benefit Coverage amount: Select the days per period: Select the Maximum Plan Benefit Coverage periodicity: C Yes Covered under Inpatient Hospital Services Category 1a Indicate number of days per period: Select the Maximum Plan Benefit Coverage periodicity: C Every three years C Every three years C Every three years C Every three months C Every three years C Every three months C Every three months C Every three months C Every three months C Every three months C Every three months Other, Describe	
elect type of benefit for Inpatient Psychiatric Hospital Services: Mandatory Optional Does this benefit have unlimited days? C Yes Indicate number Indicate number Select the days per period: C Every three years C Every three months C Every Stary Other, Describe	
Plan-specified amount per period Plan-specified amount per period Indicate number Plan-specified amount per period Plan-specified amount per period Indicate number Select Maximum Plan Benefit Coverage periodicity: C Yes Indicate number Select the days per period: C Every three years C Every three months C	
Mandatory Indicate Auximum Plan Benefit Coverage amount: Does this benefit have unlimited days? Indicate Auximum Plan Benefit Coverage periodicity: C Yes Select Maximum Plan Benefit Coverage periodicity: Indicate number of days per period: C Every three years Select the days periodicity: C Every three years Select the days periodicity: C Every three years C Every three years C Every three years C Every three years C Every three months C Every star C Every three months C Every star C Every three months C Every star C Other, Describe	
Does this benefit have unlimited days? C Yes C No, indicate number Indicate number of days per period: C Every three years Select the days periodicity: C Every three years C Every three months C Every stay C Other, Describe	
C Yes Select Maximum Plan Benefit Coverage periodicity: Indicate number of days per period: C Every three years Indicate number of days per period: C Every three years Select the days periodicity: C Every three years C Every three years C Every three months C Every stay C Other, Describe	
C No, indicate number Select med ays per period: C Every three years Indicate number of days per period: C Every three years Select the days periodicity: C Every three years C Every three years C Every three months C Every three years C Every three months C Every star C Every star C Every star C Other, Describe	
Indicate number of days per period: C Every three years Indicate number of days per period: C Every two years Select the days periodicity: C Every three months C Every three years C Every three months C Every three years C Every three months C Every three months C Every stay C Every three months C Every three months	
Indicate number of days per period: C Every year Select the days periodicity: C Every three months C Every three months C Every three months C Every stay C Every three months C Every three months C Every stay C Every	
Select the days periodicity: C Every three wonths C Every three years C Every Stay C Every Stay C Every Stay C Every Stay C Every Stay C Other, Describe C Every Stay C Other, Describe C Every Stay C Every Stay C Other, Describe C Every Stay C Every Stay	
Select the days periodicity: C Every Benefit Period C Every three years C Every Stay C Every star O Other, Describe C Every star months C Every Star C Every three months C Every Star C Every Star Other, Describe	
C Every two years C Other, Describe C Every six months C Every six months C Every three months C Every Benefit Period C Every Stay	
C Every year C Every six months C Every three months C Every Benefit Period C Every Stay	
C Every three months C Every Benefit Period C Every Stay	
C Every Benefit Period C Every Stay	

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ious Next (Validate) Validate)		
re a service-specific Maximum Enrollee Out-of-Pocket Cost?		
'es	Ti la	
10		
ect the Maximum Enrollee Out-of-Pocket Cost type:	-	
Covered under the Inpatient Hospital Services Category 1a Plan-specified amount per period		
dicate Maximum Enrollee Out-of-Pocket Cost amount:		
elect the Maximum Enrollee Out-of-Pocket Cost periodicity:		
Every three years	Ti la	
Every two years Every year		
Every year Every six months		
Every three months		
Every Benefit Period		
C Every Stay O Other, Describe		
Other, Describe		

BP Data Entry System - Section B-1 Help		<u></u>
evious Next (Validate)	Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 3	
here an enrollee Coinsurance?	Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered, e.g., 1 to 999):	
Yes No	(enter "999" if unlimited days are offered; e.g., 1 to 999). Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
dicate Coinsurance percentage per stay:		
dicate the number of day intervals for the stay:	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
 Zero (No Coinsurance per Day) One Two 	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
Three		

revious Next (Validate) Go To (Validate) Validate)	≇1b Inpatient Hospital Psychiatric (B Only) - Base 4	
there an enrollee Deductible? Yes No Indicate Deductible Amount: there an enrollee Copayment? Yes No Indicate Copayment amount per stay: Indicate the number of day intervals for the stay: C Zero (No Copayment per Day) C One C Two C Three	Indicate the copayment amount and day interval(s) for the stay (enter '999'' i'unlimited days are offered; e.g., 1 to 999): Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 2: Copayment Amt Interval 2 Begin Day Interval 3: End Day Interval 3: Do you charge cost sharing on the day of discharge? Yes No	Is authorization required?

vious	Next (Validate)	Exit (No Validate)	#1b Inpatient Hospital Psychiatric (B Only		<u> </u>	
ent Hospit	al Psychiatric Notes	valuate)				
		escribe benefit in this service ca	tegory. Do not repeat information captu	rred in data entry.		
5:					-	
				-	<u> </u>	
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#2 SNF – Base 1

PBP Data Entry System - Section B-2, Contract)	K0001, Plan 001, Segment 000	
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Exit Exit No evious Next (Validate) Validate)		
LICK FOR DESCRIPTION OF BENEFIT	Do you allow less than 3 day inpatient hospital stay prior to SNF admission? C Yes	
efit under Part C? Yes	C No	
No	Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	
ect enhanced benefits: Additional days beyond Medicare-covered Non-Medicare-covered stay (MMP Only)	C Zero C One	
elect type of benefit for Additional Days beyond Medicare-covered:	C Two	
O Mandatory O Optional	Maximum Plan Benefit Coverage is not applicable for this Service Category.	
this benefit unlimited for Additional Days?		
) Yes) No, indicate number	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
No, Indicate number	O Yes O No	
ndicate the number of Additional Days beyond Medicare-covered per senefit period:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
elect type of benefit for the Non-Medicare-covered stay:	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
Mandatory	O Every three years	
Optional	C Every two years C Every year	
	O Every six months	
	C Every three months	
	○ Every Stay ○ Other, Describe	

#2 SNF – Base 2

PBP Data Entry System - Section B-2, Co	ontract X0001, Plan 001, Segment 000	
Help	Go To: ⊭2 SNF - Base 2 ▼	
revious Next (Validate) Validate)		
es this plan's Medicare-covered benefit cost sharing vary by th rsing Facility in which an enrollee obtains care?	e Skilled Is there an enrollee Coinsurance?	
Yes No	O No	
ow many cost sharing tiers do you offer?	Medicare-covered Coinsurance Cost Sharing for Tier 1:	
'hat is your lowest cost tier?	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	
Tier 1	C Yes	
) Tier 2) Tier 3	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 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 3

	ract X0001, Plan 001, Segment 000	_ 8
Help revious Next (Validate) Sevious Next (Validate) Exit (Validate)	To: #2 SNF - Base 3	
dicare-covered Coinsurance Cost Sharing for Tier 2:	Medicare-covered Coinsurance Cost Sharing for Tier 3:	
you charge the Medicare-defined cost shares? (These are the al 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.)	
Yes No	C Yes C No	
dicate Coinsurance percentage for the Medicare-covered stay:	Indicate Coinsurance percentage for the Medicare-covered stay:	
dicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
Zero (No Coinsurance per Day) One	○ Zero (No Coinsurance per Day) ○ One	
Two Three	C Two C Three	
dicate the coinsurance percentage and day interval(s) for Medicare- vered stay (e.g., 1 to 20; 21 to 100):	Indicate the coinsurance percentage and day interval(s) for Medicare- covered stay (e.g.; 1 to 20; 21 to 100):	
insurance % Interval 1: Begin Day Interval 1: End Day Interval	1: Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
vinsurance % Interval 2: Begin Dav Interval 2: End Day Interval	2' Octoverse Matter 10: Decis Decis Decision 10: End Decision 10:	
insurance % Interval 2: Begin Day Interval 2: End Day Interval	2: Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
vinsurance % Interval 3: Begin Day Interval 3: End Day Interval	3: Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3:	

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ile Help	SNF - Base 4	
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Does this plan's Additional Days cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	Additional Days Coinsurance Cost Sharing for Tier 2: Indicate the number of day intervals for Additional Days:	
C No How many cost sharing tiers do you offer?	C Zero (No Coinsurance per Day) C One C Two	
What is your lowest cost tier?	C Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999):	
C Tier 2 C Tier 3	Coinsurance % Interval 1: End Day Interval 1: End Day Interval 1:	
Additional Days Coinsurance Cost Sharing for Tier 1: Indicate the number of day intervals for Additional Days:	Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:	
C Zero (No Coinsurance per Day) C One C Two	Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
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 1:		
Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:		
Coinsurance % Interval 3: End Day Interval 3:		

PBP Data Entry System - Section B-2, Contract	t X0001, Plan 001, Segment 000	_ 8 ×
ile Help	#2 SNF - Base 5	
Previous Next (Validate) Go To:		
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: O Zero (No Coinsurance per Day) O One	C Yes C No	
C Two C Three	Indicate Coinsurance percentage for the Non-Medicare-covered stay:	
Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999):	Indicate the number of day intervals for the Non-Medicare-covered stay:	
Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	C Zero (No Coinsurance per Day) C One C Two	
Coinsurance % Interval 2: End Day Interval 2: End Day Interval 2:	Ô 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 3: Begin Day Interval 3: End Day Interval 3:	Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
	Coinsurance % Interval 2: End Day Interval 2:	
	Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	

BP Data Entry System - Section B-2, Contra Jelp		-
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vious Next (Validate) Validate)		_
do not have a service-specific deductible for this benefit but	Is there an enrollee Copayment?	
a plan-specific deductible, then enter the plan deductible in on D.	C Yes C No	
rganizations are not permitted to tier deductibles.	Medicare-covered Copayment Cost Sharing for Tier 1:	
s there an enrollee Deductible?	Do you charge the Medicare-defined cost shares? (These are the total	
D Yes D No	charges for all services provided to the enrollee in the SNF.)	
Indicate Deductible Amount Tier 1:	C Yes C No	
	Indicate Copayment amount for Medicare-covered stay:	
Indicate Deductible Amount Tier 2:		
	Indicate the number of day intervals for the Medicare-covered stay: C Zero (No Copayment per Day)	
Indicate Deductible Amount Tier 3:	C One O Two	
	O Two O Three	
	Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g., f to 20, 21 to 100). For more information on costshare 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: End Day Interval 3: End Day Interval 3:	

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ous Next	Exit (Validate)	Exit (No Validate)			
re-covered Copava	ient Cost Sharing for 1	Tier 2:		Medicare-covered Copayment Cost Sharing for Tier 3:	
	e-defined cost shares		the total	Do you charge the Medicare-defined cost shares? (These are the total	
es for all services pro	vided to the enrollee i	n the SNF.)	ure total	charges for all services provided to the enrollee in the SNF.)	
es O				C Yes C No	
ate Copayment amour	nt for Medicare-covere	d stay:		Indicate Copayment amount for Medicare-covered stay:	
cate the number of day	intervals for the Medio	are-covered	stav:	Indicate the number of day intervals for the Medicare-covered stay:	
Zero (No Copayment p				C Zero (No Copayment per Day)	
Dne Two				C One C Two	
Three				C Three	
cate the copayment am (e.g.; 1 to 20; 21 to 100 tations please view the): For more information	s) for Medicar on on cost sh	e-covered are	Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g., 1 to 20, 2 t to 100): For more information on cost share limitations please view the variable help.	
ayment Amt Interval 1:	Begin Day Interval	1: End Day	Interval 1:	Copayment Amt Interval 1: End Day Interval 1: End Day Interval 1:	
ayment Amt Interval 2:	Begin Day Interval	2: End Day	Interval 2:	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
ayment Amt Interval 3:	Begin Day Interval	3: End Day	Interval 3:	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	

PBP Data Entry System - Section B-2, Contrac	t X0001, Plan 001, Segment 000	_ 8)
e Help Go To: Exit Exit (No	#2 SNF - Base 8	
Previous Next (Validate) Validate)		
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 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):	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 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: End Day Interval 3: End Day Interval 3:	

PBP Data Entry System - Section B-2, Contract	: X0001, Plan 001, Segment 000	_ 8 ;
Previous Next (Validate) Go To:	#2 SNF - Base 9	
Additional Days Copayment Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days: Cere (No Copayment per Day) One Two Tree 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: Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3: Copayment Amt Interval 3: Begin Day Interval 4: End Day Interval 4: Copayment Amt Interval 5: Begin Day Interval 5: End Day Interval 5: Copayment Amt Interval 5: Begin Day Interval 5: End Day Interval 5: Copayment Amt Interval 5: Begin Day Interval 5: End Day Interval 5: Copayment Amt Interval 5: Begin Day Interval 5: End Day Interval 5: Copayment Amt Interval 5: Begin Day Interval 5: End Day Interval 5: Copayment Amt Interval 5: End Day Interval 5: End Day Interval 5: Copayment Amt Interval 5: End Day Interval 5: End Day Interval 5: Copayment Amt Interval 5: End Day Interval 5: End Day Interval 5: Copayment Amt Interval 5: End Day Interval 5: End Day Interval 5: Copayment Amt Interval 5: End Day Interval 5: End Day Interval 5: Copayment Amt Interval 5: End Day Interval 5: End 5: Copayment Amt Interval 5: En	Is the Copayment structure for the Non-Medicare-covered stay?	

PBP Data Entry System - Section B-2, Conti	ract X0001, Plan 001, Segment 000	_ 8
Help	To: #2 SNF - Base 10	
revious Next (Validate) Go 1 Exit Exit (No (Validate) Validate)		
hat is your SNF benefit period? Original Medicare	SNF Notes	
Annual	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
Per Admission or Per Stay Other, Describe	Notes:	
f "Other, Describe" is selected enter description below:	A	
you charge cost sharing on the day of discharge?		
Yes		
No		
uthorization required?		
Yes No		
referral required for SNF Services? Yes		
Yes No	v	

		4	Exit (No	Go To: #2 SNF (B Only) - Base 1	
vious	Next	Exit (Validate)	Exit (No Validate)		
CK FOR DE	ESCRIPTION	OF BENEFIT		Do you allow less than 3 day Inpatient hospital stay prior to SNF admission?	
				O Yes	
unu offer Chil	F Care as a b	an afit?		C No	
Yes	r Gare as a bi	enent?		Indicate the Number of Hospital Days Required Prior	
No				to SNF Admission (0-2):	
		1111		C Zero	
	penefit for SNI	F Care:		C One C Two	
Mandatory				NO TWO	
optional				Is there a service-specific Maximum Plan Benefit	
oes this bene	fit have unlim	ited days?		Is there a service-specific maximum Plan Benefit Coverage amount?	
7 Yes				C Yes	
No, indicat	te number			C No	
Indicate numb	per of days pe	r period:		Indicate Maximum Plan Benefit Coverage amount:	
C Every thr	ys periodicity	n		Select Maximum Plan Benefit Coverage periodicity: © Every three years	
C Every two				C Every two years	
C Every ye	ar			C Every year	
C Every six				C Every six months	
C Every thr				C Every three months	
C Every Sta	ау			O Every Stay	
C Other, D	escribe			C Other, Describe	

evious Next (Validate) Go	D To: #2 SNF (B Only) - Base 2	
there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the number of day intervals for the stay:	
Yes No	C Zero (No Coinsurance per Day)	
dicate amount for Maximum Enrollee Out-of-Pocket Cost:	C Two	
	C Three	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g.; 1 to 999);	
C Every three years	Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
C Every two years		
C Every year C Every six months	Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
C Every three months C Every Stay		
O Other, Describe	Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
here an enrollee Coinsurance?		
Yes No		

Vious Visit Exit Exit <th>Hep</th> <th>, Contract X0001, Plan 001, Segment 000</th> <th><u></u></th>	Hep	, Contract X0001, Plan 001, Segment 000	<u></u>
Vious Exit Exit Exit (No ere an enrollee Deductible? Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999): Copayment Amt Interval 1 End Day Interval 1: Copayment Amt Interval 1 Bein Day Interval 1: Copayment Amt Interval 2 Copayment Amt Interval 2 End Day Interval 2: Copayment Amt Interval 3 Bein Day Interval 3: Copayment Amt Interval 4 Copayment Amt Interval 3 Bein Day Interval 3: Copayment Amt Interval 4 End Day Interval 3: Copayment Amt Interval 5 Copayment Amt Interval 5 Copayment Amt Interval 5 Copayment Amt Interval 6 Differed in the stay: Copayment Amt Interval 7 Copayment Amt Interval 7 Copayment Amt Interval 8 End Day Interval 9: Copayment Amt Interval 9: Copa		Go To: #2 SNF (B Only) - Base 3	
ere an enrollee Deductible? /res No	Exit Exit (No		
Ves unlimited days are offered; e.g., 1 to 999): No Copayment Amt Interval 1 Idicate Deductible Amount: Egin Day Interval 1: Copayment Amt Interval 2 Egin Day Interval 2: ere an enrollee Copayment? Copayment Amt Interval 3 Yes Copayment Amt Interval 3 No Copayment Amt Interval 3 Goayment Amt Interval 3 Begin Day Interval 3: Copayment Amt Interval 4 Begin Day Interval 3: Copayment Amt Interval 5 End Day Interval 3: Vo Copayment Amt Interval 5 Zero (No Copaymentper Day) One O me Copayment Amt Interval 5	(validate) validate)		
Vo Copayment Amt Interval 1 Begin Day Interval 1: Indicate Deductible Amount: Copayment Amt Interval 2 Begin Day Interval 2: ere an enrollee Copayment? Copayment Amt Interval 3 Begin Day Interval 2: res Copayment Amt Interval 3 Begin Day Interval 3: idicate Deductible Amount per Stay: Copayment Amt Interval 3 End Day Interval 3: idicate the number of day intervals for the stay: Copayment per Day) Copayment per Day) One Two Copayment per Day	nere an enrollee Deductible?	Indicate the copayment amount and day interval(s) for the stay (enter "999" if	
indicate Deductible Amount: Copayment Amt Interval 2: End Day Interval 2: ere an enrollee Copayment? Copayment Amt Interval 3: End Day Interval 3: res Copayment Amt Interval 3: End Day Interval 3: vo Interval 3: End Day Interval 3: vidicate Copayment amount per Stay: Interval 3: Interval 3: vidicate the number of day intervals for the stay: Interval 4: Interval 4: Vo Vo Interval 5: Interval 5:	Yes	unlimited days are offered; e.g., 1 to 999):	
Copayment Amt Interval 2 Begin Day Interval 2: ere an enrollee Copayment? Copayment Amt Interval 3: res Copayment Amt Interval 3: No Begin Day Interval 3: Idicate Copayment amount per Stay: Interval 3: Copayment per Day) Copayment per Day) One Two	No	Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	
ere an enrollee Copayment? Copayment Amt Interval 3 Begin Day Interval 3: Copayment Amt Interval 3 Copayment Post Copayment Post Copay	ndicate Deductible Amount:		
Copayment Amt Interval 3 Begin Day Interval 3: No Image: Copayment Amt Interval 3: vdicate Copayment amount per Stay: Image: Copayment Amt Interval 3: vdicate the number of day intervals for the stay: Image: Copayment Per Day) Cone Two		Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
Ves	ere an enrollee Copayment?	Canaumant Ant Interval 9. Basin Day Interval 9. End Day Interval 9.	
dicate Copayment amount per Stay: dicate the number of day intervals for the stay: D Zero (No Copayment per Day) O One D Two	Yes	Copayment Amt Interval 5 Begin Day Interval 5. End Day Interval 5.	
ndicate the number of day intervals for the stay: D Zero (No Copayment per Day) O One D Two			
2 Zero (No Copayment per Day) 2 One 2 Two	ndicate Copayment amount per Stay:		
2 Zero (No Copayment per Day) 2 One 2 Two	adjeate the number of day intervals for the story		
One D Two			
	O One		
□ Three			
	O Three		

telp	Go To: #2 SNF (B Only) Exit (No	Base 4		
evious Next (Validate) Validate)			
uthorization required?				
Yes No				
referral required for SNF Services?				
Yes				
No				
ed Nursing Facility (B-Only) Notes e may include additional information to	describe benefit in this service			
gory. Do not repeat information captur	ed in data entry.			
5:				
			*	

PBP Data Entry System - Section B-3, Contract	t X0001, Plan 001, Segment 000	_ 5
	#3 Cardiac and Pulmonary Rehabilitation Services - Base 1	
revious Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services?	
pes the plan provide Cardiac and Pulmonary Rehabilitation Services as a pplemental benefit under Part C?	0.16	
) Yes	C No, indicate number	
No	Indicate number of visits for Additional Intensive Cardiac Rehabilitation Services:	
Select enhanced benefit: Additional Cardiac Rehabilitation Services		
Additional Intensive Cardiac Rehabilitation Services	Select the Additional IntensiveCardiac Rehabilitation Services periodicity:	
Additional Pulmonary Rehabilitation Services elect type of benefit for Additional Cardiac Rehabilitation Services:	C Every three years C Every two years	
Mandatory	O Every year	
O Optional	C Every six months C Every three months	
this benefit unlimited for Additional Cardiac Rehabilitation Services?	O Other, Describe	
) Yes) No, indicate number	Select type of benefit for Additional Pulmonary Rehabilitation Services:	
Indicate number of visits for Additional Cardiac Rehabilitation Service	nee: O Mandatory	
	C Optional	
Select the Additional Cardiac Rehabilitation Services periodicity:	Is this benefit unlimited for Additional Pulmonary Rehabilitation Services?	
O Every three years	C Yes C No, indicate number	
C Every two years C Every year	Indicate number of visits for Additional Pulmonary Rehabilitation Services:	
C Every year C Every six months		
C Every three months C Other, Describe	Select the Additional Pulmonary Rehabilitation Services periodicity:	
lect type of benefit for Additional Intensive Cardiac Rehabilitation Service		
Mandatory	C Every two years C Every year	
Optional	C Every year	
	C Every three months	
	C Other, Describe	

	ontract X0001, Plan 001, Segment 000			_ 8
	Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base	2		
evious Next (Validate) Validate)				
aximum Plan Benefit Coverage is not applicable for this Service	Category. Select which Cardiac and Pulmonary Rehabilitation Coinsurance (Select all that apply):	Services have a	a	
here a service-specific Maximum Enrollee Out-of-Pocket Cost?	Medicare-covered Cardiac Rehabilitation Service			
Yes	Medicare-covered Intensive Cardiac Rehabilitation			
No	Medicare-covered Pulmonary Rehabilitation Serv Additional Cardiac Rehabilitation Services	ices		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Additional Intensive Cardiac Rehabilitation Services	ces		
	Additional Pulmonary Rehabilitation Services			
		Minimum	Maximum Coinsurance	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:				
 Every three years Every two years 	Indicate Coinsurance percentage for Medicare- covered Cardiac Rehabilitation Services:			
O Every year	Indicate Coinsurance percentage for Medicare-			
C Every six months	covered Intensive Cardiac Rehabilitation Services:			
C Every three months C Other, Describe	Indicate Coinsurance percentage for Medicare-			
ourner, Describe	covered Pulmonary Rehabilitation Services:			
cility cost sharing. If you have a variety of cost sharing, please e minimum and maximum fields to reflect the lowest and highe	utilize Indicate Coinsurance percentage for Additional			
e minimum and maximum fields to reflect the lowest and highe. haring that a beneficiary may pay.	st cost Cardiac Rehabilitation Services:	I		
	Indicate Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:			
there an enrollee Coinsurance?				
O Yes O No	Indicate Coinsurance percentage for Additional Pulmonary Rehabilitation Services:			

Image: Serie Series
Yes Indicate Copayment amount for Medicare-covered Cardiac Rehabilitation Services: icata Deductible Amount: Indicate Copayment amount for Medicare-covered Intensive Cardiac Rehabilitation Services: indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services: Indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services: indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services Indicate Copayment amount for Additional Cardiac Rehabilitation Services: indicate Copayment amount for Additional Cardiac Rehabilitation Services Indicate Copayment amount for Additional Pulmonary Rehabilitation Services: Medicare-covered Pulmonary Rehabilitation Services Indicate Copayment amount for Additional Pulmonary Rehabilitation Services: Medicare-covered Pulmonary Rehabilitation Services Indicate Copayment amount for Additional Pulmonary Rehabilitation Services: Additional Cardiac Rehabilitation Services Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:

vious Next (Validate)	Go To: #3 Cardiac Exit (No Validate)	and Pulmonary Rehabilitation Services - Base 4		
1	Validate)			
ithorization required? Yes				
ves No	2			
referral required?				
Yes No				
tiac and Pulmonary Rehabilitation Service may include additional information to d				
gory. Do not repeat information captured s:	d in data entry.			
			*	
			~	

#4a Emergency Care/Post-Stabilization Care – Base 1

	#4a Emergency Care/Post-Stabilization Care - Base 1
Previous Next (Validate) Validate)	
Previous Next (Validate) CLICK FOR DESCRIPTION OF BENEFIT Cost Enhanced Benefits are not applicable for this Service Category. Is the service category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is the service-specific Maximum Enrollee Out-of-Pocket Cost? Indicate Maximum Enrollee Out-of-Pocket Cost amount: In Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: In Select Maximum Enrollee Out-of-Pocket Cost periodicity: In C Every three years In C Every six months Is th adm C Other, Describe Is finder	Image: state in the second the greater than the amount established by CMS the final Call terr for Medicare-covered Emergency CarePost-statilization Care. Image: state an enrolled Colonsurance percentage for Medicare-covered Emergency CarePost-statilization Consurance percentage for Medicare-covered Emergence

#4a Emergency Care/Post-Stabilization Care – Base 2

revious Next	Exit Exit (No (Validate) Validate)	Go To: #4a Emergency Care/Post-Stabilization Care - Base 2
	(Validate) Validate)	
here an enrollee Copayn	nent?	Authorization is not applicable for this Service Category.
Yes No		Referral is not applicable for this Service Category.
Indicate Minimum Copay	ment amount for Medicare-covere	Emergency Care/Post-Stabilization Care Notes
Benefits:		Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
Indicate Maximum Copa	yment amount for Medicare-covere	red Notes:
Benefits:		<u>A</u>
s the Copayment for Me	dicare-covered Benefits waived if	
admitted to hospital?		
O No		
Select either Days or Hou or waiver:	urs within which admission must o	iccur
C Days		
C Hours		
Enter number of Days or	Hours:	
es the Emergency Care/F inttowards any plan-leve	Post-Stabilization Care cost sharin el deductible?	19
Yes		
No		

#4b Urgently Needed Services – Base 1

📟 PBP Data Entry System - Section B-4, C	Contract X0001, Plan 001, Segment 000	_ 8 ×
Elle Help Previous Next Exit Exit (No Validate)	Go To: #4b Urgently Needed 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 C Yes C Overed under Emergency CarelPost-Stabilization C Covered under Emergency CarelPost-Stabilization C Covered under Emergency CarelPost-Stabilization C Plan-specified amount per period	Indicate Maximum Enrollee Out-of- Pochet Cost amount: Steet Maximum Enrollee Out-of- Pochet Cost periodicity: C Every three years C Every three months C Every three three months C Every three three months C Every three three three months C Every three t	

#4b Urgently Needed Services – Base 2

vious view ere an enrollee Copayment? Yes No lcade Minimum Copayment amount for Medicare icade Minimum Copayment amount for Medicare Select either Days or Hours within which admission us the Urgently Needed Services costsharing the Urgently Needed Services costsharing	PBP Data Entry System - Section	B-4, Contract X0001, Plan 001, Segment 000	
Vious Exit (Wo ere an enrollee Copayment? Is the Copayment for Medicare-covered Benefits waived if admitted to hospital? Yes C No C Icate Minimum Copayment amount for Medicare Select either Days or Hours within which admission must occur for waiver: Icate Maximum Copayment amount for Medicare Select either Days or Hours within which admission must occur for waiver: Icate Maximum Copayment amount for Medicare Enter number of Days or Hours: Is the Urgently Needed Services costsharing nttowards any plan-level deductible? Firster number of Days or Hours:	Help	Co To: ##h Irrently Needed Services - Rase 2	
ere an enrollee Copayment? Is the Copayment for Medicare-covered Benefits waived if admitted to hospital? Yes C Yes No C Yes icate Minimum Copayment amount for Medicare Select either Days or Hours within which admission must occur for waiver: icate Maximum Copayment amount for Medicare Select either Days or Hours within which admission must occur for waiver: icate Maximum Copayment amount for Medicare C Days C Hours Enter number of Days or Hours: Enter number of Days or Hours: Enter number of Days or Hours: mttowards any plan-level deductible? Yes	revious Next (Validate) Vali	(No	
Yes admitted to hospital? No Cryster Benefits: Select either Days or Hours within which admission must occur for waiver: Cryster Benefits: Select either Days or Hours: Cryster Benefits: Select either Days or Hours: Select either Days	(vandato) van		
Yes No. C Yes No. Select either Days or Hours within which admission must occur for waiver: C No Select either Days or Hours within which admission must occur for waiver: C Days C Hours C Days C Hours C Days C Hours: C Days C Days C Hours C Days Or Hours: Enter number of Days or Hours: Select either Days or Hours: C Days C Days C Hours C Days Or Hours: C Days C Days C Hours C Days Or Hours: C Days C Days C Hours C Days Or Hours: C Days Days Or Hours:		Is the Copayment for Medicare-covered Benefits waived if	
Icate Minimum Copayment amount for Medicare Image: Comparison of the Cays or Hours within which admission must occur for waiver: Select either Days or Hours within which admission must occur for waiver: Image: Comparison of Cays or Hours within which admission must occur for waiver: icate Maximum Copayment amount for Medicare Image: Comparison of Cays or Hours icate Maximum Copayment amount for Medicare Image: Comparison of Cays or Hours icate Maximum Copayment amount for Medicare Image: Comparison of Cays or Hours is the Urgently Needed Services costsharing nttowards any plan-level deductible? Image: Comparison of Cays or Hours Yes Yes	Yes No		
icate Maximum Copayment amount for Medicare vered Benefits: the Urgently Needed Services costsharing httowards any plan-level deductible? Yes		C No	
icate Maximum Copayment amount for Medicare vered Benefits: Enter number of Days or Hours: En	covered Benefits:	Select either Days or Hours within which admission must occur for waiver:	
the Urgently Needed Services costsharing the Urgently Needed Services costsharing the Vrgently Needed Services costshar		C Days	
s the Urgently Needed Services costsharing nttowards any plan-level deductible? Yes	dicate Maximum Copayment amount for Medicare overed Benefits:		
nt towards any plan-level deductible? Yes		Enter number of Days or Hours:	
nt towards any plan-level deductible? Yes			
Yes	es the Urgently Needed Services cost sharing int towards any plan-level deductible?		
	Yes		
	No		

#4b Urgently Needed Services – Base 3

	Entry Syst	Exit (Validate)	Exit (No Validate)		Urgently Needed Services - Ba			_ 8
	not applicable fo							
Referral is not a	pplicable for this	Service Catego	ory.					
Note may includ ategory. Do no	d Services Notes e additional infor t repeat informati	mation to desc	ribe benefit in t data entry.	his service				
lotes:						×		
						*		

#4c Worldwide Emergency/Urgent Coverage – Base 1

#4c Worldwide Emergency/Urgent Coverage – Base 2

evious Next (Validate) Validate)	Go To: #4c Worldwide Emergency/Urgent Coverage - Base 2	
here an enrollee Coinsurance? Yes No	Is there an enrollee Copayment? C Yes C No	Is there an enrollee Deductible? C Yes C No
electwhich Worldwide Services have a Coinsurance (Select I that apply): Worldwide Emergency Coverage Worldwide Urgent Coverage Worldwide Emergency Transportation	Select which Worldwide Services have a Copayment (Select all that apply): Worldwide Emergency Coverage Worldwide Urgent Coverage Worldwide Emergency Transportation	Indicate Deductible Amount:
ndicate Minimum Coinsurance percentage for Worldwide Emergency Coverage:	Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	
ndicate Maximum Coinsurance percentage for Worldwide <u>mergency</u> Coverage:	Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	
Is this Coinsurance waived for Worldwide Emergency Coverage if admitted to hospital?	Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	
C Yes C No	C No	
ndicate Minimum Coinsurance percentage for Worldwide Irgent Coverage:	Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	
ndicate Maximum Coinsurance percentage for Worldwide Jrgent Coverage:	Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	
Is this Coinsurance waived for Worldwide Urgent Coverage if admitted to hospital?	Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	
C Yes C No	C No	
ndicate Minimum Coinsurance percentage for Worldwide Emergency Transportation:	Indicate Minimum Copayment amount for Worldwide Emergency Transportation:	
ndicate Maximum Coinsurance percentage for Worldwide Emergency Transportation:	Indicate Maximum Copayment amount for Worldwide Emergency Transportation:	
Is this Coinsurance waived for Worldwide Emergency Transportation if admitted to hospital?	Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital? O Yes	
C Yes C No	O Yes O No	

#4c Worldwide Emergency/Urgent Coverage – Base 3

	Next	Exit (Validate)	Exit (No Validate)	Go To: #4c	Vorldwide Emergency/Ur	gent Coverage - Base 3	•		
horization is	notapplicabl	e for this Service (
ferral is not a	pplicable for t	his Service Categ	lory.						
		nt Coverage Notes		this service					
	t repeat inform	nformation to des mation captured in	n data entry.						
tes:							A		
							*		

#5 Partial Hospitalization – Base 1

PBP Data Entry System - Section B-5, Contr	act X0001, Plan 001, Segment 000	
	o: #5 Partial Hospitalization - Base 1	
· · · · · ·		
LICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
nanced Benefits are not applicable for this Service Category.	C No	
imum Plan Benefit Coverage is not applicable for this Service agory.	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
ere a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Maximum Coinsurance percentage for Medicare-covered	
Yes No	Benefits:	
licate Maximum Enrollee Out-of-Pocket Cost amount:		
	Is there an enrollee Deductible?	
elect Maximum Enrollee Out-of-Pocket Cost periodicity:	C No	
Every three years Every two years Every year Every year Every six months Every three months Other, Describe	Indicate Deductible Amount:	

#5 Partial Hospitalization – Base 2

BP Data Entry System - Section B-5, Cor Help	In act A0001, Plan 001, Segment 000	_6
	o To: #5 Partial Hospitalization - Base 2	
here an enrollee Copayment?	Partial Hospitalization Notes	
Yes No	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
Indicate Minimum Copayment amount for Medicare-covered	Notes:	
Benefits per day:	<u></u>	
Indicate Maximum Copayment amount for Medicare-covered Benefits per day:		
sonons per day.		
uthorization required? Yes	-	
Yes No		
referral required for Partial Hospitalization?		
Yes		
No		

#6 Home Health Services – Base 1

Help Previous Next Exit (Validate) CLICK FOR DESCRIPTION OF BENEFIT inhanced Benefits are not applicable for this revice Category, except for MMPs. Itaximum Plan Benefit Coverage is not pplicable for this Service Category.	Go To: B Home Health Services - Bat Validate) Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every three years C Every year C Every year C Every year C Every year	Is there an enrollee Coinsurance?	
CLICK FOR DESCRIPTION OF BENEFIT inhanced Banefits are not applicable for this iervice Category, except for MMPs.	Validate) Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Ores No Indicate Maximum Enrollee Out-of-Pocket Cost periodicity: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every two years Cevery two years Cevery sex Cevery s	C Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
inhanced Benefits are not applicable for this iervice Category, except for MMPs. faximum Plan Benefit Coverage is not	C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every six months	C Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
inhanced Benefits are not applicable for this iervice Category, except for MMPs. faximum Plan Benefit Coverage is not	C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every six months	C Yes No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
ervice Category, except for MMPs. Aaximum Plan Benefit Coverage is not	No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every two years Every six months	C No Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for	
faximum Plan Benefit Coverage is not	Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every there years C Every two years C Every six months	Medicare-covered Benefits:	
pplicable for this Service Category.	Cost periodicity: C Every three years C Every thwo years C Every year C Every six months	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
	Cost periodicity: C Every three years C Every thwo years C Every year C Every six months	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
	C Every two years C Every year C Every six months		
	C Every year C Every six months		
	C Every six monuts		
	C Every three months		
	C Other, Describe		

#6 Home Health Services – Base 2

PBP Data Entry System - Section B-6, Contract X0001, Plan 001, Segment 000	
Help Go To: #6 Home Health Services - Base 2	
evious Next (Validate) Go To: #0 Home Health Services - Base 2	
ere an enrollee Deductible? Yes	
No	
licate Deductible Amount:	
rere an enrollee Copayment? Yes	
No	
dicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
dicate Maximum Copayment amount per visit for Medicare-covered Benefits:	

#6 Home Health Services – Base 3

<u>H</u> elp	ry System - Sec	tion B-6, Con	tract X0001, Plan 001, Se	gment 000		5
	Exit	🗶 Go	To: #6 Home Health Services - Base 3			
evious Ne	xt (Validate)	Kon Exit (No Validate)				
uthorization require	d?					
Yes						
No						
	r Home Health Services?	1				
Yes No						
ne Health Services	Notes					
	ional information to desc t information captured in	ribe benefit in this ser	vice			
gory. Do notrepea es:	t information captured in	data entry.				
IS.						
					<u>×</u>	

#6 Home Health Services – MMP – Base 1

3P Data Entry System - Section B-6, Contrac	t X0001, Plan 001, Segment 00	0	_ 5
Go To:	#6 Home Health Services - MMP - Base 1		
vious Next (Validate) Validate)			
ICK FOR DESCRIPTION OF BENEFIT	Is there a limit on the services provided?		
s this plan provide Non-Medicare-covered Home Health Services?	C Yes C No		
Yes	Select Non-Medicare-covered Home Heal	th Services where limit applies:	
No Select Non-Medicare-covered Home Health Services: Additional Hours of Care	Additional Hours of Care Personal Care Services Other 1 Other 2		
Personal Care Services Other 1 Other 2		ndicate units a limit will be provided in for Personal Care Services:	
Enter name of Other 1 Service:	C Sessions O Visits O Hours	C Sessions C Visits C Hours	
Enter name of Other 2 Service:	O Points O Meals	C Points C Meals C Items/Other, Describe	
: there a service-specific Maximum Plan Benefit Coverage Amount? O Yes	Indicate numerical limit on the services provided for Additional Hours of Care:	Indicate numerical limit on the services provided for Personal Care Services:	
O No Indicate Maximum Plan Benefit Coverage amount:	Select limit on services periodicity for Additional Hours of Care:	Select limit on services periodicity for Personal Care Services:	
Select Maximum Plan Benefit Coverage periodicity:	C Every day C Every week C Every month	○ Every day ○ Every week ○ Every month	
C Every three years C Every two years C Every year C Every six months C Every three months	C Every year C Other, Describe	C Every year C Other, Describe	
O Other, Describe			

#6 Home Health Services – MMP – Base 2

	ction B-6, Contract X0001, Pla	an 001, Segment 000
Help	💥 Go To: #6 Home Health Se	ervices - MMP - Base 2
Exit	Exit (No	ervices - MMP - Base 2
revious Next (Validate)	Validate)	
ndicate units a limit will be provided in for	Indicate units a limit will be provided in for	Is there an enrollee Coinsurance?
ther 1:	Other 2:	O Yes
Sessions	C Sessions	
Visits	C Visits	
Hours	C Hours	Select which Non-Medicare-covered Home Health
Points	C Points	Services have a Coinsurance (select all that apply): Additional Hours of Care
Meals	C Meals	Personal Care Services
Items/Other, Describe	C Items/Other, Describe	Other 1
licate numerical limit on the services ovided for Other 1:	Indicate numerical limit on the services provided for Other 2:	Other 2
ovided for Other 1:	provided for Other 2:	Indicate coinsurance Minimum Maximum
		percentage for one Coinsurance Coinsurance
lect limit on services periodicity for	Select limit on services periodicity for	or more of the following services:
ner 1:	Other 2:	Additional Hours of Care
Every day	C Every day	
Every week	C Every week	Personal Care Services
Every month	C Every month	Other 1:
Every year	C Every year	Other 2:
Other, Describe	C Other, Describe	

#6 Home Health Services – MMP – Base 3

BP Data Entry System - Section B-6, Co	ntract X0001, Plan 001, Segment 000	
Help	io To: #6 Home Health Services - MMP - Base 3	
Vious Next (Validate)		
(
ere an enrollee Copayment?	Is authorization required?	
Yes No	C Yes C No	
Select which Non-Medicare-covered Home Health Services hav	e l	
Copayment (select all that apply): Additional Hours of Care	Is a referral required for Services?	
Personal Care Services	C Yes C No	
Other 1	0.10	
Other 2	Home Health Services MMP Notes	
ndicate copayment	Note may include additional information to describe benefit in this service	
mount for one or more of Minimum Maximum refollowing services: Copayment Copayment	category. Do not repeat information captured in data entry.	
dditional Hours of Care:	Notes:	
ersonal Care Services:	<u>*</u>	
ther 1:		
Other 2:		
s any service require qualification for and enrollment in a state-		
rated waiver program?		
Yes		
No Select which service requires qualification for and enrollment in		
state-operated waiver program:	a	
Additional Hours of Care Personal Care Services		
Other 1		
Other 2	*	

#7a Primary Care Physician Services – Base 1

Help		
revious Next (Validate) Go	To: #7a Primary Care Physician Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
hanced Benefits are not applicable for this Service Category	C No	
ximum Plan BenefitCoverage is not applicable for this vice Category.	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
here a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Yes No		
	Is there an enrollee Deductible?	
dicate Maximum Enrollee Out-of-Pocket Cost amount:	C Yes C No	
lect the Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Deductible Amount:	
Every three years		
Every two years Every year	Is there an enrollee Copayment?	
Every six months Every three months	C Yes C No	
Other, Describe	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
	Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	

#7a Primary Care Physician Services – Base 2

PBP Data Entry Syste	em - Section B-7,	Contract X0001, Plan 001, Segmen	t 000	
	Exit Exit (No Validate)	Go To: #7a Primary Care Physician Services - Base	2	
Authorization is not applicable for				
Referral is not applicable for this s				
Primary Care Physician Services 1 Note may include additional inform category. Do not repeat informatio	nation to describe benefit in t	nis service		
Notes:			<u>×</u>	
λ			<u>×</u>	

#7b Chiropractic Services – Base 1

Help	Go To: #7b Chiropractic Services - Base 1		
evious Next (Validate) Valid	ate)		
CLICK FOR DESCRIPTION OF BENEFIT	Enter Name of Other Service:	Is there a service-specific Maximum Plan Benefit Coverage amount?	
es the plan provide Chiropractic Services as a oplemental benefit under Part C?	Select type of benefit for Other Service:	C Yes C No	
Yes No	C Mandatory C Optional	Indicate Maximum Plan Benefit Coverage amount:	
elect enhanced benefit: Routine Care Other	Is this benefit unlimited for Other Service?	Select Maximum Plan Benefit Coverage periodicity: C Every three years C Every two years	
Select type of benefit for Routine Care: O Mandatory	C No, indicate number Indicate number of visits for Other Service:	C Every year C Every six months	
O Optional Is this benefit unlimited for Routine Care?	Select Other Service periodicity:	C Every three months C Other, Describe	
C Yes C No, indicate number	C Every three years C Every two years	Is there a service-specific Maximum Enrollee Out-of- Pocket Cost?	
Indicate number of visits for Routine Care:	C Every year C Every six months C Every three months C Other, Describe	C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select Routine Care periodicity: C Every three years			
C Every two years C Every year C Every six months		Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years	
C Every three months C Other, Describe		C Every two years C Every year C Every six months C Every three months	
your Chiropractor Services benefit combined th either the Acupuncture or Alternative erapies benefit, or both?		C Other, Describe	
Yes No			
Select the enhanced benefits that are included in the combined benefit (Select all that apply): Routine Care Other			

#7b Chiropractic Services – Base 2

4		4	Exit (No	Go To: #7b Chiropractic Services - Base 2		
evious	Next	Exit (Validate)	Exit (No Validate)			
Yes	ollee Coinsura	nce?		Is there an enrollee Copayment?	Is there an enrollee Deductible?	
No				O No	O No	
Select all th	nat apply):	Services have a C		Select which Chiropractic Services have a Copayment (Select all that apply):	Indicate Deductible Amount:	
		opractic Services	5	Medicare-covered Chiropractic Services		
Routine (Care			Routine Care Other	Is authorization required?	
ndicate Min	nimum Coinsur overed Benefit	ance percentage s:	pervisitfor	Indicate Minimum Copayment amount for Medicare- covered Benefits:	C Yes C No	
					Is a referral required for Chiropractic Services?	
ndicate Max Medicare-co	ximum Coinsu overed Benefit	rance percentage s:	e per visit for	Indicate Maximum Copayment amount for Medicare- covered Benefits:	O Yes	
ndicatethe	Minimum Coir	surance percent	aga parvisit	Indicate Minimum Copayment amount per visit for	Ô No	
or Routine		isurance percent	age per visit	Routine Care:		
ndicate the or Routine	Maximum Coir	nsurance percent	tage per visit	Indicate Maximum Copayment amount per visit for		
or Routine	Gare.			Routine Care:		
ndicate the or Other Se	Minimum Coir	surance percent	age per visit	Indicate Minimum Copayment amount per visit for Other Service:		
or other 3e	STVICE.					
		nsurance percent	tage per visit	Indicate Maximum Copayment amount per visit for		
or Other Se	ervice:			Other Service:		

#7b Chiropractic Services – Base 3

elp			Contract X0001, Plan 001, Se Go To: #7b Chiropractic Services - Base 3		1	_
ous	Next (Validate	Exit (No Validate)	Go To: #/o Uniropractic Services - Base 3	k	1	
ractic Se	rvices Notes					
	e additional information to	describe benefit in th	is service category. Do not repeat information	captured in data entry.		
1				*		
				-		

#7c Occupational Therapy Services – Base 1

Help					
◀		Exit	Go To: #7c Occupational Therapy Section 2015	Services - Base 1	
evious	Next	(Validate)	Validate)		
		1	Select the Maximum Enrollee Out-of-Pocket Cost	Is there an enrollee Deductible?	
LICK FOR D	ESCRIPTION	OF BENEFIT	periodicity:	O Yes	
nanced Bene vice Categor	fits are not ap y, except for I	plicable for this MMPs.	C Every three years C Every two years	C No	
rimum Plan P	Benefit Covera	ge is not	C Every year C Every six months	Indicate Deductible Amount:	
licable for th	is Service Cal	egory.	C Every six months C Other, Describe		
here a servic -of-Pocket C	e-specific Ma	kimum Enrollee	You must include total cost sharing to the	Is there an enrollee Copayment?	
Yes	/031:		beneficiary, including any facility cost sharing. Is there an enrollee Coinsurance?	C Yes C No	
No			O Yes	Indicate Minimum Copayment amount per visit for	
ndicate Maxi Cost amount:		Out-of-Pocket	C No	Medicare-covered Benefits:	
Jost amount.			Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits:	Indicate Maximum Copayment amount per visit	
			visit for medicare-covered Benefits:	for Medicare-covered Benefits:	
			Indicate Maximum Coinsurance percentage per		
			visit for Medicare-covered Benefits:		

#7c Occupational Therapy Services – Base 2

evious exit exit for Occupational Therapy Services - Base 2 uthorization required? Yes ves No ves verterral required for Occupational Therapy Services? Yes No uthorization required for Occupational Therapy Services? Yes No cupational Therapy Services Notes temay include additional information to describe benefit in this service		7, Contract X0001, Plan 001, Segment 000	<u>_</u> [
uthorization required? Yes No referral required for Occupational Therapy Services? Yes No cupational Therapy Services Notes te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry. es:	Hep Exit Exit (No Previous Next (Validate) Validate)	Go To: #7c Occupational Therapy Services - Base 2	
Yes No referral required for Occupational Therapy Services? Yes No cupational Therapy Services Notes te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry. es:			
No referral required for Occupational Therapy Services? Yes No cupational Therapy Services Notes te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry. es:	authorization required?		
Yes No cupational Therapy Services Notes te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry. es:	No		
No cupational Therapy Services Notes te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry. es:	a referral required for Occupational Therapy Services?		
cupational Therapy Services Notes te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry. tes:	Yes		
te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry. les:			
	te may include additional information to describe benefit i egory. Do not repeat information captured in data entry.	n this service	
	tes:	×	
7			
		w.	

#7c Occupational Therapy Services – MMP – Base 1

BP Data Entry System - Section B-7, Contract.	Kooo1, Plan oo1, Segment ooo	
	c Occupational Therapy Services - MMP - Base 1	
evious Next (Validate)		
(validato) validato)		
CLICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
Eloci on besome non of benefit	C Yes	
es this plan provide Non-Medicare-covered Occupational Therapy Service	C No	
Yes	Indicate Minimum Coinsurance percentage:	
No		
nter name of Non-Medicare-covered Occupational Therapy Service:	Indicate Maximum Coinsurance percentage:	
here a service-specific Maximum Plan Benefit Coverage amount?		
Yes	Is there an enrollee Copayment?	
No	C Yes	
ndicate Maximum Plan Benefit Coverage amount:	C No	
	Indicate Minimum Copayment amount:	
Select Maximum Plan Benefit Coverage periodicity:		
C Every three years	Indicate Maximum Copayment amount:	
C Every two years C Every year		
C Every six months		
C Every three months C Other, Describe		
C Other, Describe		

#7c Occupational Therapy Services – MMP – Base 2

Yes No a referral required for Services? Yes No coupational Therapy Services MMP Notes otemas include additional information to describe benefit in this service ategory. Do not repeat information captured in data entry. otes:	
Cryss No ccupational Therapy Services MMP Notes ofe may include additional information to describe benefit in this service ategory. Do not repeat information captured in data entry. ofes:	
No Coupational Therapy Services MMP Notes Ote may include additional information to describe benefit in this service tegory. Do not repeat information captured in data entry. Ses:	
te may include additional information to describe benefit in this service gory. Do not repeat information captured in data entry. tes:	

#7d Physician Specialist Services – Base 1

	tion B-7, Contract X0001, Plan 00	1, Segment 000	>
Previous Next (Validate)	Go To: #7d Physician Specialist Se Exit (No Validate)	srvices - Base 1	
	Select the Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every year C Every six months C Other, Describe Is there an enrollee Coinsurance procentage for Medicare-covered Benefits: Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	Is there an enrollee Deductible? C Yes Indicate Deductible Amount: Is there an enrollee Copayment? C Yes C No Indicate Maximum Copayment amount per visit for Medicare-covered Benefits: Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	

#7d Physician Specialist Services – Base 2

Image: Second	
thorization required? Yes No referral required for Physician Specialist Services? Yes No sician Specialist Services Notes sician Specialist Services Notes emay include additional information to describe benefit in this service gory. Do not repeat information captured in data entry.	*
Yes No referral required for Physician Specialist Services? Yes No sician Specialist Services Notes may include additional information to describe benefit in this service gory. Do not repeat information captured in data entry.	*
No referral required for Physician Specialist Services? Yes No sician Specialist Services Notes may include additional information to describe benefit in this service gory. Do not repeat information captured in data entry.	×
referral required for Physician Specialist Services? Yes No sician Specialist Services Notes emay include additional information to describe benefit in this service gory. Do not repeat information captured in data entry.	×
Yes No sician Specialist Services Notes smay include additional information to describe benefit in this service gory. Do not repeat information captured in data entry.	2
No sician Specialist Services Notes emay include additional information to describe benefit in this service gory. Do not repeat information captured in data entry.	*
emay include additional information to describe benefit in this service gory. Do not repeat information captured in data entry.	*
gory. Do not repeat information captured in data entry.	×
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#7e Mental Health Specialty Services – Base 1

PBP Data Entry System - Section B-7, Contract 3	
evious Next (Validate) Go To:	e Mental Health Specialty Services - Base 1
CLICK FOR DESCRIPTION OF BENEFIT	
hanced Benefits are not applicable for this Service Category.	
ximum Plan Benefit Coverage is not applicable for this Service Category.	
here a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Yes No	
dicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
C Every three years C Every two years	
C Every year C Every six months	
C Every three months C Other, Describe	

#7e Mental Health Specialty Services – Base 2

PBP Data Entry System - Section B-7, Co		
Exit Exit (No	Go To: #7e Mental Heath Specialty Services - Base 2	
revious Next (Validate) Validate)		
there an enrollee Coinsurance?	Is there an enrollee Copayment?	
Yes	O Yes	
No	C No	
elect which Mental Health Specialty Services have a	Select which Mental Health Specialty Services have a Copayment	
oinsurance (Select all that apply): Medicare-covered Individual Sessions	(Select all that apply):	
Medicare-covered Group Sessions	Medicare-covered Group Sessions	
Indicate Minimum Coinsurance percentage for Medicare- covered Individual Sessions:	Indicate Minimum Copayment amount for Medicare-covered	
	Individual Sessions:	
Indicate Maximum Coinsurance percentage for Medicare-	Indicate Maximum Copayment amount for Medicare-covered	
covered Individual Sessions:	Individual Sessions:	
Indicate Minimum Coinsurance percentage for Medicare-		
covered Group Sessions:	Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	
Indicate Maximum Coinsurance percentage for Medicare-		
covered Group Sessions:	Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	
here an enrollee Deductible? Yes		
No		
Indicate Deductible Amount:		

#7e Mental Health Specialty Services – Base 3

evious ivext (Validate)	Exit (No Validate)		
authorization required? Yes No			
referral required for Mental Health Specialty Se Yes	rvices - Non-Physician?		
No ntal Health Specialty Services Notes e may include additional information to describ gory. Do not repeat information captured in di es:	e benefit in this service ta entry.		
cs.		*	
		<u>×</u>	

#7f Podiatry Services – Base 1

PBP Data Entry System - Section	on B-7, Contract X0001, Plan 001, Segm	ent 000		_ 8
Exit	Go To: #7f Podiatry Services - Base 1 Exit (No			
revious Next (Validate)	Validate)		_	_
CLICK FOR DESCRIPTION OF BENEFIT	Select the Routine Foot Care periodicity: C Every three years	Is there a service-specific Maximum Enrollee Out -of-Pocket Cost?		
loes the plan provide Podiatry Services as a upplemental benefit under Part C?	O Every two years O Every year	C Yes C No		
) Yes) No	C Every six months C Every three months C Other, Describe	Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
Select enhanced benefits: Routine Foot Care	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select the Maximum Enrollee Out-of-Pocket		
Select type of benefit for Routine Foot Care:	O Yes O No	Cost periodicity: C Every three years		
C Mandatory C Optional	Indicate Maximum Plan Benefit Coverage amount:	C Every two years C Every year C Every year C Every six months		
Is this benefit unlimited for Routine Foot Care?	Select Maximum Plan Benefit Coverage periodicity:	C Every three months C Other, Describe		
C No	C Every three years C Every two years C Every year C Every six months C Every three months			
	O Other, Describe			

#7f Podiatry Services – Base 2

PBP Data Entry System - Section B-7, Contrac	ct X0001, Plan 001, Segment 000	_ 8 ×
ile Help 🖌 🖌 🖌 Go To:	#7f Podiatry Services - Base 2	
Previous Next (Validate) Go To:		
(,		
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
O Yes O No	O Yes O 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	s: Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Maximum Coinsurance percentage for Medicare-covered Benefit	ts: Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	
Indicate Minimum Coinsurance percentage for Routine Foot Care:	Indicate Minimum Copayment amount per visit 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?		
O Yes O No		
Indicate Deductible Amount:		

#7f Podiatry Services – Base 3

PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Sec	gment 000	
Help Exit Exit Exit No revious Next (Validate) Go To: #7f Podiatry Services - Base 3 (Validate)	T	
		-
authorization required? Yes		
No		
referral required for Podiatrist Services?		
Yes		
No		
diatry Services Notes		
te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry.		
tes:	×	
	U I	

#7g Other Health Care Professional – Base 1

Help	on B-7, Contract X0001, Plan 001,	, Segment 000
	Go To: #7g Other Health Care Profes	ssional - Base 1
Exit	Exit (No	
evious Next (Validate)	Validate)	
CLICK FOR DESCRIPTION OF BENEFIT	Select the Maximum Enrollee Out-of-Pocket Cost periodicity:	
	C Every three years	C Yes C No
hanced Benefits are not applicable for this rvice Category.	C Every two years	C No
vice category.	C Every year	Indicate Deductible Amount:
ximum Plan Benefit Coverage is not applicable	C Every six months	
this Service Category.	C Every three months C Other, Describe	
here a service-specific Maximum Enrollee Out-	O Other, Describe	Is there an enrollee Copayment?
Pocket Cost?	Is there an enrollee Coinsurance?	C Yes C No
Yes	C Yes	
No	C No	Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:
dicate Maximum Enrollee Out-of-Pocket Cost	Indicate Minimum Coinsurance percentage for	tor medicare-covered benefits:
nount:	Medicare-covered Benefits:	
	1	Indicate Maximum Copayment amount per visit
	Indicate Maximum Coinsurance percentage for	for Medicare-covered Benefits:
	Medicare-covered Benefits:	

#7g Other Health Care Professional – Base 2

PBP Data Entry System - Section B-7, Contract X000	1, Plan 001, Segment 000	6
Go To: #7g Other	Health Care Professional - Base 2	
revious Next (Validate) Validate)		_
authorization required?		
Yes No		
a referral required for Other Health Care Professional Services?		
Yes		
ner Health Care Professional Notes te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry. tes:		
	*	
	*	

#7h Psychiatric Services – Base 1

anced Benefits are not applicable for this Service Category. stimum Plan Benefit Coverage is not applicable for this Service Category. tere a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No dicate Maximum Enrollee Out-of-Pocket Cost amount: elect the Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every three years Every year Every six months Every this Service Cost Service Co	-
kimum Plan Benefit Coverage is not applicable for this Service Category. ere a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No dicate Maximum Enrollee Out-of-Pocket Cost amount: elect the Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every year Every year Every year Every year Every six months Every three months Every three the	
here a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No dicate 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 year C Every three months C Every three months	
Yes No dicate 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 three months C Every three months C Every three months C Every three months	
dicate 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 six months C Every three months	
C Every three years C Every two years C Every year C Every six months C Every three months	
C Every three years C Every two years C Every year C Every six months C Every three months	
C Every year C Every hire months C Every three months	
C Every three months	
C Other, Desoribe	

#7h Psychiatric Services – Base 2

PBP Data Entry System - Section B-7, Cor	ntract X0001, Plan 001, Segment 000	_ 8 ×
Elle Help	o To: #7h Psychiatric Services - Base 2	
Previous Next (Validate) G Validate) G Exit Exit (No Validate)		
(vanuate) vanuate)		
Is there an enrollee Coinsurance?	Is there an enrollee Copayment?	
Is there an enrollee Coinsurance? Yes Select which Psychiatric Services have a Coinsurance (Select all t Medicare-covered Individual Sessions Medicare-covered Group Sessions Indicate Minimum Coinsurance percentage for Medicare-cover Individual Sessions: Indicate Maximum Coinsurance percentage for Medicare-cover Group	C Yes No Select which Psychiatric Services have a Copayment (Select all that apply): Get which Psychiatric Services have a Copayment (Select all that apply): Get Medicare-covered Individual Sessions Medicare-covered Group Sessions Indicate Minimum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Medicare-covered Indicate Minimum Copayment amount for Medicare-covered Group Sessions: Get Minimum Copayment amount for Medicare-covered Indicate Minimum Copayment amount for Medicare-covered I	

#7h Psychiatric Services – Base 3

	a Entry S	/stem - Se	ction B-7,	Contract X	0001, Plan 001	1, Segment 000				
Help		Exit	Exit (No	Go To: #7h	Psychiatric Services - B	Base 3		<u>.</u>		
evious	Next	(Validate)	Validate)			_	_	_	_	_
uthorization	required?									
Yes No										
	uired for Psych	niatric Services?								
Yes No										
chistric San	vices Notes									
e may includ	de additional in	nformation to des nation captured i	cribe benefit in t	his service						
es:	strepearmon	nation captured i	in data entry.							
							<u></u>			
							-1			
							<u></u>			

#7i PT and SP Services – Base 1

	tion B-7, Contract X0001, Plan 001, Segment 000	_8>
Previous Next (Validate)	Go To: #7/PT and SP Services - Base 1 Exit (No Validate)	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category, except for MMPs. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes ON Indicate Maximum Enrollee Out-of-Pocket Cost amount	Select Maximum Enrollee Out-of-Pockel Cost Cervery years Cervery years Cervery years Cervery three months Cervery three months Correct Describe You must include total: cost sharing to the beneficiary, including any facility costs sharing. Indicate Maximum Consurance percentage per wist for Medicar-covered Benefits: Indicate Maximum Consurance percentage per wist for Medicar-covered Benefits: Indicate Maximum Consurance percentage per wist for Medicar-covered Benefits: Correct Description of the total cost sharing to the Description of the total cost sh	

#7i PT and SP Services – Base 2

PBP Data Entry System - Section B-7, Contract X000	, Plan 001, Segment 000	
Help Exit Exit No Go To: #7/PT and	SP Services - Base 2	
evious Next (Validate) Go To: #7/PT and Exit Exit (No (Validate) Validate)		
authorization required?		
Yes		
No		
a referral required for Physical Therapy and Speech-Language Pathology rvices?		
Yes No		
and SP Services Notes		
te may include additional information to describe benefit in this service		
egory. Do not repeat information captured in data entry. es:		
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#7i PT and ST – MMP – Base 1

	A Contrast effective and effec
DLICK FOR DESCRIPTION OF BENEFIT Is there an enrollee Coinsurance? es this plan provide Non-Medicare-covered Physical and/or eech Therapy services? Select Which Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (select all that apply): Other 1 Yes Select Which Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (select all that apply): Other 1 Other 2 Indicate coinsurance (Select all that apply): Other 1 Other 2 Indicate coinsurance (Select all that apply): Other 1 Enter name of Other 1 Service: Other 1: Other 2: Enter name of Other 2 Service: Other 1: Other 2: Other 2: Other 2: Other 2: Other 2: Other 3: Other 2: Other 4: Other 2: Other 5: Other 2: Other 6: Other 2: Other 7: Other 2: Other 8: Other 2: Other 9: Other 3: Select Maximum Plan Benefit Coverage amount Select Maximum Plan Benefit Coverage periodicity: Every three years <td< th=""><th>Exit Exit (No</th></td<>	Exit Exit (No
se shis plan provide Non-Medicare-covered Physical and/or Yes No Select which Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (select all that apply): Other 1 Other 2 Enter name of Other 1 Service: Enter name of Other 2 Service: Enter name of Ot	(Valluate) Valluate)
Is his plan provide Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (select all that apply): elect Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (select all that apply): elect Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (select all that apply): elect Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (select all that apply): elect Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (select all that apply): elect Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (select all that apply): elect Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (coinsurance coinsurance or more of the fore) other 1 enter name of Other 1 Service: Enter name of Other 2 Service: Other 1: Maximum Plan Benefit Coverage amount elect Maximum Plan Benefit Coverage amount elect Maximum Plan Benefit Coverage periodicity: Every three years Every three years Every three months Every three months	
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elect Non-Medicare-covered Physical and/or Speech Therapy Services: Other 1 Other 2 Indicate coinsurance or more of Other 1 Service: Other 1: Other 1: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 2: Other 3: Other 2: Other 4: Other 2: Other 2: Other 2: Other 2: Other 2: Other 3: Other 4: Other 2: Other 2: Other 4: Other 2: Other 4: Other 4: Other 2: Other 4: Other 4: Other 2: Other 4: Other 4: Other 4: Other 4: Other 5: Other 4: Other 5: Other 4: Other 5: Other 4: Other 4: Other 5: Other 4: Other 5: Other 6: Other 6: Other 7: O	Select which Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (selectall that apply):
Other 2 Indicate coinsurance Enter name of Other 1 Service: Other 1 Other 2 Service: Other 1: Other 2: Other 3: Other 4: Other 4: Other 5: Other 2: Other 3: Other 4: Other 4: Other 5: Other 5: Other 6: Other 7:	
following services: Other 1: Other 2: Other 4: Other 2: Other 4: Other 2: Other 4: Other 2: Other 4: Other 4: Other 4: Other 4: Other 5: Other	percentage for one Coinsurance Coinsurance
Enter name of Other 2 Service: Other 2: Other 2:	following services:
ere a service-specific Maximum Plan Benefit Coverage amount Yes No dicate Maximum Plan Benefit Coverage amount: elect Maximum Plan Benefit Coverage periodicity: Every three years Every three years Every three years Every three months Every this months	2 Service:
Yes No dicate Maximum Plan Benefit Coverage amount: elect Maximum Plan Benefit Coverage periodicity: Every three years Every three years Every three years Every three months	
Indicate Maximum Plan Benefit Coverage amount: elect Maximum Plan Benefit Coverage periodicity: © Every three years © Every thoy ears	c Maximum Plan Benefit Coverage amount
elect Maximum Plan Benefit Coverage periodicity: Every three years Every two years Every two reads Every three months Every th	
Cevery three years Every two years Every year Every six months Every three months	1 Benefit Coverage amount
© Every two years © Every year © Every six months © Every three months	Benefit Coverage periodicity:
C Every year C Every six months C Every three months	
© Every six months © Every three months	
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#7i PT and ST – MMP – Base 2

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Exit Exit (No	To: #71PT and ST - MMP - Base 2	
evious Next (Validate) Validate)		
here an enrollee Copayment?	Is authorization required?	
Yes	C Yes	
No	C No	
Select which Non-Medicare-covered Physical and/or Speech Thera	upy Is a referral required for Services?	
ervices have a Copayment (select all that apply):	O Yes	
Other 1	C No	
Other 2		
n dicate copayment mount for one or Minimum Maximum	PT and SP Services MMP Notes	
lore of the following Copayment Copayment	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
ervices:	Notes:	
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ther 2:		
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evious Nex		Exit (No Validate)	Go To: #34 00	oatient Diag Procs/Tests/	Lab Services - Base 1			
	PTION OF BENEFIT							
	not applicable for this :							
	Coverage is not applica							
there a service-spec Yes	ific Maximum Enrollee C	Dut-of-Pocket Co	st?					
No								
idicate Maximum En	rollee Out-of-Pocket Co	ost amount:						
Select Maximum Enri C Every three year	ollee Out-of-Pocket Cos	st periodicity:	P					
C Every two years C Every year								
C Every six month:								
C Every three mon O Other, Describe	ths							

must include total cost sharing to the beneficiary, including any facility cost ing. If you have a variety of cost sharing, please utilize the minimum and imm fields to reflect the lowest and highest cost sharing that a beneficiary pay. ere an enrollee Coinsurance? Yes No	Help			: X0001, Plan 001, Segment 000
Violus Next (Validate) Validate) Indicate Minimum Coinsurance percentage for Medicare-covered Lab Image: Services Indicate Minimum Coinsurance percentage for Medicare-covered Lab Services: Indicate Minimum Coinsurance percentage for Medicare-covered Lab Services: Indicate Maximum Coinsurance percentage for Medicare-covered Lab Services: Indicate Minimum Coinsurance percentage for Medicare-covered Lab Services: Indicate Minimum Coinsurance percentage for Medicare-covered Lab Services: Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests: Indicate Maximum Coinsurance percentage for Medicare-covered Indicate Maximum Coinsurance percentage for Medicare-covered Indicate Maximum Coinsurance percentage for Medicare-covered	< b	4	🗶 🛛 Go To: 🖡	#8a Outpatient Diag Procs/Tests/Lab Services - Base 2
Indicate Maximum Coinsurance percentage for Medicare-covered	evious Next	(Validate) Val	dt (No lidate)	
Indicate Maximum Coinsurance percentage for Medicare-covered				
ere an enrollee Coinsurance? Ves Indicate Maximum Coinsurance percentage for Medicare-covered Lab Services: Indicate Maximum Coinsurance percentage for Medicare-covered Indi	aring. If you have a variety ximum fields to reflect the	v of cost sharing, please u	utilize the minimum and	Services:
Yes Services: No Services: Serv		ance?		
elect which Outpatient Diag Procs/Tests/Lab Services have a Coinsurance elect all that apply): Medicare-covered Diagnostic Procedures/Tests Medicare-covered Lab Services Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests:	Yes			
elect all that apply): Medicare-covered Diagnostic Procedures/Tests Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests: Indicate Maximum Coinsurance percentage for Medicare-covered	No			
Medicare-covered Lab Services Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests: Indicate Maximum Coinsurance percentage for Medicare-covered	Select all that apply):			ce.
Diagnostic Procedures/Tests:				
Indicate Maximum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests:			Medicare-covered	
Indicate Maximum Coinsurance percentage for Medicars-covered Diagnostic Procedures/Tests:				
	Indicate Maximum Coin Diagnostic Procedures	nsurance percentage for M s/Tests:	Medicare-covered	

PBP Data Entry System - Section B-8, Contr	ract X0001, Plan 001, Segment 000
🖌 📐 🖌 🦉 Go 1	o: #8a Outpatient Diag Procs/Tests/Lab Services - Base 3
revious Next Exit Exit (No (Validate) Validate)	
there an enrollee Deductible?	
Yes	
No ndicate Deductible Amount:	
here an enrollee Copayment?	
Yes No	
elect which Outpatient Diag Procs/Tests/Lab Services have a	
opayment (Select all that apply): Medicare-covered Diagnostic Procedures/Tests	
Medicare-covered Lab Services	
dicate Minimum Copayment amount for Medicare-covered agnostic Procedures/Tests:	
dicate Maximum Copayment amount for Medicare-covered	
agnostic Procedures/Tests:	
dicate Minimum Copayment amount for Medicare-covered Lab	
arvices:	
dicate Maximum Copayment amount for Medicare-covered Lab	
rvices:	
a member receives multiple services at the same location on	
e same day, does only the maximum copay apply? Yes	
No	

PBP Data Entry System - Section B-8, Co	ntract X0001, Plan 001, Segment 000		
	Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 4		
revious Next (Validate) Validate)			
authorization required?			
Yes			
No			
referral required for Outpatient Diagnostic Procedures/Test/La Yes	b Services?		
No			
tpatient Diag/Procs/Tests/Lab Services Notes:			
	service category. Do not repeat information captured in data entry	5.*	
ignostic Procedures/Tests Notes:	Lab Services Notes:		
		-	
	w.	×	

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

PBP Data Entry System - Section B-8, Contra	act X0001, Plan 001, Segment 000	_ 8
e Help Exit Exit Exit (No	o: #8b Outpatient Diag/Therapeutic Rad Services - Base 1	
Previous Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Select which OutpatientDiag/Therapeutic Rad Services have a Coinsurance (Select all that apply):	
Enhanced Benefits are not applicable for this Service Category.	Medicare-covered Diagnostic Radiological Services	
Maximum Plan Benefit Coverage is not applicable for this Service Category.	Medicare-covered Therapeutic Radiological Services	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	
C Yes		
C No	Indicate Maximum Coinsurance percentage for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:		
Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Minimum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services:	
C Every three years C Every two years		
C Every year	Indicate Maximum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services:	
C Every six months C Every three months		
O Other, Describe	Indicate Minimum Coinsurance percentage for Medicare-covered X-Ray	
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?	Services: Indicate Maximum Coinsurance percentage for Medicare-covered X-Ray Services:	
O Yes		
O Yes		

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

🗏 PBP Data Entr	y System - Se	ection B-8,	Contract X(001, Plan 001	, Segment 000			_ 8
le <u>H</u> elp	4	×	Go To: #8b (utpatient Diag/Therape	utic Rad Services - Base 2	 T		
Previous Next	Fxit	Exit (No Validate)	00 10. <u>pros</u>	alpation blag morapo				
Is there an enrollee Ded C Yes	uctible?							
C No								
Indicate Deductible Am	iount:							
Is there an enrollee Cop	ayment?							
C Yes C No								
Select which Outpatient	Diag/Therapeutic Ra	d Services have a	Copayment					
(Select all that apply): Medicare-covered Dia								
Medicare-covered Th Medicare-covered X-		al Services						
Indicate Minimum Co Diagnostic Radiologi	payment amount for o cal Services (e.g., CT	ther Medicare-co , MRI, etc):	overed					
Indicate Maximum Co	payment amount for	other Medicare-c	overed					
Diagnostic Radiologi	cal Services (e.g., CT	, MRI, etc):						
Indicate Minimum Co	payment amount for N	Medicare-covered	Therapeutic					
Radiological Services								
Indicate Maximum Co Radiological Services	payment amount for I ::	Medicare-covered	d Therapeutic					
Indicate Minimum Co	payment amount for N	Medicare-covered	i X-Ray					
Services:								
Indicate Maximum Co Services:	payment amount for I	Medicare-covere	d X-Ray					
If a member receives mu the same day, does only	the maximum copay	same location on apply?	I					
O Yes O No								

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

Help			
	Go To: #8b Outp itt (No	patient Diag/Therapeutic Rad Services - Base 3	
evious Next (Validate) Vali	tit (No lidate)		
authorization required?	Į	Therapeutic Radiological Services Notes:	
Yes		×.	
No	2		
a referral required for Outpatient Diagnostic/Therape ay Services?	eutic Radiological, and X		
Yes			
No			
tpatient Diag/Therapeutic Rad Services Notes			
te may include additional information to describe be	enefit in this service		
egory. Do not repeat information captured in data e			
gnostic Radiological Services (e.g., CT, MRI, etc.)	Notes:	K-Ray Services Notes:	
	-	-1	

#9a Outpatient Hospital Services – Base 1

Exit Exit Exit Exit Inclusion CK FOR DESCRIPTION OF BENEFIT	Ign Outpatient Hospital Services - Base 1 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? C Yes No	_
nced Benefits are not applicable for this Service Category. num Plan Benefit Coverage is not applicable for this Service Category re a service-specific Maximum Enrollee Out-of-Pocket Cost?	costsharing, Ifyou have a variety of costsharing, 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? C Yes	
nced Benefits are not applicable for this Service Category. num Plan Benefit Coverage is not applicable for this Service Category re a service-specific Maximum Enrollee Out-of-Pocket Cost?	costsharing, Ifyou have a variety of costsharing, 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? C Yes	
num Plan Benefit Coverage is not applicable for this Service Category e a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?	
re a service-specific Maximum Enrollee Out-of-Pocket Cost?	O Yes	
	S NO	
35 D	Select which Services have a Coinsurance (Select all that apply): Medicare-covered Outpatient Hospital Services	
ect which Services have a Maximum Enrollee Out-of-Pocket Cost	Medicare-covered Observation Services	
ect all that apply): Medicare-covered Outpatient Hospital Services Medicare-covered Observation Services	Indicate Minimum Coinsurance percentage for Medicare-covered Outpatient Hospital Services:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare- covered Outpatient Hospital Services:	Indicate Maximum Coinsurance percentage for Medicare-covered	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity for	Outpatient Hospital Services:	
Medicare-covered Outpatient Hospital Services: C Every three years	Indicate Minimum Coinsurance percentage for Medicare-covered Observation Services:	
C Every two years C Every year C Every six months		
C Every three months C Other, Describe	Indicate Maximum Coinsurance percentage for Medicare-covered Observation Services:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare- covered Observation Services:		
Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Observation Services:		
C Every three years C Every two years		
C Every year		
C Every six months C Every three months		
C Other, Describe		

#9a Outpatient Hospital Services – Base 2

U Sext Calidate) Validate) Go To Exit Exit (No Ous Next (Validate) Validate)	#9a Outpatient Hospital Services - Base 2	
Constants, succession		
e an enrollee Deductible?	Is there an enrollee Copayment?	Is authorization required for Medicare-covered Outpatient Hospital Set
S	C Yes C No	C Yes C No
ect which Services have a Deductible (Select all that apply): Medicare-covered Outpatient Hospital Services	Select which Services have a Copayment (Select all that apply): Medicare-covered Outpatient Hospital Services	Is authorization required for Medicare-covered Observation Services?
Vedicare-covered Observation Services	Medicare-covered Observation Services	C No
ndicate Deductible Amount for Medicare-covered Outpatient Iospital Services:	Indicate Minimum Copayment amount per visit for Medicare- covered Outpatient Hospital Services:	
		Is a referral required for Medicare-covered Outpatient Hospital Service
ndicate Deductible Amount for Medicare-covered Observation	Indicate Maximum Copayment amount pervisit for Medicare-	C Yes
Services:	covered Outpatient Hospital Services:	C No
		Is a referral required for Medicare-covered Observation Services?
	Indicate Minimum Copayment amount per visit for Medicare-	O Yes
	covered Observation Services:	C No

#9a Outpatient Hospital Services – Base 3

elp					patient Hospital Servic	Segment 000				<u> </u>
ous	Next	Exit (Validate)	Exit (No Validate)	Go Io: #9a Ou	patient Hospital Servic	ces - Base 3				
	vices Notes	2 2 2			0 % R.K					
	de additional infor	mation to desc	ribe benefit in t	his service category.	Do not repeat inform	ation captured in data	entry.			
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#9b ASC Services – Base 1

	X0001, Plan 001, Segment 000	_ 8
Help Go To:	PB ASC Services - Base 1	
revious Next (Validate) Go To:		
CLICK FOR DESCRIPTION OF BENEFIT	You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize	
nhanced Benefits are not applicable for this Service Category.	the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.	
aximum Plan Benefit Coverage is not applicable for this Service Category.	Is there an enrollee Coinsurance?	
there a service-specific Maximum Enrollee Out-of-Pocket Cost?	C Yes C No	
) Yes) No	Indicate Minimum Coinsurance percentage for Medicare-covered	
Select the Maximum Enrollee Out-of-Pocket Cost type:	Benefits:	
C Covered under Outpatient Hospital Services Category 9a C Plan-specified amount per period		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Select Maximum Enrollee Out-of-Pocket Cost periodicity:		
C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe		

#9b ASC Services – Base 2

<u>i</u> elp		
	#9b ASC Services - Base 2	
vious Next (Validate) Go To		
ere an enrollee Deductible?	Is authorization required?	
Yes No	C Yes C No	
ndicate Deductible Amount:		
	Is a referral required for Ambulatory Surgical Center Services?	
ere an enrollee Copayment?	C No	
Yes No		
ndicate Minimum Copayment amount pervisit for Medicare-covered		
enefits:		
ndicate Maximum Copayment amount per visit for Medicare-covered		
enefits:		

#9b ASC Services – Base 3

on to describe benefit in this service catego	ry. Do not repeat information captured in da	ta entry.	
		*	
		-	
	on to describe benefit in this service catego	on to describe benefit in this service category. Do not repeat information captured in da	

#9c Outpatient Substance Abuse – Base 1

<u>H</u> elp	-				X0001, Plan 001, Segm		<i></i>		
evious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#9c Outpatient Substance Abuse - Base	1	-		
	ESCRIPTION								
		plicable for this S	ervice Category	10					
ximum Plan	Benefit Covera	ige is not applica	ble for this Servi	ce Category.					
here a servio	ce-specific Max	kimum Enrollee O	ut-of-Pocket Co	st?					
Yes No									
	cimum Enrolle	e Out-of-Pocket C	ost type:	6					
Covered u	inder Outpatie	nt Hospital Servic							
	ified amount p	Out-of-Pocket C	ost amount						
roncate widx		OUPUI-FUCKELUI	ost amount.						
Select Maxi	mum Enrollee	Out-of-Pocket Co	st periodicity:						
C Every th C Every tw C Every y C Every s C Every s	nree years vo years ear ix months nree months		(
C Other, E	Describe								

#9c Outpatient Substance Abuse – Base 2

PBP Data Entry System - Section B-9, Contra	ct X0001, Plan 001, Segment 000	
Help Go To: Exit Exit (No	#9c Outpatient Substance Abuse - Base 2	
revious Next (Validate) Validate)		
uu must include total cost sharing to the beneficiary, including any cility cost sharing. If you have a variety of cost sharing, please utilize e minimum and maximum fields to reflect the lowest and highest cost aring that a beneficiary may pay.	Is there an enrollee Deductible? C Yes C No	
there an enrollee Coinsurance?	Indicate Deductible Amount:	
) Yes) No	Is there an enrollee Copayment?	
Select which Outpatient Substance Abuse Services have a Coinsurance (Select all that apply):	C Yes C No	
Medicare-covered Individual Sessions Medicare-covered Group Sessions	Select which Outpatient Substance Abuse Services have a Copayment	
Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions:	(Select all that apply): ☐ Medicare-covered Individual Sessions	
Indicate Maximum Coinsurance percentage for Medicare-covered Individual Sessions:	Medicare-covered Group Sessions Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	
ndicate Minimum Coinsurance percentage for Medicare-covered 3roup Sessions:	Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	
ndicate Maximum Coinsurance percentage for Medicare-covered Group 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

	System - Section B-9), Contract X0001, Plan 001, S	egment 000	
Help	Exit Exit (No (Validate) Validate)	Go To: #9c Outpatient Substance Abuse	Base 3	
authorization required?				
Yes				
No		2		
	tpatient Substance Abuse Servic	es?		
Yes No				
tpatient Substance Abuse	e Notes			
te may include additional	l information to describe benefit i	n this service		
egory. Do notrepeat info tes:	ormation captured in data entry.			
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			v]	

#9d Outpatient Blood Services – Base 1

Per def Previous Previous </th <th>P Data Entry System - Section B-9, Contract</th> <th>t X0001, Plan 001, Segment 000</th> <th>_8</th>	P Data Entry System - Section B-9, Contract	t X0001, Plan 001, Segment 000	_8
Previous Exit (No Validate) Exit (Validate) Exit (No Validate) CLICK FOR DESCRIPTION OF BENEFIT Select Maximum Enrollee Out-of-Pocket Cost periodicity: If blood is given as a part of an inpatient hospital cost sharing for the blood should be included in the inpatient hospital cost sharing for the blood should be included in the inpatient hospital cost sharing. Select Maximum Enrollee Out-of-Pocket Cost periodicity: Obst he plan provide Outpatient Blood Services as a supplemental benefit under Part C? Select enhanced benefit: Select Outpatient Blood Services as a supplemental O Three (3) pint deductible waived Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefit: One Maximum Plan Benefit Coverage is not applicable for this Service Category. Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefit: Maximum Plan Benefit Coverage is not applicable for this Service Category. Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits: Yes Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits:		#9d Outpatient Blood Services - Base 1	
If blood is given as a part of an inpatient hospital stay, the cost sharing.	Exit Exit (No		
If blood is given as a part of an inpatient hospital stay, the costsharing. Every three years Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C? Every three years C Yes Every three wears C No Is there an enrollee Collsurance? Select type of benefit for Three (3) Pint Deductible Waived: Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefit: C Mandatory Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefit: Indicate Maximum Plan Benefit Coverage is not applicable for this Service Category. Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefit: C Yes Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefit: No Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefit: No Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefit: No Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefit: No Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefit: No Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefit:			
If blood is given as a part of an inpatient hospital stay, the costsharing. C Every two years Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C? C Every six months C Yes C Other, Describe Select enhanced benefit: C Yes Select type of benefit for Three (3) Pint Deductible Waived: Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefit: Maximum Plan Benefit Coverage is not applicable for this Service Category. Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefit: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefit:	CK FOR DESCRIPTION OF BENEFIT		
C res Is there an enrollee Coinsurance? Select enhanced benefit: C Yes Three (3) pint deductible waived Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: Select type of benefit for Three (3) Pint Deductible Waived: Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: C Mandatory Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: Maximum Plan Benefit Coverage is not applicable for this Service Category. Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits:	ood should be included in the inpatient hospital cost sharing. the plan provide Outpatient Blood Services as a supplemental	C Every two years C Every year C Every six months C Every three months	
Select enhanced benefit: C Yes Three (3) pint deductible waived Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: Select type of benefit for Three (3) Pint Deductible Waived: Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: C Mandatory Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: Maximum Pian Benefit Coverage is not applicable for this Service Category. Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Image: C Yes C Yes No			
Select type of benefit for Three (3) Pint Deductible Waived: Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: C Mandatory Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: Maximum Plan Benefit Coverage is not applicable for this Service Category. Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes	na Angelan an Angelan a		
C Mandatory Benefits: C Optional Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C C Yes C No			
C Mandatory Image: Construction of the service of	ect type of benefit for Three (3) Pint Deductible Waived:	Indicate Minimum Coinsurance percentage per unit for Medicare-covered	
Indicate Maximum Coinsurance per unit for Medicare-covered Benefits: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Mandatory	oriens.	
C Yes C No		Page after	
C Yes C No	re a service-specific Maximum Enrollee Out-of-Pocket Cost?		
	es		
Indicate Maximum Enrollee Out-of-Pocket Cost amount:			
	cate Maximum Enrollee Out-of-Pocket Cost amount:		

#9d Outpatient Blood Services – Base 2

here an enrollee Deductible?	Outpatient Blood Services Notes
Yes No	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
dicate Deductible Amount:	Notes:
ere an enrollee Copayment?	
Yes No	
vo idicate Minimum Copayment amount per unit for Medicare-covered	
enefits:	
dicate Maximum Copayment amount per unit for Medicare-covered	
enefits:	
ithorization required? Yes	-
res No	
referral required for Outpatient Blood Services?	
Yes	
Yes No	
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#10a Ambulance Services – Base 1

	🖌 🎽 Go To: Exit Exit (No	10a Ambulance Services - Base 1	
evious Nex	ct (Validate) Validate)		
CLICK FOR DESCRIP	TION OF BENEFIT	Is there an enrollee Coinsurance?	Is this Coinsurance waived if admitted to hospital?
		C Yes C No	C Yes C No
hanced Benefits are i	not applicable for this Service Category.		€ NU
ximum Plan Benefit C	Coverage is not applicable for this Service Category	Select which Services have a Coinsurance (Select all that apply): Medicare-covered Ground Ambulance Services Medicare-covered Air Ambulance Services	
	fic Maximum Enrollee Out-of-Pocket Cost?		
) Yes) No		Indicate the Minimum Coinsurance percentage for Medicare-covered Ground Ambulance Services:	
Select which Service	es have a Maximum Enrollee Out-of-Pocket Cost		
(Select all that apply Medicare-covered	r): d Ground Ambulance Services	Indicate the Maximum Coinsurance percentage for Medicare-	
	d Air Ambulance Services	covered Ground Ambulance Services:	
	n Enrollee Out-of-Pocket Cost amount for Medicare-		
covered Ground	Ambulance Services:	Indicate Minimum Coinsurance percentage for Medicare-covered Air Ambulance Services:	
I			
	Enrollee Out-of-Pocket Cost periodicity for d Ground Ambulance Services:		
C Every three ye		Indicate Maximum Coinsurance percentage for Medicare-covered Air Ambulance Services:	
C Every two year C Every year	ars		
C Every six mor			
C Every three m C Other, Descril			
lo oner, besen			
Indicate Maximum	n Enrollee Out-of-Pocket Cost amount for Medicare-		
covered Air Ambu	lance Services:		
I			
Select the Maximu Medicare-coverer	um Enrollee Out-of-Pocket Cost periodicity for d Air Ambulance Services:		
C Every three ye			
0 -	ars		
C Every two yea			
C Every year	nths		
	ionths		

#10a Ambulance Services – Base 2

Help	ystem - section	D 10, Contrac	t X0001, Plan 001, Segment 000		_ 6
evious Next	Exit Exit (Validate) Vali	K Go To: t (No date)	f10a Ambulance Services - Base 2		
vere an enrollee Deductib Yes No	le?		Is there an enrollee Copayment? C Yes C No	Is this Copayment waived if admitted to hospital?	
Select which Services hav	ve a Deductible (Select all und Ambulance Services Ambulance Services	that apply):	Select which Services have a Copayment (Select all that apply): Medicare-covered Ground Ambulance Services Medicare-covered Air Ambulance Services		
Indicate Deductible Am Ambulance Services:	ount for Medicare-covered	d Ground	Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:		
Indicate Deductible Am Services:	ount for Medicare-covere	d Air Ambulance	Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:		
			Indicate Minimum Copayment amount per visit for Medicare- covered Air Ambulance Services:		
			Indicate Maximum Copayment amount per visit for Medicare- covered Air Ambulance Services:		

#10a Ambulance Services – Base 3

PBP Data Entry Sy Help	stem - Section B-10	, Contract X0001, Plan 001, Segn	ent 000	
	Exit Exit (No	Go To: #10a Ambulance Services - Base 3		
evious Next	(Validate) Validate)			
	n-emergency Medicare services	2		
Yes No				
ferral is not applicable for th	is Service Category.			
oulance Services Notes				
te may include additional int egory. Do not repeat inform	formation to describe benefit in t ation captured in data entry.	his service		
tes:				
			*	

#10b Transportation Services – Base 1

Exit Exit	No		
VIOUS NEXT (Validate) Valid	ate)		
	Select Type of Transportation Services - Base 1 Select Type of Transportation for Plan-approved Location: Cone-way Con	Indicate number of trips for Any Health-related Location: Indicate number of trips for Any Health-related Location Trips Image: Ima	

#10b Transportation Services – Base 2

PBP Data Entry System - Section			
Help			
	Go To: #10b Transportation Services - t (No	Base 2	
revious Next (Validate) Valid	t (No date)		
(validate) valid	Jate)		
there a service-specific Maximum Plan Benefit overage amount?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?	
) Yes	C Yes	C Yes	
D No	C No	C No	
		Indicate Minimum Coinsurance percentage:	
ndicate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of- Pocket Cost amount:		
-last Maximum Disc Day 64 Courses a solid distant		Indicate Maximum Coinsurance percentage:	
Select Maximum Plan Benefit Coverage periodicity:	Select Maximum Enrollee Out-of-		
C Every three years C Every two years	Pocket Cost periodicity:	Is there an enrollee Deductible?	
Every year	C Every three years	C Yes	
Every six months	C Every two years	O Yes O No	
Every three months	C Every year C Every six months		
Other, Describe	C Every three months	Indicate Deductible Amount:	
	C Other, Describe		

#10b Transportation Services – Base 3

Volume Volume Vest	PBP Data Entry System - Section B-10, Cont	ract X0001, Plan 001, Segment 000	
WOUS Next Validate)		p: #10b Transportation Services - Base 3	
Yes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Indicate Maximum Copayment amount per trip: Notes: Indicate Maximum Copayment amount per trip: Image: Comparison of the service o	evious Next (Validate) Exit Exit (No (Validate) Validate)		
Yes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Indicate Maximum Copayment amount per trip: Notes: Indicate Maximum Copayment amount per trip: Image: Comparison of the service o			
No category. Do not repeat information captured in data entry. ndicate Minimum Copayment amount per trip: Notes: ndicate Maximum Copayment amount per trip: Image: Comparison of the second sec			
Notes: Notes:	Yes No	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.	
ndicate Maximum Copayment amount per trip: uthorization required? Yes No referral required for Transportation Services? Yes	Indicate Minimum Copayment amount per trip:	Notes:	
uthorization required? Yes No referral required for Transportation Services? Yes			
Yes No referral required for Transportation Services? Yes	Indicate Maximum Copayment amount per trip:		
Yes No referral required for Transportation Services? Yes			
No referral required for Transportation Services? Yes			
referral required for Transportation Services? Yes	Yes No		
Yes			
	No	*	

#11a DME – Base 1

	on B-11, Contract X0001, Plan 001, Se	gment 000	_ 8
Previous Next (Validate)	K Go To: #11a DME - Base 1 Exit (No Validate)	×	
CLICK FOR DESCRIPTION OF BENEFIT			
Enhanced Benefits are not applicable for this Service Category, except for MMPs. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out- of-Pocket Cost?	Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe	Is there an enrollee Deductible? C Yes C No Indicate Deductible Amount:	
C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost	Is there an enrollee Coinsurance? C Yes C No	Is there an enrollee Copayment?	
indicate Maximum Enrollee Out-of-Pocket Cost amount:	O No Indicate Minimum Coinsurance percentage for Medicare- covered Benefits:	C No Indicate Minimum Copayment amount per item for Medicare-covered Benefits:	
	Indicate Maximum Coinsurance percentage for Medicare- covered Benefits:	Indicate Maximum Copayment amount per item for Medicare-covered Benefits:	

#11a DME – Base 2

PBP Data Entry	System - Sect	ion B-11,	Contract X0	001, Plan 001	l, Segment 00)			E
Help	Exit	Exit (No	Go To: #11a D	ME - Base 2					
revious Next	Exit (Validate)	Exit (No Validate)							
a there preferred vendo	rs/manufacturers for D	urable Medical							
e there preferred vendo uipment (DME)?		urable medical							
Yes No									
uthorization required?									
Yes No									
	for this Service Catego								
		ry.							
able Medical Equipme e may include addition	nt Notes al information to descr formation captured in o	ibe benefit in th	is service						
egory. Do notrepeatir	normation captured in t	Jata entry.							
es.									
							*		

#11a DME – MMP – Base 1

PBP Data Entry System - Section B-11, Contr	act X0001, Plan 001, Segment 000	<u> </u>
	#11a DME - MMP - Base 1	
vious Next (Validate) Validate)		
LICK FOR DESCRIPTION OF BENEFIT	Is there an enrollee Coinsurance?	
es this plan provide Non-Medicare-covered Durable Medical Equipme	C Yes C No	
Yes No	Select which Non-Medicare-covered Durable Medical Equipment(s) (select all that apply):	
lect Non-Medicare-covered Durable Medical Equipment:	Durable Medical Equipment for use outside the home Other 1	
Durable Medical Equipment for use outside the home	Other 2	
Other 1 Other 2	Indicate coinsurance percentage for one Minimum Maximum	
inter name of Other 1 Service:	or more of the Coinsurance Coinsurance	
inter name of Other 2 Service:	Durable Medical Equipment for use	
	outside the home:	
there a service-specific Maximum Plan Benefit Coverage amount?	Other 1:	
Yes	Other 2:	
No Indicate Maximum Plan Benefit Coverage amount:		
Select Maximum Plan Benefit Coverage periodicity: C Every three years C Every two years C Every year C Every six months C Every hree months C Other, Describe		

#11a DME – MMP – Base 2

Fext Exit Go To: #18 DME - MMP - Base 2 revious Exit (No Validate) Validate		System - Section B-11	Contract X0001, Plan 001, Segment 000	
Yes No Select which Non-Medicare-covered Durable Medical Equipment(s) have a copayment (select all that apply): Outable Medical Equipment for use outside the home Other 2 Indicate copayment amount for one or more of the following Services: Durable Medical Equipment Copayment	e Help Previous Next	Exit Exit (No (Validate) Validate)	Go To: #11a DME - MMP - Base 2	
Yes No Select which Non-Medicare-covered Durable Medical Equipment(s) have a copayment (select all that apply): Outable Medical Equipment for use outside the home Other 2 Indicate copayment amount for one or more of the following Services: Durable Medical Equipment Copayment				
No Image: Comparent (spinwert) Selectwhich Non-Medicare-covered Durable Medical Equipment(s) have a (copayment select all that apply): Image: Comparent (spinwert) Durable Medical Equipment for use outside the home Image: Comparent (spinwert) Indicate copayment services Image: Comparent (spinwert) amount for one or more of the following Maximum (spinwert) Durable Medical Equipment for use outside the home: Image: Comparent (spinwert) Other 1: Image: Comparent (spinwert) Other 2: Image: Comparent (spinwert)		nent?		
Copayment (select all that apply): Is a referral required for Services? Durable Medical Equipment for use outside the home C Yes Other 1 Durable Medical Equipment MMP Notes Indicate copayment amount for one or more of the following services: Maximum Copayment Copayment Copayment Durable Medical Equipment for use outside the home. Durable Medical Equipment MMP Notes Notemay include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes: Notes: Other 2: Other 2:	C Yes C No			
Other 2 Indicate copayment amount for one or more of the following services: Maximum Copayment Durable Medical Equipment MMP Notes Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Durable Medical Equipment for use outside the home: Image: Comparison of the following Comparison of the following Other 2: Notes: Other 2: Image: Comparison of the following Comparison of the following Comparison of the following Other 2: Image: Comparison of the following Comparison o	Copayment (select all the Durable Medical Equip	at apply):	Is a referral required for Services?	
Indicate copayment amount for one or services: Copayment Durable Medical Equipment for use outside the home. Copayment Copayment Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes: Notes:	Other 2			
Durable Medical Equipment for use outside the home: Image: Constraint of the home: Other 1: Image: Constraint of the home: Image: Constraint of the home: Other 2: Image: Constraint of the home: Image: Constraint of the home:	amount for one or more of the following	inimum Maximum opayment Copayment	Note may include additional information to describe benefit in this service	
Other 2:	Durable Medical Equipment for use outside the home:			
		18 km = 1.		
			*	

#11b Prosthetics/Medical Supplies – Base 1

e Help Previous Next Exit (No (Validate) Go To: #11b Prosthetics/Medical Supplies - Base 1 CLICK FOR DESCRIPTION OF BENEFIT Is there an enrollee Coinsurance? Enhanced Benefits are not applicable for this Service Category, except for MMPs. Is there an enrollee Coinsurance? Maximum Plan Benefit Coverage is not applicable for this Service Category. Select Which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply): Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Select Maximum Enrollee Out-of-Pocket Cost type: C Yes Medicare-covered Prosthetic Devices Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices: Indicate Minimum Coinsurance percentage for Medicare-covered
Previous Next (Validate) CLICK FOR DESCRIPTION OF BENEFIT Is there an enrollee Coinsurance? Enhanced Benefits are not applicable for this Service Category, except for Yes No Maximum Plan Benefit Coverage is not applicable for this Service Category. Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply): Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Medicare-covered Prosthetic Devices Yes Medicare-covered Medical Supplies have a Coinsurance (Select all that apply): Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices: Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:
C Yes C No Maximum Plan Benefit Coverage is not applicable for this Service Category, except for C Yes Maximum Plan Benefit Coverage is not applicable for this Service Category. Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply): Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C Yes C No Select Maximum Enrollee Out-of-Pocket Cost type:
C Ves C No Select Maximum Enrollee Out-of-Pocket Cost type:
O Plan-specified amount period Indicate Maximum Coinsurance percentage for Medicare-covered Indicate Maximum Enrollee Out-of-Pocket Cost amount: Indicate Maximum Coinsurance percentage for Medicare-covered Select Maximum Enrollee Out-of-Pocket Cost periodicity: Indicate Minimum Coinsurance percentage for Medicare-covered O Every three years Medical Supplies: O Every two years Indicate Maximum Coinsurance percentage for Medicare-covered O Every two Indicate Maximum Coinsurance percentage for Medicare-covered Indicate Maximum Coinsurance percentage for Medicare-covered Indicate Maximum Coinsurance percentage for Medicare-covered

#11b Prosthetics/Medical Supplies – Base 2

Prior use Validate) ver an enrollee Deductible? Indicate Minimum Copayment amount per item for Medicare- covered Prosthetic Devices: dicate Deductible Amount: Indicate Maximum Copayment amount per item for Medicare- covered Prosthetic Devices: dicate Deductible Amount: Indicate Maximum Copayment amount per item for Medicare- covered Prosthetic Devices: rere an enrollee Copayment? Indicate Minimum Copayment amount per item for Medicare- covered Medical Supplies: ves Indicate Maximum Copayment amount per item for Medicare- covered Medical Supplies: Select which Prosthetic Supplies have a Copayment (Select all that apply): Indicate Maximum Copayment amount per item for Medicare- covered Medical Supplies;	Exit Exit (No	To: #11b Prosthetics/Medical Supplies - Base 2	
Yes covered Prosthetic Devices: No Indicate Maximum Copayment amount per item for Medicare- covered Prosthetic Devices: Indicate Minimum Copayment amount per item for Medicare- covered Medical Supplies: Yes Indicate Minimum Copayment amount per item for Medicare- covered Medical Supplies: Select which Prosthetics/Medical Supplies have a Copayment Medicare-covered Medical Supplies: Select which Prosthetics/Medical Supplies have a Copayment Medicare-covered Prosthetic Devices	evious Next (Validate) Validate)		
Yes covered Prosthetic Devices: No Indicate Deductible Amount: indicate Deductible Amount: Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices: intere an enrollee Copayment? Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies: Yes Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies: Select which Prosthetics/Medical Supplies have a Copayment Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies: Select all that apply): Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:	nere an enrollee Deductible?	Indicate Minimum Consyment amount per item for Medicare-	
No Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices: Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies: Yes No Select which Prosthetics/Medical Supplies have a Copayment Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies: Select which Prosthetics/Medical Supplies have a Copayment Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies: Select all that apply):		covered Prosthetic Devices:	
Indicate Maximum Copayment amount per item for Medicare- covered Prosthetic Devices: rere an enrollee Copayment? Indicate Minimum Copayment amount per item for Medicare- covered Medical Supplies: No Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply): Select which Prosthetic Devices			
here an enrollee Copayment? Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies: Yes covered Medical Supplies: No Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies: Select which Prosthetics/Medical Supplies have a Copayment Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies: Medicare-covered Prosthetic Devices Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies;	dicate Deductible Amount:	Indicate Maximum Copayment amount per item for Medicare-	
Yes covered Medical Supplies: No Select which Prosthetics/Medical Supplies have a Copayment Select all that apply): Medicare-covered Prosthetic Devices Indicate Maximum Copayment amount per item for Medicare- covered Medical Supplies;		covered Prosthetic Devices:	
Yes covered Medical Supplies: No Select which Prosthetics/Medical Supplies have a Copayment Select all that apply): Medicare-covered Prosthetic Devices Indicate Maximum Copayment amount per item for Medicare- covered Medical Supplies;			
No Select which Prosthetics/Medical Supplies have a Copayment Indicate Maximum Copayment amount per item for Medicare- covered Medical Supplies: Medicare-covered Prosthetic Devices		Indicate Minimum Copayment amount per item for Medicare-	
Select which Prosthetics/Medical Supplies have a Copayment Select all that apply): Indicate Maximum Copayment amount per item for Medicare- covered Prosthetic Devices		covered medical Supplies.	
Select all that apply): covered Medical Supplies; Medicare-covered Prosthetic Devices			
	(Select all that apply):	Indicate Maximum Copayment amount per item for Medicare- covered Medical Supplies:	
	 Medicare-covered medical Supplies 		

#11b Prosthetics/Medical Supplies – Base 3

BP Data I	Entry System -	Section B-11, Co	ontract X0001, Plan 001, Se	gment 000		5
A evious	Next (Validate	Exit (No	o To: #11b Prosthetics/Medical Supplies - E	lase 3	_	
vious	Next (Validate) Validate)				_
thorization re ('es	quired?					
No						
rral is not app	licable for this Service C	Category.				
	al Supplies Notes	describe benefit in this se	envice			
gory. Do notr	epeat information captu	red in data entry.				
15:						

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

OLICK FOR DESCRIPTION OF PENEET	Is there an enrollee Copayment?
CLICK FOR DESCRIPTION OF BENEFIT	C Yes
bes this plan provide Non-Medicare-covered Prosthetics/Medical Supplies?	
Yes No	Indicate Copayment Amount:
Enter name of Non-Medicare-covered Service:	
	Is authorization required? C Yes
I there a service-specific Maximum Plan Benefit Coverage amount?	C No
Yes	Is a referral required for Services?
No	C Yes
Indicate Maximum Plan Benefit Coverage amount:	C No
Select Maximum Plan Benefit Coverage periodicity:	Prosthetics/Medical Supplies MMP Notes
C Every three years	Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
C Every two years C Every year	Notes:
C Every six months	
C Every three months C Other, Describe	
there an enrollee Coinsurance?	
Yes	
No	
Indicate Coinsurance Percentage:	
	*

#11c Diabetic Supplies and Services – Base 1

PBP Data Entry System - Section B-11, Contrac	act X0001, Plan 001, Segment 000	_ 8 >
e Help Previous Next (Validate) Validate)	#11c Diabetic Supplies and Services - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Enhanced Benefits are not applicable for this Service Category. Maximum Plan Benefit Coverage is not applicable for this Service Category. Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes	Select which Diabetic Supplies Medicare-covered Diabetic Supplies Medicare-covered Diabetic Supplies Indicate Minium Coinsurance percentage for Medicare-covered Diabetic Supplies: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Supplies: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Supplies: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts: Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts: Indicate Deductible? Yets No Indicate Deductible Amount:	

#11c Diabetic Supplies and Services – Base 2

elo ViOUS NeXt Exit (No Validate) Go To: It 10 Diabetic Supplies and Services - Base 2 rea en enrollee Copayment? Is authorization required? res 10 Is au
Viols Next (Validate) Validate)
ere an enrollee Copayment? Is authorization required? (es to elect which Diabetic Supplies and Services have a Copayment elect which Diabetic Supplies and Services have a Copayment elect which Diabetic Supplies Medicare-covered Diabetis Supplies Medicare-covered Diabetis Supplies idicate Minimum Copayment amount per item for Medicare- overed Diabetes Supplies: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Supplies: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- overed Diabetes Therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- is the formation therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- is the formation therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- is the formation therapeutic Shoes or Inserts: idicate Minimum Copayment amount per item for Medicare- is the formation therapeutic Shoes or Inserts: idicate Minimum Copayment
res C Yes lo C No elect which Diabetic Supplies and Services have a Copayment elect all that apply): Referral is not applicable for this Service Category. Medicare-covered Diabetic Supplies Diabetic Supplies and Services Notes Medicare-covered Diabetic Supplies Diabetic Supplies and Services Notes Moticate Minimum Copayment amount per item for Medicare- overed Diabetic Supplies: Notes: dicate Minimum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: Notes: dicate Minimum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: Notes:
No Image: Constraint of No Delect which Diabetic Supplies and Services have a Copayment interface-covered Diabetic Supplies Referral is not applicable for this Service Category. Medicare-covered Diabetic Supplies Diabetic Supplies and Services Notes Modicare-covered Diabetic Supplies: Diabetic Supplies and Services Notes Moticare-covered Diabetic Supplies: Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry. Notes: Notes:
elect which Diabetic Supplies and Services have a Copayment elect all that apply): Medicare-covered Diabetic Supplies Medicare-covered Diabetic Therapeutic Shoes or Inserts dicate Minimum Copayment amount per item for Medicare- overed Diabetic Supplies: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- overed Diabetic Therapeutic Shoes or Inserts: dicate Maximum Copayment amount per item for Medicare- dicate M
ou limit Diabetic Supplies and Services to those from specified indeturers?

#12 Dialysis Services – Base 1

📟 PBP Data Entry System - Sectio	on B-12, Contract X0001, Plan 001	l, Segment 000		_ _ _ _ ×
Elle Help Previous Next (Validate)	Kit (No Validate) Go To: #12 Dialysis Services - Base	1	•	
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? C Yes C No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Select Maximum Enrollee Out-of-Pocket Cost periodicity: Cevery three years Every two years Cevery year Cevery year Cother, Describe You must include total cost sharing to the enerficiary, including any facility cost sharing. If you are a variety of cost sharing, please utilize the ninimum and maximum fields to reflect the lowest ind highest cost sharing that a beneficiary may pay. Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for Medicare-covered Benefits: Common Section S	Is there an enrollee Deductible? Yes Indicate Deductible Amount: Indicate Deductible Amount: Yes No Indicate Minimum Copayment amount per session for Medicare-covered Benefits: Indicate Maximum Copayment amount per session for Medicare-covered Benefits: Reminder: Dialysis received from an Out-of-Network provider will be covered at the In-Network cost.		

#12 Dialysis Services – Base 2

Help Go To: #12 Dialysis Services - Base 2 authorization required? Yes No areferral required for Dialysis Services? Yes No	
authorization required? Yes No a referral required for Dialysis Services? Yes No	
Yes No a referral required for Dialysis Services? Yes No	
No a referral required for Dialysis Services? Yes No	
a referral required for Dialysis Services? ¹ Yes ² No	
) Yes No	
alysis Services Notes	
ote may include additional information to describe benefit in this service legory. Do not repeat information captured in data entry.	
stes:	

#13a Acupuncture – Base 1

BPBP Data Entry System - Section	n B-13, Contract X0001, Plan 0	01, Segment 000	_ 8 ×
File Help	Go To: #13a Acupuncture - Base		
Previous Next (Validate) Va	xit (No alidate)		
CLICK FOR DESCRIPTION OF BENEFIT			
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out- of-Pocket Cost?	
O Yes O No	C Yes C No	C Yes C No	
Select enhanced benefit:	Indicate Maximum Plan Benefit Coverage amount:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select type of benefit for Number of Treatments:	Select Maximum Plan Benefit Coverage periodicity:	Select Maximum Enrollee Out-of-Pocket Cost periodicity	
C Optional	C Every three years C Every two years	C Every three years C Every two years C Every year	
Is this benefit unlimited for Number of Treatments	C Every six months C Every three months C Other, Describe	C Every seal C Every six months C Every three months C Other, Describe	
Indicate limit for Number of Treatments:			
Indicate Number of Treatments periodicity:		Is your Acupuncture benefit combined with either	
C Every three years C Every two years		the Chiropractor Services benefit or Alternative Therapies benefit, or both?	
C Every year C Every six months C Every three months C Other, Describe		C Yes C No	
C Other, Describe			
			//

#13a Acupuncture – Base 2

	M Contra Management and a second se	
evious Next (Validate)	Exit (No Validate)	
(valuate)	aunany	
nere an enrollee Coinsurance?	Is there an enrollee Copayment?	
Yes No	C Yes C No	
ndicate Minimum Coinsurance percentage:	Indicate Minimum Copayment amount per treatment:	
ndicate Maximum Coinsurance percentage:	Indicate Maximum Copayment amount per treatment:	
iere an enrollee Deductible? Yes	Is authorization required?	
No	C No	
ndicate Deductible Amount:	Is a referral required for Acupuncture?	
	C Yes	
	C No	

#13a Acupuncture – Base 3

ious	Next	Exit (Validate)	Exit (No Validate)	Go To: #13e	Acupuncture - Base 3				
ncture No									
ay includ	e additional ir	nformation to desc	cribe benefit in t	his service catego	ry. Do not repeat informatio	on captured in data entry.			
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#13b OTC Items – Base 1

Exit Exit (No	#13b OTC terms - Base 1	
evious Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
dicare-Medicaid plans may not use this section to provide benefit ormation about any OTC items that are submitted under the grated formulary. Information about hose benefits will be rered in the Rtx section of the PBP. This section should only be at op provide benefit information about OTC items that are vered as a supplemental benefit.	C Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
oes the plan provide Over-The-Counter (OTC) Items as a upplemental benefit under Part C?	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
Yes No	C Every three years C Every two years C Every year	
elect type of benefit for OTC Items:	C Every year C Every six months C Every three months	
0 Mandatory 0 Optional	C Every month	
there a service-specific Maximum Plan Benefit Coverage amount? Yes		
No	Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	
ndicate Maximum Plan Benefit Coverage amount:	C Yes O No	
Select Maximum Plan Benefit Coverage periodicity:	Nicotine Replacement Therapy (NRT) Attestation:	
C Every three years C Every two years C Every year C Every six months C Every three months C Every month	☐ The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.	
es your Maximum Plan Benefit Coverage amount carry forward to e next period ifit is unused?		
Yes		

#13b OTC Items – Base 2

Help	and the balance of th		Contract X0001, Plan 001, Segment 000	
4 Þ	Exit	X Exit (No	Go To: #13b OTC Items - Base 2	
evious Next	(Validate)	Validate)		
here an enrollee Coinsu	irance?		Is there an enrollee Copayment?	
Yes No			C Yes C No	
Indicate Minimum Coins	urance percentage:		Indicate Minimum Copayment amount:	
ndicate Maximum Coin:	surance percentage:		Indicate Maximum Copayment amount:	
nere an enrollee Deduc	tible?		Does this cover all of the OTC list which may befound in Chapter 4 of the Medicare Managed Care Manual?	
Yes			C Yes	
ndicate Deductible Amo	ount		C No	
			Authorization is not applicable for this service category.	
			Referral is not applicable for this service category.	

#13b OTC Items – Base 3

p			Go To: #13b OTC Items					
ious Nex	t (Validate)	Exit (No Validate)		- 5656 3				
ems Notes								
	onal information to des	cribe benefit in th	is service category. Do not	repeat information capture	d in data entry			
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						*		

#13c Meal Benefit – Base 1

BP Data Entry System - Section B-13, Contr	act X0001, Plan 001, Segment 000	
	#13c Meal Benefit - Base 1	
LICK FOR DESCRIPTION OF BENEFIT		
s the plan provide a Meal Benefit as a supplemental benefit	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
er Part C? Yes No	C Yes C No	
lect type of benefit for Meals:	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Mandatory Optional		
How many days does your Meal Benefit last?	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	
What is the maximum number of meals the benefit provides?	C Every three years C Every two years C Every year C Every six months	
there a service-specific Maximum Plan Benefit Coverage amount Yes No	C Every three months C Other, Describe	
elect Maximum Plan Benefit Coverage periodicity: Every three years Every two years Every year Every six months Every six months Every three months Other, Describe		

#13c Meal Benefit – Base 2

PBP Data Entry System - Section B-1 Help	3, Contract X0001, Plan 001, Segment 000	
Exit Exit (No	Go To: #13c Meal Benefit - Base 2	
revious Next (Validate) Validate)		
there an enrollee Coinsurance?	Is there an enrollee Copayment?	
Yes No	C Yes C No	
No Indicate Minimum Coinsurance percentage:	Indicate Minimum Copayment amount:	
ndicate Maximum Coinsurance percentage:	Indicate Maximum Copayment amount:	
here an enrollee Deductible? Yes	Is authorization required?	
No	C No	
ndicate Deductible Amount:	Is a referral required for the Meal Benefit?	
	C Yes	
	C No	

#13c Meal Benefit – Base 3

may include additional infor	rmation to describe benefit in this ser	vice category. Do not repeat information ca	otured in data entry.	
2				

#13d Other 1 – Base 1

PBP Data e <u>H</u> elp	a Entry S	ystem - Se	ction B-13,	, Contr	act X0001, Plan 001, Segment 000
		Exit	Exit (No	Go To	#13d Other 1 - Base 1
Previous	Next	(Validate)	Validate)	_	
CLICK FOR	DESCRIPTIO	N OF BENEFIT			Indicate Maximum Plan Benefit Coverage amount:
Note: After com ALL text in the 'I all previously e	Enter name of	ata entry in this o Service (Optiona	ategory, if you de al):' field you will	elete lose	Select Maximum Plan Benefit Coverage periodicity:
You may edit th previously ente		service text parti	ally without losin	g all	O Every two years
Do not put Med	icare-covered	benefits in this s utritional suppor	ervice category (e.g.,	C Every year C Every six months
medical device	s etc).	ounional suppor	i, nanopenateri,		C Every three months C Other, Describe
Over-the-Count should only be	ter (e.g., adult entered in B-1	diapers, band-ai 13B.	ds, etc) benefits		
If providing a si	upplemental b	enefit, enter a de:	scriptive title. "Oti	ner:	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
is not an accep	table title.				C Yes C No
Enter name of 9	Service (Optio	nal):		[
					Indicate Maximum Enrollee Out-of-Pocket Cost amount:
Select type of b		er 1:			Select Maximum Enrollee Out-of-Pocket Cost periodicity:
O Mandatory					C Every three years
C Optional					C Every two years C Every year
In these a convis	o consilio Ma	ximum Plan Ben	oft Courses an	euret?	C Every ski months
	se-specific Ma	IXIMUM Plan Den	ent Coverage an	ounty	O Every three months
C Yes C No					C Other, Describe

#13d Other 1 – Base 2

ep	Contract X0001, Plan 001, Segment 000	
vious Next (Validate) Validate)	Go To: #13d Other 1 - Base 2	
vious Next (Validate) Validate)		
ere an enrollee Coinsurance?	Is there an enrollee Copayment?	
/es	C Yes	
No	C No	
idicate Minimum Coinsurance percentage:	Indicate Minimum Copayment amount:	
idicate Maximum Coinsurance percentage:	Indicate Maximum Copayment amount:	
ere an enrollee Deductible?	Is authorization required?	
(es	O Yes	
No	C No	
idicate Deductible Amount:	Is a referral required for Other Services?	
	C Yes	
	C No	

#13d Other 1 – Base 3

ous	Next	Exit (Validate)	Exit (No Validate)	Go To: ≢	3d Other 1 - Base 3			_	
I Notes			2						
ay includ	de additional i	nformation to des	cribe benefit in	this service cate	gory. Do not repeat information	captured in data entry.			
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#13e Other 2 – Base 1

e <u>H</u> elp		
Previous Next (Validate) Go T	To: #13e Other 2 - Base 1	
(valuate) valuate)		
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Plan Benefit Coverage amount:	
Note: After completing your data entry in this category, if you delete ALL text in the "Enter name of Service (Optional):" field you will lose all previously entered data. You may edit the name of the service text partially without losing all previously entered data. Do not put Medicare-covered benefits in this service category (e.g., do not include homehealth, nutritional support, transportation, medical devices etc). Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-138. If providing a supplemential benefit, enter a descriptive title, "Other" is not an acceptable title.	Select Maximum Plan Benefit Coverage periodicity: C Every three years C Every two years C Every year C Every year C Every three months C Other, Describe Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes C No	
Enter name of Service (Optional):	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
Select type of benefit for Other 2: C Mandatory C Optional Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes No	C Every three years Every three months Every six months Every three months Other, Describe	

#13e Other 2 – Base 2

	Help	Contract X0001, Plan 001, Segment 000	
here an enrollee Coinsurance? Is there an enrollee Copayment? Yes C Yes No C No Indicate Minimum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Coinsurance percentage: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: here an enrollee Deductible? Is authorization required? Yes C Yes No No Indicate Deductible Amount: Is a referral required for Other Services? C Yes	Exit Exit (No	So To: #13e Other 2 - Base 2	
Yes C Yes No C No Indicate Minimum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Yes C Yes C No C Indicate Deductible Amount: Is authorization required for Other Services? C Yes	evious Next (Validate) Validate)		
No C: No ndicate Minimum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Deductible? Is authorization required? Yes C: Yes No C: No Indicate Deductible Amount: Is a referral required for Other Services? C: Yes C: Yes	nere an enrollee Coinsurance?	Is there an enrollee Copayment?	
Indicate Minimum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Deductible? Is authorization required? Yes C Yes No No		C Yes C No	
Indicate Maximum Coinsurance percentage: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Deductible? Is authorization required? Yes No C Yes C No Is a referral required for Other Services? C Yes C			
ere an enrollee Deductible? Is authorization required? Yes C Yes C No ndicate Deductible Amount: Is a referral required for Other Services? C Yes			
Yes C Yes C No C No C No C Yes C No C Yes C No C Yes C Y Yes C Y Yes C Y YES C	ndicate Maximum Coinsurance percentage:	Indicate Maximum Copayment amount:	
Yes C Yes C No ndicate Deductible Amount: Is a referral required for Other Services? C Yes			
No C: No Indicate Deductible Amount: Is a referral required for Other Services? C: Yes			
Is a referral required for Other Services?	No		
C Yes	ndicate Deductible Amount:	Is a referral required for Other Services?	
C No		C Yes	
		C No	

#13e Other 2 – Base 3

ious	Next	Exit (Validate)	Exit (No Validate)	Go To: 📰	3e Other 2 - Base 3				
2 Notes									
ay includ	e additional i	nformation to des	cribe benefit in	this service categ	ory. Do not repeat inform	nation captured in data entry			
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							7		

#13f Other 3 – Base 1

BPD Data Entry System - Section B-13, Co	ntract X0001, Plan 001, Segment 000	_ _
Ele Help	To: #13f Other 3 - Base 1	
Previous Next (Validate) Go		
(
CLICK FOR DESCRIPTION OF BENEFIT	Indicate Maximum Plan Benefit Coverage amount:	
CLICK FOR DESCRIPTION OF BENEFIT Note: After completing your data entry in this category, if you delete ALL text in the "Enter name of Service (Optional):" field you will lose all previously entered data. You may edit the name of the service text partially without losing all previously entered data. Do not put Medicare-covered benefits in this service category (e.g., do not include homenealth, nutritional support, transportation, medical devices etc). Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13B. If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title. Enter name of Service (Optional): C C Mandatory C Optional Is there a service-specific Maximum Plan Benefit Coverage amount? C Yes No	Select Maximum Plan Benefit Coverage periodicity: C Every three years C Every two years C Every six months C Every three months C Other, Describe Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: C Every three years C Every three years C Every six months	

#13f Other 3 – Base 2

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evidus Next (Validate) Here an enrollee Coinsurance? Is there an enrollee Copayment? Yes C No C Indicate Minimum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Coinsurance percentage: Indicate Maximum Copayment amount: Indicate Maximum Coinsurance percentage: Indicate Maximum Copayment amount: Indicate Deductible? Is authorization required? Yes No No No	
Yes C Yes No C No Indicate Minimum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Deductible? Is authorization required? Yes C No No Indicate Deductible Amount: Is a referral required for Other Services? C Yes	
Yes C Yes No C No Indicate Minimum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Coinsurance percentage: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Deductible? Is authorization required? Yes C Yes No C No Indicate Deductible Amount: Is a referral required for Other Services? C Yes	
No C No Idicate Minimum Coinsurance percentage: Indicate Minimum Copayment amount: Indicate Maximum Coinsurance percentage: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: Indicate Maximum Copayment amount: ere an enrollee Deductible? Is authorization required? Yes C No C Indicate Maximum Copayment amount: Is authorization required? Yes C No C Indicate Maximum Copayment amount: Is a referral required for Other Services? C Yes	
Indicate Maximum Coinsurance percentage: Indicate Maximum Copayment amount: Indicate Deductible? Is authorization required? Yes C No C Indicate Deductible Amount: Is a referral required for Other Services? C Yes	
ere an enrollee Deductible? Is authorization required? Yes C Yes C No ndicate Deductible Amount: Is a referral required for Other Services?	
ere an enrollee Deductible? Is authorization required? Yes C Yes C No ndicate Deductible Amount: Is a referral required for Other Services?	
Yes C Yes C No ndicate Deductible Amount: Is a referral required for Other Services? C Yes	
Yes C Yes C No ndicate Deductible Amount: Is a referral required for Other Services? C Yes	
No C No dicate Deductible Amount: Is a referral required for Other Services? C Yes	
Is a referral required for Other Services?	
C Yes	

#13f Other 3 – Base 3

	Next	Exit (Validate)	Exit (No Validate)	Go To: #13f Other 3 - Base 3		•	
er 3 Notes							
e may includ	le additional i	nformation to des	cribe benefit in	this service category. Do not repeat inf	ormation captured in data entry.		
s:							
						y.	

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

PBP Data Entry System - Section B-13, Contract X00	01, Plan 001, Segment 000
Previous Next (Validate) Go To: F139 Dut	I Eligible SNPs with Highly Integrated Services - Base 1
· ·	
CLICK FOR DESCRIPTION OF BENEFIT	Is there a service-specific Maximum Plan Benefit Coverage amount?
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.	C Yes C No Indicate Maximum Plan Benefit Coverage amount:
Dual Eligible SNPs with Highly Integrated Services Benefit Attestation	
I attest that I have received written notification from CMS that this individual SNP	Select Maximum Plan Benefit Coverage periodicity:
plan qualifies for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services for CY 2019. I turther 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) thatenrollees 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.	C Every three months
You may edit the name of the service text partially without losing all previously	C Other, Describe
entered data.	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes
If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.	O Yes O No
Enter name of Service (Optional):	Indicate Maximum Enrollee Out-of-Pocket Cost amount:
	Select Maximum Enrollee Out-of-Pocket Cost periodicity:
Select type of benefit for Dual Eligible SNPs with Highly Integrated Services: C Mandatory C Optional	C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe

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

Help	ystem - Sectio			
• •	Exit	it (No	NPs with Highly Integrated Services - Base 2	
evious Next	(Validate)	idate)		
there an enrollee Coinsur	ance?	Is there an enrollee (opayment?	
Yes	ande:	C Yes	opuyment:	
No		C No		
ndicate Minimum Coinsu	rance percentage:	Indicate Minimum	Copayment amount:	
ndicate Maximum Coins	irance percentage:	Indicate Maximum	Copayment amount:	
here an enrollee Deductil	ble?	Is authorization requ	red?	
Yes No		C Yes C No		
ndicate Deductible Amou	nt	S. NO		
Indicate Deductible Amot		Is a referral required	for Other Services?	
		C Yes C No		
		10 100		

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

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Eligible SNPs wit	h Highly Integrated Servi				
			y. Do not repeat information capture	in data entry.	
es:		an commence and a state of			
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CLICK FOR DESCRIPTION OF BENEFIT		
CLICK FOR DESCRIPTION OF BENEFIT	Enter name of Other 1 Service:	
s the plan provide Additional Services?	Enter name of Other 2 Service:	
res Io	Enter name of Other 2 Service:	
Select Additional Services (select all that apply):		
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women	Enter name of Other 3 Service:	
Freestanding Birth Center Services		
Respiratory Care Services Family Planning Services	Enter name of Other 4 Service:	
Nursing Home Services		
Home and Community Based Services Personal Care Services	Enter name of Other 5 Service:	
Self-Directed Personal Assistance Services		
Private Duty Nursing Services Case Management (Long Term Care)		
nstitution for Mental Disease Services for Individuals 65 or Older Services in an Intermediate Care Facility for Individuals with Intellectual Disabili	Enter name of Other 6 Service:	
Case Management		
Dther 1 Dther 2	Enter name of Other 7 Service:	
Other 3		
Other 4 Other 5	Enter name of Other 8 Service:	
Other 6		
Other 7 Other 8	Enter name of Other 9 Service:	
Other 9 Other 10		
Other 11		
Other 12 Other 13	Enter name of Other 10 Service:	
Other 14		
Other 15 Other 16	Enter name of Other 11 Service:	
Other 17		
Other 18 Other 19	Enter name of Other 12 Service:	
Other 20 Other 21		
Other 22	Entrement of Other 10 One-last	
Other 23	Enter name of Other 13 Service:	
58161 25		

vious Next (Validate) G		
r name of Other 14 Service:	Enter name of Other 27 Service:	
r name of Other 15 Service:	Enter name of Other 28 Service:	
r name of Other 16 Service:	Enter name of Other 29 Service:	
r name of Other 17 Service:	Enter name of Other 30 Service:	
r name of Other 18 Service:	Enter name of Other 31 Service:	
r name of Other 19 Service:	Enter name of Other 32 Service:	
r name of Other 20 Service:	Enter name of Other 33 Service:	
r name of Other 21 Service:	Enter name of Other 34 Service:	
r name of Other 22 Service:	Enter name of Other 35 Service:	
r name of Other 23 Service:	Enter name of Other 36 Service:	
r name of Other 24 Service:	Enter name of Other 37 Service:	
r name of Other 25 Service:	Enter name of Other 38 Service:	
r name of Other 26 Service:		

Yeards Yeards Yeards		Exit Exit (Go To: #13h A	Additional Services - Base 3
Yes Safed Additional Services where a limit applies: Enty Proceeds Construct, Dispracis, and Treatment (EPSDT) Services Freestanding Efficiences Services Respiratory Care Services Respiratory Care Services Nardia Fore Services Nardia Fore Services Service Services Indicate numerical limit on the services provided for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: Services in an Internetate Care Facility for Individuals 86 or Other Services in an Internetate Care Facility for Individuals 86 or Other Other 1 Other 2 Other 3 Other 4 Other 1 Other 1 Other 1 Other 1 Other 1 Other 1 Other 2 Other 3 Other 4 Other 3 Other 4 Other 4 Other 3 Other 4 Other 4 Other 5 Other 4 Other 4 Other 5 Other 4 Other 4 Other 5	is Next	(Validate) Valida	,No ate)	
Yes Seted Additional Garcies where a limit applies: Entry and Franced arrowshy (by Polic, and Treatment (EPSOT) Services Feakh and Bith Carlier Services Respiratory Carlier Services Respiratory Services Norman Control Services Namagement (Long Terrices for thoriduals of Sor Ober SetContext Personal Assistance Services Phyrolity: and Treatment (EPSOT) Services: Private Duty Numing Services SetContext Personal Assistance Services Private Duty Numing Services SetContext Personal Assistance Services Private Duty Numing Services SetContext Personal Assistance Services for thoriduals with Intelectual Disatility Case Management (Long Term Care) SetContext Personal Assistance Services for thoriduals with Intelectual Disatility Other 1 Other 2 Other 3 Other 4 Other 4 Other 10 Other 4 Other 4 Other 4 Other 4 Other 5 Other 4 Other 5 Other 4 Other 5 Other 5 O				
No Seried Additional Services where a limit applies: Enty and Periods Corresing. Diagnosis, and Treatment (PSDT) Services Freestandy Diagnosis, and Treatment (PSDT) Services Parsonal Care Services Berlored Periods Services in Intermediate Care Services Private Diagnosis, and Treatment (PSDT) Services: Private Diagnosis, and Treatment (PSDT) Services Private Diagnosis, and Treatment (PSDT) Services: Services in Intermediate Care Services Other 1 Other 3 Other 4 Other 4 Other 5 Other 10 Other 10 Other 10 Other 10 Other 12 Other 13 Other 14 Other 14 Other 15 Other 16 Other 17 Other 18 <	imit on the Additi	onal Services provided?		Indicate units a limit will be provided in for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:
Sade2 Additional services internant (EPSOT) Services Freestands Care Services Freestands Fre				
Lafy and periods Screening, Usgnassis, and Treatment (E-SUI) Services Thoraco Cassabio for Program Women Respiratory Care Services Hursing from Services Hursing from Services Hursing from Services Hursing from Services How and Care Services How and Care Services How and Disease Services for holdwalk 65 or Older Services in an Intermediate Care Facility for Individuals with Intelectual Disability Case Management Case				
Freestandy Gene Services Family Planting Services Family Planting Services Family Planting Services Family Planting Services Friende Care Genes Fr			ant (EPSDT) Services	C Points
Family Planning Services Indicate numerical limit on the services provided for Early and Periodic Screening. Wrans home Services Diagnostic, and Treatment (EPSOT) Services: Services in thermodate Care Facility for Individuals 65 or Other Select limit on services provided for Early and Periodic Screening. Diagnostic, and Treatment (EPSOT) Services: Services in an thermodate Care Facility for Individuals 65 or Other Select limit on services provided for Early and Periodic Screening. Diagnostic, and Treatment (EPSOT) Services. Services in an thermodate Care Facility for Individuals 65 or Other Select limit on services provided for Early and Periodic Screening. Diagnostic, and Treatment (EPSOT) Services. Case Management Cervery adv Cervery adv Other 2 Cervery vesk Cervery vesk Cherey Session/Nistit Cervery Vest month Cervery Vest month Other 10 Cervery Vest Monter Cervery Vest Monter Other 13 Cervery Vest Monter Cervery Vest Monter Other 23 Cervery adv Cervery des for Other Other 23 Select limit on services provided for Tobacco Cessation Counseling for Pregnant Women: Other 23 Select limit on services provided for Tobacco Cessation Counseling for Pregnant Women: Cervery day Cervery day Cervery vesk Cervery day Ce	standing Birth Cer	ter Services		
Nursing forme Services Indicate numerical limit on the services provided for Early and Periodic Screening, Diagnostic, and Teatment (EPSDT) Services: Sel Ortect de Personal Assistance Services Private Duty Nursing Services Private Duty Nursing Services Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Teatment (EPSDT) Services: Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Teatment (EPSDT) Services: Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Teatment (EPSDT) Services: Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Teatment (EPSDT) Services: Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Teatment (EPSDT) Services: Services in an Instrument (EPSDT) Services: Cervery assisted to services periodicity for Early and Periodic Screening, Diagnostic, and Teatment (EPSDT) Services: Other 3 Cervery assisted to services periodicity for Early and Periodic Screening, Diagnostic, and Teatment (EPSDT) Services: Other 4 Cervery assisted to services periodicity for Early and Periodic Screening, Diagnostic, and Teatment (EPSDT) Services: Other 5 Cervery assisted to services periodicity for Tobacco Cessation Counseling for Pregnant Women: Other 40 Cervery assisted to services provided for Tobacco Cessation Counseling for Pregnant Women: Other 20 Cervery das Cervery assisted to services period				
Personal Care Services Selectlimit on services periodicity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. Selectlimit on for liental Disease Services for Individuals 65 or Older Selectlimit on services periodicity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. Case Management C Every day Other 1 C Every year C Every Session/Nisit C Every Session/Nisit C Every Very Utefance C Every Session/Nisit C Every Session/Nisit C Every Session	ing Home Service	3		Indicate numerical limit on the services provided for Early and Periodic Screening, Diagnostic and reatment (PERDT) Services
Private Duty Nursing Services Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Technology for Early and Periodic Screening, Diagnostic, and Technology for Early and Periodic Screening, Diagnostic, and Technology for Individuals 65 or Older Services in an Intermediate Care Facility for Individuals with Intelectual Disability Every day Case Management Every week Other 1 Every week Other 3 Every perpancy Cher 4 Every perpancy Other 5 Every Perpancy Other 6 Other, Describe Indicate units a limit will be provided in for Tobacco Cessation Counseling for Tengant Women: Other 10 Sessions Other 12 Visit Other 13 Every war Other 14 Sessions Other 22 Visit Other 23 Visit Select limit on the services provided for Tobacco Cessation Counseling for Pregnant Women: Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women: Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women: Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women: Other 23 Select limiton the services provided for Tobacco Cessation Counseli	onal Care Service	5		Diagnositi, and Treatment (LFSDT) Services.
Case Management (Long Term Care) histuiton for Metal Disease Services for Individuals 65 or Older Services in an Intermedide Care Facility for Individuals with Intellectual Disability Other 3 Other 4 Other 4 Other 4 Other 5 Other 6 Other 6 Other 7 Other 6 Other 7 Other 9 Other 10 Other 11 Other 11 Other 13 Other 14 Other 14 Other 14 Other 15 Other 17 Other 18 Other 19 Other 20 Other 20 Other 23 Other 23 Other 23 Other 22 Other 24 Other 24 Other 25 Other 25 Other 24 Other 25 Other 3 Other 4 Other 4 Other 4 Other 5 Other 5 Other 5 Other 6 Other 7 Other 5 Other 7 Other 5 Other 10 Other 10 Other 11 Other 14 Other 15 Other 16 Other 19 Other 20 Other 23 Other 23 Other 24 Other 24 Other 24 Other 24 Other 24 Other 24 Other 24 Other 24 Other 25 Other 25 Ot				
Services in an intermediate Care Facility for individuals with Intellectual Disability Case Management Other 1 Other 3 Other 3 Other 4 Other 4 Other 4 Other 5 Other 6 Other 7 Other 6 Other 7 Other 7 Other 7 Other 8 Other 9 Other 9 Other 10 Other 11 Other 11 Other 13 Other 14 Other 14 Other 15 Other 19 Other 19 Other 22 Other 23 Select limit on services provided for Tobacco Cessation Counseling for Pregnant Women: Other 6 Other 10 Other 10 Other 11 Other 11 Other 12 Other 12 Other 3 Other 3 Other 3 Other 3 Other 4 Other 4 Other 4 Other 4 Other 4 Other 4 Other 5 Other 5 Other 4 Other 4 Other 5 Other 5 Other 5 Other 4 Other 10 Other 20 Other 2	Management (Lo	ng Term Care)		Select limit on services periodicity for Larly and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:
case Management C Every week Other 1 C Every week Other 2 Select Minton services provided for Tobacco Cessation Counseling for Pregnant Other 10 C Serving Selection Counseling for Pregnant Other 13 C Serving Selection Counseling for Pregnant Other 14 C Selection Counseling for Pregnant Other 15 C Selection Counseling for Pregnant Other 16 C Selection Counseling for Pregnant Other 18 C Selection Counseling for Pregnant Other 19 C Selection Counseling for Pregnant Other 22 Selecting Selection Counseling for Pregnant Other 23 Selecting Selection Counseling for Pregnant				C Every day
other 2 other 3 other 4 other 4 other 5 other 6 other 6 other 7 other 7 other 7 other 9 other 10 other 11 other 12 other 13 other 14 other 14 other 15 other 14 other 18 other 18 other 18 other 19 other 22 other 22 other 23 Therefore the services provided for Tobacco Cessation Counseling for Pregnant Women: C Sessions Other 10 other 11 other 12 other 12 other 12 other 13 other 14 other 14 other 15 other 12 other 22 other 22 other 22 other 23 Therefore the services provided for Tobacco Cessation Counseling for Pregnant Women: C Sessions C Mails C Items/other, Describe Indicate numerical limit on the services provided for Tobacco Cessation Counseling for Pregnant Women: C Every day C Every week C Every week C Every week C Every week C Every Year C Every Year C Every Year C Every Session/Nisit C Every Year C Every Ye	Management	date care racinty for individual	a with intellectual biadbillit	
other 3 C Every Session/Nsit other 4 C Every Pregnancy other 5 C Every Pregnancy other 6 C Other, Describe other 7 Indicate units a limit will be provided in for Tobacco Cessation Counseling for other 7 Indicate units a limit will be provided in for Tobacco Cessation Counseling for other 7 Sessions other 10 C Sessions other 12 Visits other 14 O Iter, Describe other 16 Meals other 10 Indicate numerical limiton the services provided for Tobacco Cessation Counseling for other 13 Hems/Other, Describe other 14 Other, Describe other 15 Meals other 20 Indicate numerical limiton the services provided for Tobacco Cessation Counseling for Pregnant Women: other 21 Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women: other 22 Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women: C Every day Every year C Every year Every year C Every Year Every Year C Every Year Every Year				
Other 5 C berly Frégliant/y Other 6 C berly Lifetime Other 7 Indicate units a limit/y Other 10 Sessions Other 12 Sessions Other 15 Hours Other 16 Hours Other 18 Indicate numerical limiton the services provided for Tobacco Cessation Counseling for Pregnant Women: Indicate numerical limiton the services provided for Tobacco Cessation Counseling for Pregnant Women: Other 20 Other 21 Other 22 Other 23	r 3			C Every Session/Visit
Other 6 Cother, Describe Other 7 Indicate units a limit will be provided in for Tobacco Cessation Counseling for Other 10 Pregnant Women: Other 11 Sessions Other 12 Visits Other 13 Hours Other 16 Hours Other 16 Hours Other 17 Indicate units a limit will be provided for Tobacco Cessation Counseling for Other 18 Indicate units a limit will be provided for Tobacco Cessation Counseling for Pregnant Women: Other 19 Indicate units a limit will be provided for Tobacco Cessation Counseling for Pregnant Women: Other 22 Select limiton services periodicity for Tobacco Cessation Counseling for Pregnant Women: Other 23 Every day Every day Every weak Every vear Every weak Every vear Every vear Every Session/Visit Every Vear Every Utifutine Every Utifutine				
Other 8 Indicate units a limit will be provided in for Tobacco Cessation Counseling for Pregnant Women: Other 10 C Other 11 C Other 12 Visits Other 13 Hours Other 16 Hours Other 16 Meals Other 17 Indicate numerical limit on the services provided for Tobacco Cessation Counseling for Pregnant Women: Other 18 Indicate numerical limit on the services provided for Tobacco Cessation Counseling for Pregnant Women: Other 20 Indicate numerical limit on the services provided for Tobacco Cessation Counseling for Pregnant Women: Other 23 Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women: C Every day C Every day C Every week C Every year C Every year C Every Session/Visit C Every Ufetime				
Other 9 Pregnant Women: Other 10 © Sessions Other 11 © Sessions Other 12 © Visits Other 13 © Hours Other 14 © Hours Other 15 © Points Other 16 © Items/Other, Describe Indicate numerical limit on the services provided for Tobacco Cessation Counseling for Pregnant Women: Other 20 Indicate numerical limit on the services provided for Tobacco Cessation Counseling for Pregnant Women: Other 22 Select limiton services periodicity for Tobacco Cessation Counseling for Pregnant Women: Other 23 Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women: © Every week Every week © Every week Every week © Every gasnocy Every Session/Visit © Every Lifetime Every Lifetime				Indiana verita a limituili ha pravidad in far Tabasan Caractian Cavarating far
Other 11 C Sessions Other 12 Visits Other 13 Points Other 14 Points Other 15 Meals Other 16 Indicate numerical limiton the services provided for Tobacco Cessation Counseling for Pregnant Women: Other 21 Select limiton services periodicity for Tobacco Cessation Counseling for Pregnant Other 23 Select limiton services periodicity for Tobacco Cessation Counseling for Pregnant © Every weak © Every weak © Every weak © Every weak © Every sear © Every pregnancy © Every SesionNisit © Every Lifetime				
Other 13 Other 13 Other 14 Other 15 Other 15 Meals Other 16 Indicate numerical limit on the services provided for Tobacco Cessation Counseling for Pregnant Women: Other 20 Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women: Other 22 Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women: Other 23 Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women: C Every week C Every session/Visit C Every Session/Visit C Every Lifetime	r 11			
Other 14 Other 13 Other 16 Other 16 Other 17 Other 18 Other 19 Other 20 Other 21 Other 22 Other 23 Select limit on services provided for Tobacco Cessation Counseling for Pregnant Women: Every weak Every buffetime Every Lifetime Every Lifetime 			-	
Other 16 C Meals Other 17 C Items/Other, Describe Other 19 C Indicate numerical limiton the services provided for Tobacco Cessation Counseling for Pregnant Women: Other 20 C Select limiton services periodicity for Tobacco Cessation Counseling for Pregnant Other 22 C Select limiton services periodicity for Tobacco Cessation Counseling for Pregnant Other 23 C Every weak C Every weak Every weak C Every year Every year C Every Sesion/Nsit Every Sesion/Nsit C Every Lifetime Every Lifetime	r 14			
Other 17 C Items/Other 18 Other 18 Indicate numerical limiton the services provided for Tobacco Cessation Counseling for Pregnant Women: Other 20 Select limiton services periodicity for Tobacco Cessation Counseling for Pregnant Women: Other 22 Select limiton services periodicity for Tobacco Cessation Counseling for Pregnant Women: C Every day C Every week C Every year C Every year C Every Session/Visit C Every Lifetime				
Other 19 Indicate Indicate Indicate Provided for Focace Cessation Courseling Other 20 Select limiton services periodicity for Tobacco Cessation Courseling for Pregnant Other 22 Select limiton services periodicity for Tobacco Cessation Courseling for Pregnant Other 23 C Every day C Every week Every week C Every year Every year C Every Session/Visit Every Session/Visit C Every Lifetime Every Lifetime	r 17			C Items/Other, Describe
Other 20 Other 21 Other 22 Select limiton services periodicity for Tobacco Cessation Counseling for Pregnant Women: C Every day C Every weak C Every weak C Every year C Every year C Every Session/Nsit C Every Pregnancy C Every Lifetime				
Other 22 Other 23 Select limiton services periodicity for Tobacco Cessation Counseling for Pregnant Women: C Every day Every day C Every week Every week C Every year Every year C Every Pregnancy Every Pregnancy C Every Lifetime Every Lifetime				
Women: C Every day C Every week C Every month C Every year C Every Session/Nit C Every Session/Nit C Every Pregnancy C Every Lifetime				
C Every week C Every month C Every year C Every Session/Visit C Every Session/Visit C Every Pregnancy C Every Lifetime	r 23			Select limit on services periodicity for I obacco Cessation Counseling for Pregnant Women:
C Every week C Every month C Every year C Every Session/Nitt C Every Pregnancy C Every Lifetime				
C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime				
C Every Session/Visit C Every Pregnancy C Every Lifetime				
C Every Lifetime				C Every Session/Visit

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Go To: #13h Additional Servic	rs - Base 4
Previous Next (Validate) Validate)	
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Indicate units a limit will be provided in for Freestanding Birth Center Services: Indicate un	its a limit will be provided in for Family Planning Services:
O Sessions O Sessio	ns
C Visits C Visits	
C Hours C Hours	
C Points C Points	
C Meals C Meals	
O Items/Other, Describe	Dther, Describe
	imerical limit on the services provided for Family Planning Services:
Services:	
Select limit on services periodicity for Freestanding Birth Center Services: Select lim	on services periodicity for Family Planning Services:
C Every day	
O Every week O Every	
C Every month C Every	
O Every year O Every	
	Session/Visit Pregnancy
C Every Pregnancy C Every C Every Lifetime C Every	
	Describe
	nits a limit will be provided in for Nursing Home Services:
C Sessions C Sessi C Visits C Visits	ons
C Visits C Hours	
C Points C Point	
O Meals O Meals	
	Other, Describe
Indicate numerical limit on the services provided for Respiratory Care Services: Indicate r	umerical limit on the services provided for Nursing Home Services:
	t on services periodicity for Nursing Home Services:
C Every day	
C Every week C Every	
C Every month C Every	
O Every year O Every	
	Session/Visit
C Every Pregnancy C Every C Every Lifetime C Every	Pregnancy
	Describe
	Describe

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revious Next (Valid	ate) Validate)		
	for Home and Community Based Services:	Indicate units a limit will be provided in for Self-Directed Personal Assistance Services:	
Sessions		C Sessions	
O Visits		C Visits	
O Hours		C Hours	
O Points O Meals		C Points	
O Meals O Items/Other, Describe		C Meals C Items/Other, Describe	
	provided for Home and Community Based	Indicate numerical limit on the services provided for Self-Directed Personal	
Services:		Assistance Services:	
Select limit on services periodicity for H	Iome and Community Based Services:	Select limit on services periodicity for Self-Directed Personal Assistance Services:	
C Every day		C Every day	
C Every week		C Every week	
C Every month		C Every month	
O Every year		C Every year	
C Every Session/Visit		C Every Session/Visit	
C Every Pregnancy		O Every Pregnancy	
C Every Lifetime		O Every Lifetime	
C Other, Describe		O Other, Describe	
Indicate units a limit will be provided in	for Personal Care Services:	Indicate units a limit will be provided in for Private Duty Nursing Services:	
C Sessions		C Sessions	
C Visits		O Visits	
C Hours		C Hours	
C Points		O Points	
C Meals		O Meals	
C Items/Other, Describe		C Items/Other, Describe	
Indicate numerical limit on the services	provided for Personal Care Services:	Indicate numerical limit on the services provided for Private Duty Nursing Services:	
Select limit on services periodicity for F	Personal Care Services:	Select limit on services periodicity for Private Duty Nursing Services:	
C Every day		C Every day	
C Every week		C Every week	
C Every month		C Every month	
C Every year		O Every year	
C Every Session/Visit		C Every Session/Visit	
Č Every Pregnancy		O Every Pregnancy	
C Every Lifetime		O Every Lifetime	
C Other, Describe		O Other, Describe	

PBP Data Entry System - Section B-13, Contract X00	01, Plan 001, Segment 000	
jile <u>H</u> elp		
Go To: #13h Add	litional Services - Base 6	
Previous Next (Validate) Validate)		
Indicate units a limit will be provided in for Case Management (Long Term Care):	Indicate units a limit will be provided in for Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities:	
C Sessions	C Sessions	
C Visits	C Visits	
C Hours	C Hours	
C Points	C Points	
C Meals	C Meals	
C Items/Other, Describe	C Items/Other, Describe	
Indicate numerical limit on the services provided for Case Management (Long Term	Indicate numerical limit on the services provided for Services in an Intermediate Care	
Care):	Facility for Individuals with Intellectual Disabilities:	
Select limit on services periodicity for Case Management (Long Term Care):	Select limit on services periodicity for Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities:	
C Every day	C Every day	
O Every week	C Every week	
O Every month	O Every month	
C Every year	C Every year	
C Every Session/Visit	C Every Session/Visit	
C Every Pregnancy	C Every Pregnancy	
C Every Lifetime	C Every Lifetime	
C Other, Describe	C Other, Describe	
Indicate units a limit will be provided in for Institution for Mental Disease Services for Individuals 65 or Older:	Indicate units a limit will be provided in for Case Management:	
C Sessions	C Sessions	
C Visits	C Visits	
C Hours	O Hours	
C Points	C Points	
O Meals	C Meals	
C Items/Other, Describe	C Items/Other, Describe	
Indicate numerical limit on the services provided for Institution for Mental Disease Services for Individuals 65 or Older:	Indicate numerical limit on the services provided for Case Management:	
Select limit on services periodicity for Institution for Mental Disease Services for Individuals 65 or Older:	Select limit on services periodicity for Case Management:	
C Every day	C Every day	
C Every week	O Every week	
C Every month	C Every month	
O Every year	C Every year	
C Every Session/Visit	C Every Session/Visit	
C Every Pregnancy	C Every Pregnancy	
C Every Lifetime	C Every Lifetime	
O Other, Describe	C Other, Describe	

PBP Data Entry System - Section B-13, C	ontract X0001, Plan 001, Segment 000	_ 8
	Go To: #13h Additional Services - Base 7	
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Indicate units a limit will be provided in for Other 1:	Indicate units a limit will be provided in for Other 3:	
C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe	C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe	
Indicate numerical limit on the services provided for Other 1:	Indicate numerical limit on the services provided for Other 3:	
Select limit on services periodicity for Other 1:	Select limit on services periodicity for Other 3:	
C Every day C Every week C Every month C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe	C Every day C Every week C Every month C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe	
Indicate units a limit will be provided in for Other 2:	Indicate units a limit will be provided in for Other 4:	
C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe	C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe	
Indicate numerical limit on the services provided for Other 2:	Indicate numerical limit on the services provided for Other 4:	
Select limit on services periodicity for Other 2:	Select limit on services periodicity for Other 4:	
C Every day C Every week C Every month C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe	C Every day C Every week C Every month C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe	

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nettodo next	Exit Exit (No (Validate) Validate)	Go To: #13h Additional Services - Base 8
	validate) validate)	
Indicate units a limit will be provid	led in for Other 5:	Indicate units a limit will be provided in for Other 7:
C Sessions		C Sessions
C Visits		O Visits
O Hours		O Hours
C Points		O Points
C Meals		O Meals
O Items/Other, Describe		C Items/Other, Describe
ndicate numerical limit on the ser	vices provided for Other 5:	Indicate numerical limit on the services provided for Other 7:
Select limit on services periodicit	y for Other 5:	Select limit on services periodicity for Other 7:
C Every day		C Every day
C Every week		C Every week
C Every month		C Every month
C Every year		C Every year
C Every Session/Visit C Every Pregnancy		C Every Session/Visit C Every Pregnancy
C Every Lifetime		C Every Pregnancy C Every Lifetime
Ö Other, Describe		
ndicate units a limit will be provid	(ed in for Other 6:	Indicate units a limit will be provided in for Other 8:
C Sessions		C Sessions
C Visits		O Visits
C Hours		O Hours
C Points		C Points
C Meals		O Meals
C Items/Other, Describe		C Items/Other, Describe
Indicate numerical limit on the ser	vices provided for Other 6:	Indicate numerical limit on the services provided for Other 8:
Select limit on services periodicit	y for Other 6:	Select limit on services periodicity for Other 8:
C Every day		O Every day
C Every week		C Every week
C Every month		C Every month
C Every year		C Every year
C Every Session/Visit C Every Pregnancy		C Every Session/Visit C Every Pregnancy
C Every Pregnancy C Every Lifetime		C Every Lifetime
O Other, Describe		

Help		
Exit Exit (No	#13h Additional Services - Base 9	
evious Next (Validate) Validate)		
dicate units a limit will be provided in for Other 9:	Indicate units a limit will be provided in for Other 11:	
Sessions Visits Hours Points Meals Items/Other, Describe	C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe	
dicate numerical limit on the services provided for Other 9:	Indicate numerical limit on the services provided for Other 11:	
lect limit on services periodicity for Other 9:	Select limit on services periodicity for Other 11:	
Every day Every week Every month Every year Every Session/Visit Every Pregnancy Every Lifetime Other, Describe	C Every day C Every week C Every month C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe	
dicate units a limit will be provided in for Other 10:	Indicate units a limit will be provided in for Other 12:	
Sessions Visits Hours Points Meals Items/Other, Describe	C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe	
dicate numerical limit on the services provided for Other 10:	Indicate numerical limit on the services provided for Other 12:	
lect limit on services periodicity for Other 10:	Select limit on services periodicity for Other 12:	
Every day Every wek Every wek Every month Every Session/Visit Every Session/Visit Every Pregnancy Every Lifetime Other, Describe	C Every day C Every week C Every week C Every year C Every year C Every Pregnancy C Every Pregnancy C Every Lifetime C Other, Describe	

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Previous Next (Validate) Validate)	Go To: #13h Additional Services - Base 10	
Previous Next (Validate) Validate)		
ndicate units a limit will be provided in for Other 13:	Indicate units a limit will be provided in for Other 15:	
C Sessions C Visits C Hours C Points C Meals	C Sessions C Visits C Hours C Points O Meals	
C Items/Other, Describe	C Items/Other, Describe	
ndicate numerical limit on the services provided for Other 1	Indicate numerical limit on the services provided for Other 15:	
Select limit on services periodicity for Other 13:	Select limit on services periodicity for Other 15:	
C Every day C Every week C Every wonth C Every year C Every Year C Every Pregnancy C Every Lifetime C Other, Describe	C Every day C Every week C Every month C Every Session/Visit C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe	
ndicate units a limit will be provided in for Other 14:	Indicate units a limit will be provided in for Other 16:	
C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe	C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe	
ndicate numerical limit on the services provided for Other 1	Indicate numerical limit on the services provided for Other 16:	
Select limit on services periodicity for Other 14:	Select limit on services periodicity for Other 16:	
C Every day C Every week C Every month C Every year C Every Session/Visit C Every Fregnancy C Every Lifetime C Other, Describe	C Every day C Every week C Every month C Every year C Every Session/Visit C Every Pregnancy C Every Hifetime C Other, Describe	

Indicate units a limit will be provided in for Other 19: Sessions Visits Hours Points Items/Other, Describe Indicate numerical limit on the services provided for Other 19: Select limit on services periodicity for Other 19: Every day Every weak Every weak Every weak Every month Every Pregnancy Every Pregnancy Every Pregnancy Every Describe	
C Sessions C Visits C Hours O Points C Meals C Items/Other, Describe Indicate numerical limit on the services provided for Other 19: Select limit on services periodicity for Other 19: C Every day C Every week C Every week C Every year C Every year C Every Session/Visit C Every pregnancy C Every Itelime	
C Sessions C Visits C Hours O Points C Meals C Items/Other, Describe Indicate numerical limit on the services provided for Other 19: Select limit on services periodicity for Other 19: C Every day C Every week C Every week C Every year C Every year C Every Session/Visit C Every pregnancy C Every Itelime	
C Visits C Hours C Points C Meals C Items/Other, Describe Indicate numerical limit on the services provided for Other 19: Select limit on services periodicity for Other 19: C Every day C Every week C Every week C Every week C Every vear C Every vear C Every Vear C Every Vear C Every Pregnancy C Every Itelime C Every Itelime	
Indicate numerical limit on the services provided for Other 19: Select limit on services periodicity for Other 19: C Every day C Every week C Every week C Every week C Every session/Nisit C Every Session/Nisit C Every Pregnancy C Every Pregnancy C Every Itelime	
C Every day C Every week C Every month C Every Session/Visit C Every Pregnancy Every Ifetime	
C Every day C Every week C Every month C Every Session/Visit C Every Pregnancy Every Ifetime	
Indicate units a limit will be provided in for Other 20:	
C Sessions C Visits C Hours C Points C Meals C Items/Other. Describe	
Indicate numerical limit on the services provided for Other 20:	
Select limit on services periodicity for Other 20:	
C Every day C Every week C Every month C Every year C Every Session/Visit C Every Fregnancy C Every Lifetime	
	C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe Indicate numerical limit on the services provided for Other 20: Select limit on services periodicity for Other 20: C Every day C Every week C Every month C Every Session/Visit C Every Session/Visit C Every Session/Visit

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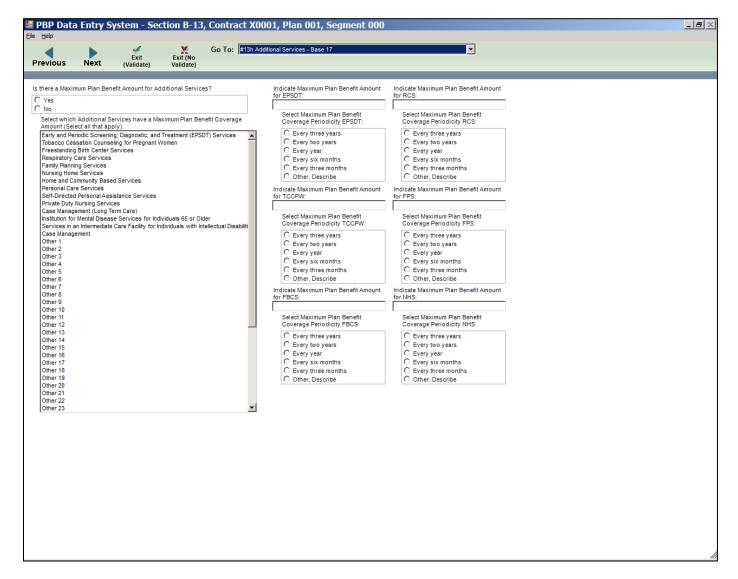
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dicate units a limit will be pro	vided in for Other 21:	Indicate units a limit will be provided in for Other 23:	
Sessions Visits Hours Points Meals Items/Other, Describe		C Sessions C Visits C Hours C Points C Meals C Items/other, Describe	
	services provided for Other 21	Indicate numerical limit on the services provided for Other 23:	
elect limit on services period	icity for Other 21:	Select limit on services periodicity for Other 23:	
Every day Every week Every month Every year Every Session/Visit Every Pregnancy Every Lifetime O ther, Describe		C Every day C Every week C Every month C Every year C Every Session/Visit C Every Prepanacy C Every Lifetime C Other, Describe	
dicate units a limit will be pro	vided in for Other 22	Indicate units a limit will be provided in for Other 24:	
Sessions Visits Hours Points Meals Items/Other, Describe		C Sessions C Visits C Hours C Points C Meals C Items/Other, Describe	
dicate numerical limit on the	services provided for Other 22	Indicate numerical limit on the services provided for Other 24:	
elect limit on services period	icity for Other 22:	Select limit on services periodicity for Other 24:	
Every day Every week Every month Every year Every Session/Visit Every Pregnancy Every Lifetime Other, Describe		C Every day C Every week C Every month C Every year C Every Session/Visit C Every Pregnancy C Every Lifetime C Other, Describe	

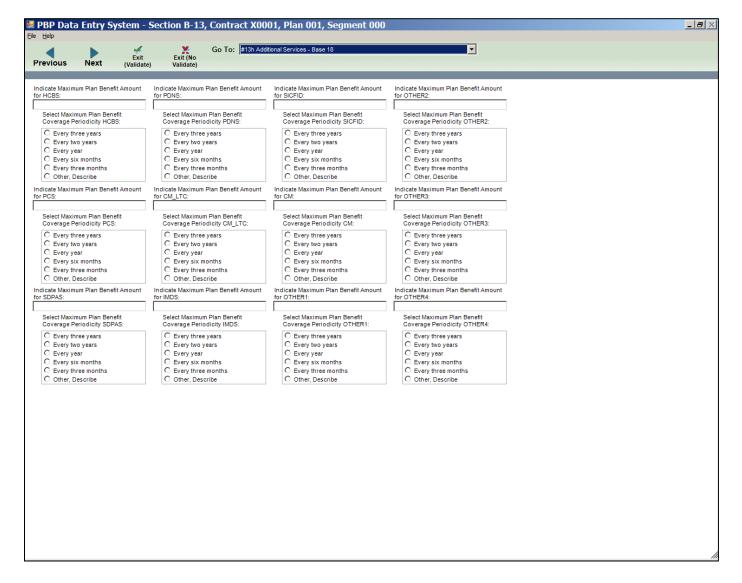
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Terious Trext	(validate) validate)	
Indicate units a limit will be p	rovided in for Other 25:	Indicate units a limit will be provided in for Other 27:
C Sessions C Visits C Hours		C Sessions C Visits C Hours
O Points O Meals		C Points C Meals
C Items/Other, Describe		O Items/Other, Describe
Indicate numerical limit on th	e services provided for Other 25:	Indicate numerical limit on the services provided for Other 27:
Select limit on services perio	dicity for Other 25	Select limit on services periodicity for Other 27:
C Every day		C Every day
C Every week		C Every week
C Every month		C Every month
C Every year		C Every year
C Every Session/Visit		C Every Session/Visit
C Every Pregnancy		C Every Pregnancy
O Every Lifetime O Other, Describe		O Every Lifetime O Other, Describe
ndicate units a limit will be p O Sessions	rovided in for Other 26:	Indicate units a limit will be provided in for Other 28:
O Visits		C sessions
C Hours		C visits C Hours
O Points		C Pours
O Meals		C Meals
C Items/Other, Describe		C Means/Other, Describe
	e services provided for Other 26:	Indicate numerical limit on the services provided for Other 28:
	e services provided for Other 26.	
Select limit on services perio	dicity for Other 26:	Select limit on services periodicity for Other 28:
C Every day		C Every day
C Every week		C Every week
C Every month		C Every month
C Every year		C Every year
C Every Session/Visit		C Every Session/Visit
C Every Pregnancy C Every Lifetime		C Every Pregnancy
O Other, Describe		C Other, Describe

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Previous Next	Exit Exit (No (Validate) Validate)	GO TO: J#1511 Auditurial Services - Dase 14
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Indicate units a limit will be p	rovided in for Other 29:	Indicate units a limit will be provided in for Other 31:
C Sessions		C Sessions
C Visits		O Visits
O Hours		O Hours
C Points		C Points
C Meals		C Meals
C Items/Other, Describe		C Items/Other, Describe
ndicate numerical limit on th	e services provided for Other 29:	Indicate numerical limit on the services provided for Other 31:
Select limit on services perio	dicity for Other 29:	Selectlimit on services periodicity for Other 31:
C Every day		C Every day
C Every week		C Every week
C Every month		C Every month
C Every year		O Every year
C Every Session/Visit		C Every Session/Visit
C Every Pregnancy		C Every Pregnancy
C Every Lifetime		C Every Lifetime
C Other, Describe		C Other, Describe
ndicate units a limit will be p	rovided in for Other 30:	Indicate units a limit will be provided in for Other 32:
C Sessions		C Sessions
O Visits		C Visits
C Hours		O Hours
C Points C Meals		O Points O Meals
C Items/Other, Describe		C Items/Other, Describe
Indicate numerical limit on th	e services provided for Other 30:	Indicate numerical limit on the services provided for Other 32:
Select limit on services perio	dicity for Other 30:	Select limit on services periodicity for Other 32:
C Every day		C Every day
C Every week		O Every week
C Every month		C Every month
C Every year		C Every year
C Every Session/Visit C Every Pregnancy		C Every Session/Visit C Every Pregnancy
Every Pregnancy		C Every Pregnancy C Every Lifetime
C Every Lifetime		C Other, Describe

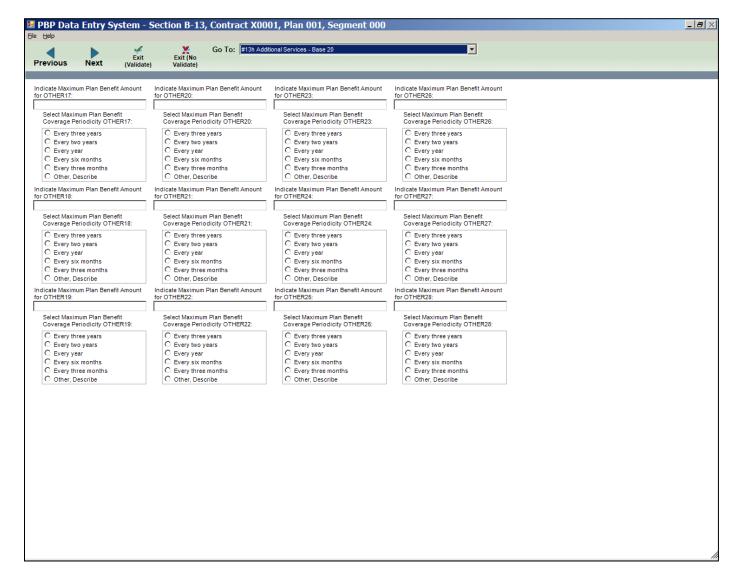
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revious next	(Validate)	Validate)		
ndicate units a limit will be	e provided in for Othe	er 33:	Indicate units a limit will be provided in for Other 35:	
C Sessions C Visits			C Sessions C Visits	
O Visits O Hours			O Visits O Hours	
O Points			O Points	
O Meals			O Meals	
C Items/Other, Describe			O Items/Other, Describe	
ndicate numerical limit on		d for Other 22:		
nuicate numericar innit on	The services provide	d for Other 55.	indicate numerical nink of the services provided for other 35.	
Select limit on services pe	riodicity for Other 33:		Select limit on services periodicity for Other 35:	
C Every day			C Every day	
C Every week			C Every week	
C Every month			C Every month	
C Every year			C Every year	
C Every Session/Visit			O Every Session/Visit	
C Every Pregnancy			O Every Pregnancy	
C Every Lifetime			O Every Lifetime	
C Other, Describe			O Other, Describe	
ndicate units a limit will be	e provided in for Othe	er 34:	Indicate units a limit will be provided in for Other 36:	
C Sessions			O Sessions	
O Visits			C Visits	
C Hours			O Hours	
C Points C Meals			O Points	
C Items/Other, Describe			C Meals C Items/Other. Describe	
ndicate numerical limit on	the services provide	d for Other 34:	Indicate numerical limit on the services provided for Other 36:	
Selectlimit on services pe	riodicity for Other 34:		Select limit on services periodicity for Other 36:	
C Every day			C Every day	
C Every week			C Every week	
C Every month			C Every month	
C Every year			O Every year	
C Every Session/Visit			O Every Session/Visit	
C Every Pregnancy			O Every Pregnancy	
C Every Lifetime			O Every Lifetime	
O Other, Describe			O Other, Describe	

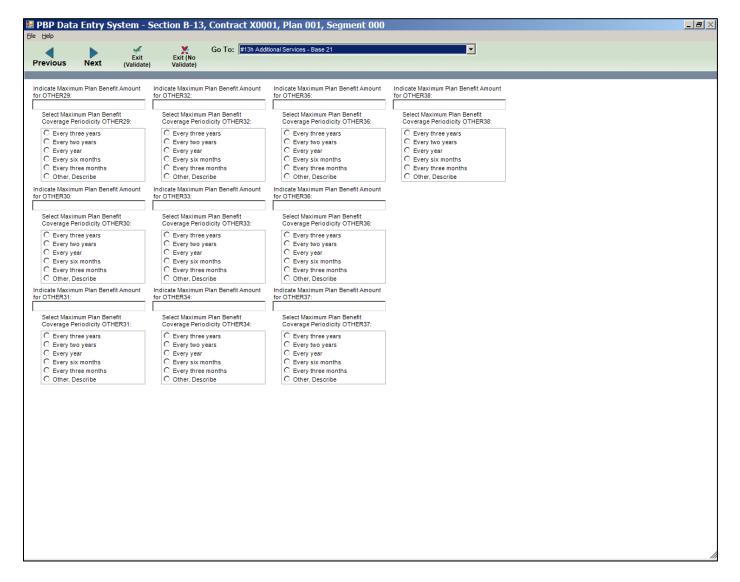
PBP Data Entry System - Section B-13, Contract X0	101, Plan 001, Segment 000
Help	itional Services - Base 16
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dicate units a limit will be provided in for Other 37:	
Sessions Visits	
Hours	
Points	
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Items/Other, Describe	
dicate numerical limit on the services provided for Other 37:	
ect limit on services periodicity for Other 37:	
Every day	
Every week	
Every month	
Every year	
Every Session/Visit	
Every Pregnancy	
Every Lifetime	
Other, Describe	
licate units a limit will be provided in for Other 38:	
Sessions	
Visits	
Hours	
Points	
Meals	
Items/Other, Describe	
dicate numerical limit on the services provided for Other 38:	
lect limit on services periodicity for Other 38:	
Every day	
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Every Session/Visit	
Every Pregnancy	
Every Lifetime	
Other, Describe	





ndicate Maximum Plan Benefit Amount or OTHER5:	Indicate Maximum Plan Benefit Amount for OTHER8:	Indicate Maximum Plan Benefit Amount for OTHER11:	Indicate Maximum Plan Benefit Amount for OTHER14:	
Select Maximum Plan Benefit Coverage Periodicity OTHER5:	Select Maximum Plan Benefit Coverage Periodicity OTHER8:	Select Maximum Plan Benefit Coverage Periodicity OTHER11:	Select Maximum Plan Benefit Coverage Periodicity OTHER14:	
C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe	C Every three years C Every two years C Every year C Every year Every six months C Every three months C Other, Describe	
ndicate Maximum Plan Benefit Amount or OTHER6:	Indicate Maximum Plan Benefit Amount for OTHER9:	Indicate Maximum Plan Benefit Amount for OTHER12:	Indicate Maximum Plan Benefit Amount for OTHER15:	
Select Maximum Plan Benefit Coverage Periodicity OTHER6:	Select Maximum Plan Benefit Coverage Periodicity OTHER9:	Select Maximum Plan Benefit Coverage Periodicity OTHER12:	Select Maximum Plan Benefit Coverage Periodicity OTHER15:	
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ndicate Maximum Plan Benefit Amount or OTHER7:	Indicate Maximum Plan Benefit Amount for OTHER10:	Indicate Maximum Plan Benefit Amount for OTHER13:	Indicate Maximum Plan Benefit Amount for OTHER16:	
or official		lor of mercia.	In OTHERIN.	
Select Maximum Plan Benefit Coverage Periodicity OTHER7:	Select Maximum Plan Benefit Coverage Periodicity OTHER10:	Select Maximum Plan Benefit Coverage Periodicity OTHER13:	Select Maximum Plan Benefit Coverage Periodicity OTHER16:	
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Help	Entry System					
	N 4	*	Go To: #13	n Additio	onal Services - Base 22	
evious	Next (Valida		o ,		_	
evious	Next (Valida	te) Validat	e)			
	require qualification fo	rand enrollmenti	n a state-operated	Is (a beneficiary receiving any benefit subject to a state-required monthly payment amount that is	
ver program?				bas	ased on his or her financial resources (for example: a "patient pay amount")?	
Yes) Yes	
No				0	D No	
	s that require qualificat	tion for and enroll	ment in a state-operat	ed	Select benefits subject to a state-required monthly payment amount that is based on his or her	
waiver program			(50007) 0 .		financial resources (for example: a "patient pay amount"):	
	dic Screening, Diagnos ation Counseling for Pre		(EPSDT) Services	_	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	
	Birth Center Services	egitalit wonten			Freestanding Birth Center Services	
Respiratory Ca					Respiratory Care Services	
Family Planning					Family Planning Services	
Nursing Home					Nursing Home Services	
	munity Based Services				Home and Community Based Services	
Personal Care					Personal Care Services	
	Personal Assistance Se	rvices			Self-Directed Personal Assistance Services	
Private Duty Nu	ursing Services				Private Duty Nursing Services	
Case Managem	nent (Long Term Care)				Case Management (Long Term Care)	
	Iental Disease Services				Institution for Mental Disease Services for Individuals 65 or Older	
	Intermediate Care Faci	lity for Individuals v	vith Intellectual Disabilit	ε	Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities	
Case Managem	nent	-			Case Management	
Other 1					Other 1	
Other 2					Other 2	
Other 3					Other 3	
Other 4					Other 4	
Other 5					Other 5	
Other 6					Other 6	
Other 7					Other 7	
Other 8					Other 8	
Other 9					Other 9 Other 10	
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Other 21					Other 21	
Other 22					Other 22	
Other 23				-	Other 23	

revious Next (Validate	🦉 Go I (#13h Additional Services - E	Base 23				
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obacco Cessation Counseling for Pregna Iomen	Int		Other 1]	
eestanding Birth Center Services			Other 2				
espiratory Care Services			Other 3]	
amily Planning Services			Other 4]	
ursing Home Services			Other 5]	
ome and Community Based Services			Other 6]	
ersonal Care Services			Other 7]	
elf-Directed Personal Assistance Service	/S		Other 8]	
ivate Duty Nursing Services			Other 9]	
ase Management (Long Term Care)			Other 10]	
stitution for Mental Disease Services for dividuals 65 or Older			Other 11]	
ervices in an Intermediate Care Facility fo dividuals with Intellectual Disabilities	or		Other 12]	

nter minimum and u uidance on what va Min Pati	Next (Validate) maximum values only if ir ralues to enter, leave the in nimum tient Pay	Exit (No Validate) nstructed to do so by the State minimum and maximum fields	#13h Additional S			•
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Pati	nimum tient Pav			lotprovide		
ther 13	iount	Maximum Patient Pay Amount		Minimum Patient Pay Amount	Maximum Patient Pay Amount	
			Other 26			
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her 15			Other 28			
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her 18			Other 31			
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ner 21			Other 34			
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ner 24			Other 37			
ner 25			Other 38			

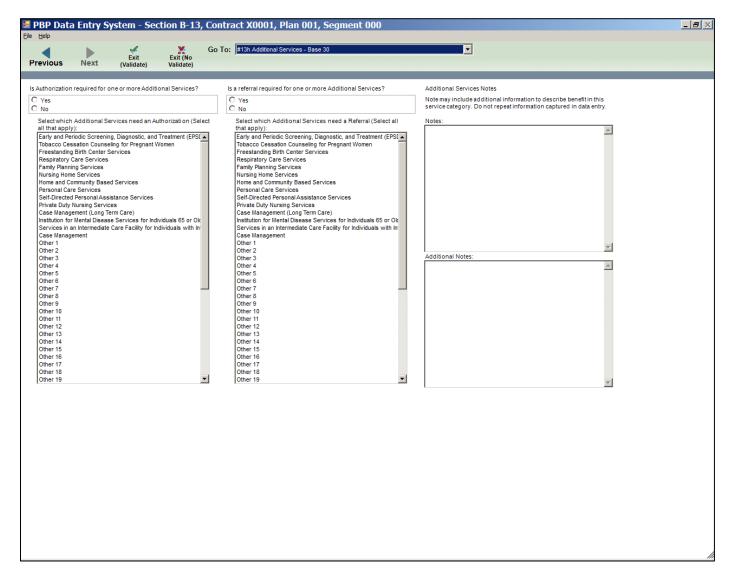
revious Next	4				
avious Nové	Exit Exit (No	Go To: #13	h Additional Services - Base 25		
evious ivext	(Validate) Validate)				
u must include total cost sha	aring to the beneficiary, includin	ng any facility cost	Indicate Coinsurance for one or more of the follow	ving services.	
	of cost sharing, please utilize th owest and highest cost sharing				
y pay.	sitestand nightsteest sharing	g anata borrononary		Minimum Maximum	
here an enrollee Coinsuran	ice?			Coinsurance Coinsurance	
Yes			Early and Periodic Screening, Diagnostic, and		
No			Treatment (EPSDT) Services		
	ices have a Coinsurance (Selec		Tobacco Cessation Counseling for Pregnant		
	Diagnostic, and Treatment (EPSD	DT) Services 🔺	Women		
bacco Cessation Counseling			Freestanding Birth Center Services		
reestanding Birth Center Ser espiratory Care Services	vices				
amily Planning Services			Respiratory Care Services		
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ome and Community Based S	Services				
ersonal Care Services			Family Planning Services		
elf-Directed Personal Assista					
ivate Duty Nursing Services			Nursing Home Services		
ase Management (Long Term					
	Services for Individuals 65 or Old		Home and Community Based Services		
ervices in an Intermediate Ca ase Management	are Facility for Individuals with Int	tellectual Disabilit	Frome and Commanity Dased Services		
ase Management ther 1					
ther 2			Personal Care Services		
ther 3					
ther 4			Self-Directed Personal Assistance Services		
ther 5					
ther 6			Private Duty Nursing Services		
ther 7			Private Duty Nursing Services		
ther 8					
ther 9			Case Management (Long Term Care)		
ther 10					
ther 11 ther 12			Institution for Mental Disease Services for		
ther 13			Individuals 65 or Older		
ther 14			Services in an Intermediate Care Facility for		
ther 15			Individuals with Intellectual Disabilities		
ther 16					
ther 17					
ther 18					
ther 19					
ther 20 ther 21					
ther 21 ther 22					
		-	1		
Other 22 Other 23		•	1		

Help Previous Nex	t (Validate)	Go To: #13h Additional Services - Base 26	
	r one or more of the following service		
	Minimum Maximum Coinsurance Coinsurance	Minimum Maximum Coinsurance Coinsurance	
ase Management		Other 13	
ther 1		Other 14	
ther 2		Other 15	
ther 3		Other 16	
her 4		Other 17	
her 5		Other 18	
her 6		Other 19	
her 7		Other 20	
her 8		Other 21	
her 9		Other 22	
her 10		Other 23	
ner 11		Other 24	
ner 12		Other 25	

Help	Exit Exit (M	Go To: #13h Additional Services - Base 27	
revious	Next (Validate) Validat	le)	
dicate Coin:	surance for one or more of the following serv		
	Minimum Maximum Coinsurance Coinsurance	C Yes C No	
ther 26		Select which Additional Services have a Copayment (Select all that apply): Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Tobacco Cessation Counseling for Pregnant Women	
her 27		Freestanding Birth Center Services Respiratory Care Services	
her 28		Family Planning Services Nursing Home Services Home and Community Based Services	
her 29		Personal Care Services Self-Directed Personal Assistance Services	
her 30		Private Duty Nursing Services Case Management (Long Term Care) Institution for Hental Disease Services for Individuals 65 or Older	
ner 31		Services in an Intermediate Care Facility for Individuals with Intellectual Disabilitik Case Management Other 1	
ner 32		Other 2 Other 3	
her 33		Other 4 Other 5 Other 6	
her 34		Other 7 Other 8	
her <mark>3</mark> 5		Other 9 Other 10 Other 11	
her 36		Other 12 Other 13	
ner 37		Other 14 Other 15 Other 16	
ner 38		Other 17 Other 18 Other 19	
		Other 20 Other 21	
		Other 22 Other 23	

Help	¥ (o To: #13h Additional	Services - Base 28		•	
revious Next (Validate)	Exit (No Validate)					
licate Copayment for one or more of the follow	ving services.					
	- Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment	
arly and Periodic Screening, Diagnostic, and eatment (EPSDT) Services			Case Management			
obacco Cessation Counseling for Pregnant omen			Other 1			
eestanding Birth Center Services			Other 2			
spiratory Care Services			Other 3			
mily Planning Services			Other 4			
rsing Home Services			Other 5			
ome and Community Based Services			Other 6			
rsonal Care Services			Other 7			
If-Directed Personal Assistance Services			Other 8			
ivate Duty Nursing Services			Other 9			
ase Management (Long Term Care)			Other 10			
stitution for Mental Disease Services for dividuals 65 or Older			Other 11			
rvices in an Intermediate Care Facility for dividuals with Intellectual Disabilities			Other 12			

Indicate Copayment for one or more of the following services. Minimum Copayment Maximum Copayment Maximum Copayment Other 13	Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: <mark>#13</mark>	n Additional Services	- Base 29
Copayment Copayment Copayment Copayment Other 13 Other 26	Indicate Copay	ment for one or	more of the follow	wing services.			
Other 13 Other 26 Image: Content of the state of			Maximum Copaymen	t		Minimum Copayment	Maximum Copayment
Other 15 Other 28 Other 16 Other 29 Other 17 Other 30 Other 18 Other 31 Other 19 Other 32 Other 20 Other 33 Other 21 Other 34 Other 22 Other 35 Other 23 Other 36 Other 24 Other 37	Other 13				Other 26		
Other 16 Other 29 Image: Constraint of the state	Other 14				Other 27		
Other 17 Other 30 Other 30 Other 18 Other 31 Other 31 Other 19 Other 32 Other 32 Other 20 Other 33 Other 33 Other 21 Other 34 Other 34 Other 22 Other 35 Other 36 Other 23 Other 36 Other 37	Other 15		[Other 28		
Other 18 Other 31 Other 19 Other 32 Other 20 Other 33 Other 21 Other 34 Other 22 Other 35 Other 23 Other 36 Other 24 Other 37	Other 16				Other 29		
Other 19 Other 32 Other 20 Other 33 Other 21 Other 34 Other 22 Other 35 Other 23 Other 36 Other 24 Other 37	Other 17				Other 30		
Other 20 Other 33 Other 21 Other 34 Other 22 Other 35 Other 23 Other 36 Other 24 Other 37	Other 18				Other 31		
Other 21 Other 34 Other 22 Other 35 Other 23 Other 36 Other 24 Other 37	Other 19		Γ	1	Other 32		
Other 22 Other 35 Other 23 Other 36 Other 24 Other 37	Other 20				Other 33		
Other 23 Other 36 Other 37 Other 37	Other 21		[1	Other 34		
Other 24 Other 37	Other 22				Other 35		
	Other 23		[1	Other 36		
Other 26 Other 38	Other 24				Other 37		
	Other 25		[1	Other 38		



#14a Medicare-covered Zero Dollar Preventive Services

	System - Sec	tion B-14, C	ntract X0001, Plan 001, Segment 000	
Help	Exit	Exit (No	To: #14a Medicare-covered Zero Dollar Preventive Services	
Previous Next	(Validate)	Validate)		
CLICK FOR DESCRI	PTION OF BENEFIT	r	Medicare-covered Zero Dollar Preventive Services Notes Note may include additional information to describe benefit in this service	
Medicare-covered Zero Do I attest that there is no co Original Medicare preve sharing.	insurance, copavir	ent, or deductible for	category. Do not repeat information captured in data entry.	
lote: Plan may not require haring preventive services	an authorization or , for example, scree	referral for certain S ming mammograms	əst	
s authorization required?				
C No				
s a referral required? O Yes O No				

#14b Annual Physical Exam – Base 1

	ntry Sy	stem - Sec	tion B-14	, Contra	ct X0001, Plan 001, Segment 000	_ 8
Help						
		Exit	Exit (No	Go To:	#14b Annual Physical Exam - Base 1	
revious N	ext	(Validate)	Validate)			
CLICK FOR DESCI	RIPTION (F BENEFIT			Is there a service-specific Maximum Plan Benefit Coverage amount?	
ou should only use	these sur	plomontal bon of	to for Appual Dk	weigel	C Yes C No	
kams not covered b ese Annual Physic	by Origina	Medicare. You r	nay charge cop	ays for		
ervices are always p	plan cover	ed, and consequ	ently they are n	ot	Indicate Maximum Plan Benefit Coverage amount:	
propriate as a sup						
oes the plan provid Ider Part C?	de the Ann	ual Physical Exa	im as a supplem	iental benefit		
Yes					Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
No					C Yes C No	
Select type of be	enefit for th	ne Annual Physic	cal Exam:			
C Mandatory	ner Lon Britel 75		en north die	-	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
C Optional						

#14b Annual Physical Exam – Base 2

enrollee Coinsurance? Is there an enrollee Copayment? C Yes C No ate Minimum Coinsurance percentage for each Annual Physical te Maximum Coinsurance percentage	BP Data Entry System - Section B-14, Contr Help		
s Next (Validate) Validate) enrollee Coinsurance? is there an enrollee Copayment? Ves No Indicate Minimum Coinsurance percentage for each Annual Physical iate Maximum Coinsurance percentage for each Annual Physical iate Maximum Coinsurance percentage for each Annual Physical ie enrollee Deductible?	Exit Exit (No	#14b Annual Physical Exam - Base 2	
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enrollee Deductible?	Exam:		
Deductible Amount:	ere an enrollee Deductible?		
Deductible Amount:	/es No		
Deductible Amount:			
	dicate Deductible Amount:		

#14b Annual Physical Exam – Base 3

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000		
Vious Next (Validate) Go To: #14b Annual Physical Exam - Base 3		
uthorization required?		
Yes		
No		
referral required for the Annual Physical Exam?		
Yes No		
ual Physical Exam Notes		
emay include additional information to describe benefit in this service gory. Do not repeat information captured in data entry.		
gory. Do not repeat information captured in data entry. es:		
a⊭		
	<u>v</u>	

EVROL Vext (Validate) Validate) LUCK FOR DESCRIPTION OF BENEFIT	Wext Validate CK-POR DESCRIPTION OF BENEFIT	4	F	/ xit	Go To: #14c Eligit Exit (No	le Supplemental Benefits as Defined in Chapter 4 - Base 1	
Anote benefit of below for becast in formation of the provided and provided in the provided in	Out Outcode (In Out	vious	Next (Val	date)	Validate)		
st he plan provide Eligible Supplemental Benefits as Defined in Chapter 4 as a benefit C Mandatory C Mandatory Ys Select type of benefit for Nutritional/Dietary Benefit: Select type of benefit for Remote Access Technologies (including web/Phone based technologies and Nursing Hotline): Select type of benefit for Remote Access Technologies (including web/Phone based technologies and Nursing Hotline): Select type of benefit for Nutritional/Dietary Benefit: C Mandatory C Mandatory C Yes Select type of Remote Access Technologies (including web/Phone based technologies and Nursing Hotline): Select type of Remote Access Technologies (including web/Phone based technologies and Nursing Hotline): Indicate number of visits for Nutritional/Dietary Benefit: Indicate number of visits for Nutritional/Dietary Benefit: Select type of Remote Access Technologies (including web/Phone based technologies and Nursing Hotline): Named Access Technologies (including Web/Phone based technologies and Nursing Hotline): Indicate number of visits for Nutritional/Dietary Benefit: Select type of Denefit for Causeling Services: Indicate number of Nutritional/Dietary Benefit: Indicate number of visits for Nutritional/Dietary Benefit: Indicate number of visits for Counseling Services: Indicate number of Nutritional/Dietary Benefit: Indicate number of visits of freed in addition to Medicare Select type of benefit for Causeling Services: Indicate runimer of visits of freed. Mandatory <th>the plan provide Eligible Supplemental Benefits as Defined in Chapter 4 as a benefit C Mandatory C Mandatory es C Mandatory C Optional Select type of benefit for Nutritional/Dietary Benefit es C Mandatory C Mandatory C Mandatory c Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Man</th> <th>LICK FOR DES</th> <th>SCRIPTION OF BEI</th> <th></th> <th></th> <th>Select type of benefit for Health Education:</th> <th>Select type of benefit for Telemonitoring Services:</th>	the plan provide Eligible Supplemental Benefits as Defined in Chapter 4 as a benefit C Mandatory C Mandatory es C Mandatory C Optional Select type of benefit for Nutritional/Dietary Benefit es C Mandatory C Mandatory C Mandatory c Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Mandatory C Man	LICK FOR DES	SCRIPTION OF BEI			Select type of benefit for Health Education:	Select type of benefit for Telemonitoring Services:
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	Services:		Indicate Maximum Coinsurance percentage for Alternative Therapi
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percentage for Health Education:	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Web/Phone based technologies):	Indicate Maximum Coinsurance percentage for Medical Nutrition Therapy (MNT):	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.
ercentage for Nutritional/Dietary	Indicate Minimum Coinsurance percentage for Remote Access Technologies (Nursing Hotline):	Indicate Minimum Coinsurance percentage for Post discharge In-Home Medication Reconciliation:	
percentage for Nutritional/Dietary	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Nursing Hotline):	Indicate Maximum Coinsurance percentage for Post discharge In-Home Medication Reconciliation:	
ercentagefor Additional sessions			
ion Counseling:	Indicate Minimum Coinsurance percentage for Bathroom Safety Devices:	Indicate Minimum Coinsurance percentage for Re-admission Prevention:	
percentage for Additional sessions ion Counseling:	Indicate Maximum Coinsurance percentage for Bathroom Safety Devices:	Indicate Maximum Coinsurance percentage for Re-admission Prevention:	
p p	ercentage for Nutritional/Dietary ercentage for Nutritional/Dietary ercentage for Additional sessions on Counseling: ercentage for Additional sessions	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Web/Phone based technologies); Indicate Minimum Coinsurance percentage for Remote Access Technologies (Nursing Hotline); Indicate Maximum Coinsurance percentage for Remote Access Technologies (Nursing Hotline); Indicate Maximum Coinsurance percentage for Bathroom Safety Devices; Indicate Maximum Coinsurance percentage for Bathroom Safety	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Web/Phone based technologies): Indicate Minimum Coinsurance percentage for Remote Access Technologies (Web/Phone based technologies): Indicate Minimum Coinsurance percentage for Remote Access Technologies (Nursing Hotline): Indicate Maximum Coinsurance percentage for Remote Access Indicate Maximum Coinsurance percentage for Bathroom Safety Indicate Maximum Coinsurance percentage for Bathroom Safety Indicate Maximum Coinsurance percentage for Re-admission

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Ele Help	a Entry S	ystem - Se	ction B-14,	Contra	act X0001, Plan 001, Segment 000		<u>_ </u>
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 8	V	
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Is there an enr	ollee Deductib	le?]	Indicate Minimum Copaymentamount for Additional sessions of Smoking and Tobacco Cessation Counseling:	Indicate Minimum Copayment amount for Bathroom Safety Devices:	Indicate Minimum Copayment amount for Re-admission Prevention:
Indicate Dedu	uctible Amount	:]	Indicate Maximum Copayment amount for Additional sessions of Smoking and Tobacco Cessation Counseling.	Indicate Maximum Copayment amount for Bathroom Safety Devices:	Indicate Maximum Copayment amount for Re-admission Prevention:
Is there an enrol O Yes O No	ollee Copaym	ent?]	Indicate Minimum Copayment amount for Fitness Benefit:	Indicate Minimum Copayment amount for Counseling Services:	Indicate Minimum Copayment amount for Wigs for Hair Loss Related to Chemotherapy:
Select which Chapter 4 ha	ve a Copayme	emental Benefits a nt (Select all that	as Defined in apply):		Indicate Maximum Copayment amount for Fitness Benefit:	Indicate Maximum Copayment amount for Counseling Services:	Indicate Maximum Copayment amount for Wigs for Hair Loss Related to Chemotherapy:
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Telemonitoring Remote Acce Bathroom Saf	ss Technologie ety Devices	ent s (including Web/P	hone based techn	olo	Indicate Maximum Copayment amount for Enhanced Disease Management:	Indicate Maximum Copayment amount for In-Home Safety Assessment:	Indicate Maximum Copayment amount for Weight Management Programs:
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authorization required?	Additional sessions of Smoking and Tobacco Cessation Counseling Notes:
Yes	Additional sessions of Smoking and Tobacco Cessation Courseing Notes.
No	
a referral required for Eligible Supplemental Benefits as Defined in Chapter	
Yes	
No	
the Constructed Department of the Charles (Martin	Fitness Benefit Notes:*
gible Supplemental Benefits as Defined in Chapter 4 Notes:	<u>*</u>
te may include additional information to describe benefit in this service egory. Do not repeat information captured in data entry.	
This notes field is required when the corresponding benefit is offered.	
	~
alth Education Notes:	Enhanced Disease Management Notes:
-	
tritional/Dietary Benefit Notes:	Telemonitoring Services Notes:*
<u>ه</u>	
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note Access Technology (Web/Phone based technologies	III-H	me Safety Assessment Notes:	*	
note Access Technologies (Nursing Hotline) Notes:		nal Emergency Response System (PERS) Notes	*	
nee recess recently reces.	×			
hroom Safety Devices Notes:*	<u>v</u>	al Nutrition Therapy (MNT) Notes:	v	
			*	
unseling Services Notes:		lischarge In-Home Medication Reconciliation No		
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PBP Data E	ntry Sys	tem - Sec	tion B-14,	Contract X)01, Plan (001, Segme	ent 000						
revious	Next	Exit (Validate)	Exit (No Validate)	Go To: #14c E	ible Supplemental	al Benefits as Defir	ined in Chapter 4 -	Base 11	•				
			vanuate)		-				-	-	-	-	-
admission Prev	vention Notes			×									
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gs for Hair Loss	Related to Cl	nemotherapy N	otes:										
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ight Manageme	ent Notes:*			A									
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rnative Therap	ies Notes:*			V									
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#14d Kidney Disease Education Services – Base 1

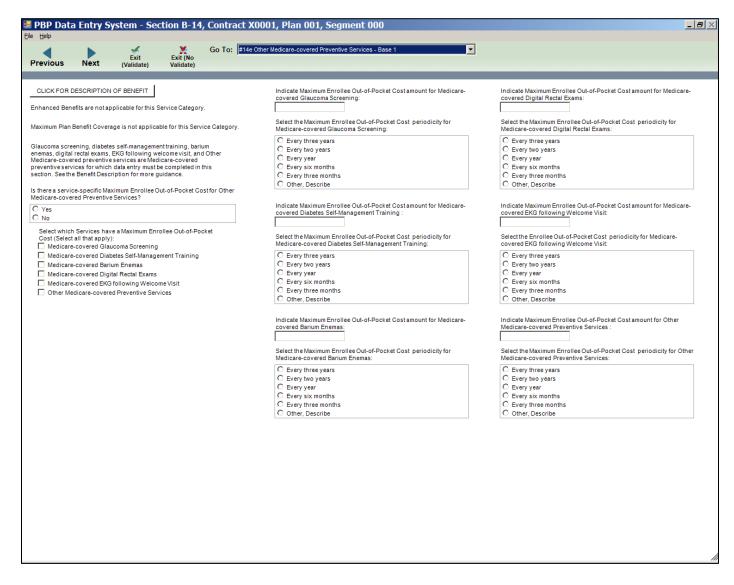
PBP Data Entry System - Section B-14, Contrac	ct X0001, Plan 001, Segment 000	_1=
Exit Exit (No	#14d - Kidney Disease Education Services Base 1	
Previous Next (Validate) Validate)		
CLICK FOR DESCRIPTION OF BENEFIT	You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost	
nhanced Benefits are not applicable for this Service Category.	sharing that a beneficiary may pay.	
aximum Plan Benefit Coverage is not applicable for this Service Category.	C Yes	
there a service-specific Maximum Enrollee Out-of-Pocket Cost?	C No	
Yes No	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	
Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity:		
C Every two years C Every year C Every year C Every six months		
C Every three months C Other, Describe		

#14d Kidney Disease Education Services – Base 2

evious Next (Validate) Go To: #14d - Kidney Disease Education Services Base 2	PBP Data Entry System - Section B-14, Help	Contract X0001, Plan 001, Segment 000	
Exit Exit (No (Validate) Prese Is authorization required? Yes C No C Indicate Deductible Amount: Is a referral required for Kidney Disease Education Services? C Yes No C Indicate Maximum Copayment amount for Medicare-covered		Go To: #14d - Kidney Disease Education Services Base 2	
here an enrollee Deductible? Is authorization required? Yes No ndicate Deductible Amount: here an enrollee Copayment? Yes No ndicate Maximum Copayment amount for Medicare-covered indicate Maximum Copayment amount for Medicare-covered	Exit Exit (No evious Next (Validate) Validate)		
Yes C Yes C No C Yes C No C Yes C Y			
No. C No ndicate Deductible Amount: Is a referral required for Kidney Disease Education Services? C Yes C No Yes No ndicate Minimum Copayment amount for Medicare-covered dicate Maximum Copayment amount for Medicare-covered	here an enrollee Deductible?		
Is a referral required for Kidney Disease Education Services? C Yes C Yes C No			
Is a referral required for Kidney Disease Education Services? C Yes C Yes No Indicate Maximum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Medicare-covered			
Are an enrollee Copayment? C No Yes No Indicate Minimum Copayment amount for Medicare-covered And icate Maximum Copayment amount for Medicare-covered Indicate Maximum Copayment amount for Medicare-covered			
Yes No Indicate Minimum Copayment amount for Medicare-covered enefits:	nere an enrollee Copayment?	C No	
ndicate Minimum Copayment amount for Medicare-covered denefits:	Yes		
Jenefits: Indicate Maximum Copayment amount for Medicare-covered			
ndicate Maximum Copayment amount for Medicare-covered	adicate Minimum Copayment amount for Medicare-covered Senefits:		
	ndicate Maximum Copayment amount for Medicare-covered		
	Benefits:		

#14d Kidney Disease Education Services – Base 3

Help	•	stem - Sec Exit (Validate)	tion B-14	, Contract X0001, Plan 001, S Go To: #14d - Kidney Disease Education			
vious	Next		Validate)				
	Education Ser		cribe benefit in t	his service category. Do not repeat information	n captured in data entry.		
95:				1997 - 1997 199	TRACTOR TO TOTAL CAR		
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evious Next	Exit (Validate)	Exit (No Validate)	Go To: #14	e Other Medicare-covered Preventive Services - Base 2	
ere an enrollee Coinsu	rance?			Is there an enrollee Deductible?	
Yes	ance			O Yes	
No				Č No	
elect which Services h			pply):	Select which Services have a Deductible (Select all that apply):	
Medicare-covered G				Medicare-covered Glaucoma Screening	
Medicare-covered Di		igement Training		Medicare-covered Diabetes Self-Management Training	
Medicare-covered Ba				Medicare-covered Barium Enemas Medicare-covered Digital Rectal Exams	
Medicare-covered El				Medicare-covered Digital Rectains	
Other Medicare-cove				Other Medicare-covered Preventive Services	
				Indicate Medicare-covered Glaucoma Screening Deductible Amount:	
	Minimum Coinsurance	Maximum Coinsurance			
fedicare-covered				Indicate Medicare-covered Diabetes Self-Management Training Deductible Amount:	
Slaucoma Screening					
Medicare-covered Diabetes Self- Management Training				Indicate Medicare-covered Barium Enemas Deductible Amount:	
fedicare-covered Bariu memas	m				
Medicare-covered Digita Rectal Exams	ll 📃			Indicate Medicare-covered Digital Rectal Exams Deductible Amount:	
Medicare-covered EKG ollowing Welcome Visit				Indicate Medicare-covered EKG following Welcome Visit Deductible Amount:	
Other Medicare-covered Preventive Services					
Teventive Services				Indicate Other Medicare-covered Preventive Services Deductible Amount:	

	🖌 Exit	Exit (No	Go To: #14e Other Medicare-covered Preventive Services - Base 3
vious Next	(Validate)	Validate)	
ere an enrollee Copaym	ent?		Is authorization required for Medicare-covered Glaucoma Screening?
Yes No			C Yes C No
elect which Services hav Medicare-covered Gla Medicare-covered Dia	ucoma Screenin	ng	Training?
Medicare-covered Bar Medicare-covered Dig		15	C No
Medicare-covered EKC Other Medicare-cover	G following Weld	come Visit	Is authorization required for Medicare-covered Barium Enemas?
	Minimum Copayment	Maximum Copayment	C Yes C No
ledicare-covered Slaucoma Screening			Is authorization required for Medicare-covered Digital Rectal Exams?
Medicare-covered Diabetes Self- Management Training			C No
Aedicare-covered Barium Enemas	(Is authorization required for Medicare-covered EKG following Welcome Visit?
Medicare-covered Digital Rectal Exams			C Yes C No
fedicare-covered EKG bllowing Welcome Visit			Is authorization required for Other Medicare-covered Preventive Services?
Other Medicare-covered Preventive Services			C Yes C No

PBP Data Entry System - Section B-14, Contract Ele Help Section B-14, Contract Ele Help Go To: #14e Exit No Exit No Go To: #14e Exit No	X0001, Plan 001, Segment 000 Other Medicare-covered Preventive Services - Base 4	 _
Previous Next (Validate) Validate)		
Is a referral required for any Services?		
C Yes C No	Medicare-covered Barium Enemas Notes:	Other Medicare-covered Preventive Services Notes:
Select which Services require a Referral (Select all that apply): Medicare-covered Glaucoma Screening Medicare-covered Glautes Self-Management Training Medicare-covered Digital Rectal Exams Medicare-covered EXG following Welcome Visit Other Medicare-covered Preventive Services Note may include additional information to describe benefit in this service ategory. Do not repeat information captured in data entry.		
category. Do notrepeat monitation captored in data entry.		T
Medicare-covered Glaucoma Screening Notes:	Medicare-covered Digital Rectal Exams Notes:	
×		*
Medicare-covered Diabetes Self-Management Training Notes:	Medicare-covered EKG following Welcome Visit Notes:	×
~		

#15 Medicare Part B Rx Drugs – Base 1

4		4	Exit (No	Go To: #15 Medicare Part B Rx Drugs - Base 1	
revious	Next	Exit (Validate)	Exit (No Validate)		
		1		Is there an enrollee Coinsurance?	
LICK FOR D	DESCRIPTION	OF BENEFIT		C Yes	
here a Mavi	mum Enrollee	Out-of-Pocket Co	ost?	C No	
Yes		Out-oi-Focket of	0317	Select which Medicare Part B Rx Drugs have a	
No				Coinsurance (Select all that apply): Medicare Part B Chemotherapy Drugs	
				C Other Medicare Part B Drugs	
dicate Maxi	mum Enrollee	Out-of-Pocket Co	ost Amount:	Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:	
				Indicate the Maximum Coinsurance percentage	
		e Out-of-Pocket (Cost periodicity:	for Medicare Part B Chemotherapy Drugs:	
Every thre Every two					
Every yea	ır			Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	
Every six					
Every mor	nth			Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:	
Other, De	scribe				

#15 Medicare Part B Rx Drugs – Base 2

			~	Cot	#15 Medicare Part B Rx Drugs - Base 2	
vious	Next	Exit (Validate)	Exit (No Validate)	GOIC	#15 Medicare Part 5 KX Urugs - base 2	
		(,	-		
ere an enrolle	e Copayme	nt?		-	s there an enrollee Deductible?	
Yes No					C Yes C No	
Select all that a	apply):	BRx Drugs ha	ve a Copayment		Indicate Deductible Amount:	
Other Medic					s Authorization Required?	
ndicate Minim Chemotherapy	um Copaym Drugs:	ent Amount for	Medicare Part B		C Yes C No	
ndicate Maxim Chemotherapy	um Copayn Drugs:	ent Amount for	Medicare Part B			
ndicate Minim rugs:	um Copaym	ent Amount for	other Medicare Pa	irt B		
dicate Maxim	um Copayn	ent Amount for	other Medicare P	art B		
rugs:	_					

#15 Medicare Part B Rx Drugs – Notes

	Exit	¥ Go⊺ Exit (No Validate)	o: #15 Medicare Part B Rx Dru	gs - Notes	×	
	ext (Validate)	Validate)	_	_	_	
care Part B Rx Di	rugs Notes					
			ce category. Do not repeat info	mation captured in data entry.		
ral is not applica s:	able for this Service Catego	ry.				
					×	
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#15 Home Infusion Bundled Services

PBP Data	a Entry S	ystem - Sec	tion B-15	, Contract	X0001, Plan 001, Segment 000	8
	•	S Exit	Exit (No	Go To: #1	5 Home Infusion Bundled Services	
Previous	Next	(Validate)	Validate)	_		_
Does the plan p	provide Part D	home infusion dru	ugs as part of a t	undled service		
as a mandatory	supplementa	benefit?			Medicaid benefit? O Yes	
C No					C No	
of a bundled se specific medica	rvice as a sup tions in a flat f	plan provide Part plemental benefit ile which must be v, June 09, 2017 a	?', you must ind uploaded throu	cate these gh the Formulary		
drug, but any se administration.	ervices and su	ur benefit includes pplies associated	with the home i	nfusion drug's		
supplemental b sharing. As des	undled servic scribed in the (of zero cost sh	provide Part D ho e then those servi CY 2010 Call Letter naring for the bunc tal benefit.	ices must be pro r this waiver is c	vided at \$0 cost onditioned on		

Help	16, Contract X0001, Plan 001, Segme		
	Go To: #16a Preventive Dental - Base 1		
evious Next (Validate) Validate	;)		_
CLICK FOR DESCRIPTION OF BENEFIT ares the plan provide Preventive Dental Items as a pplemental benefit under Part C? Yes Oral Exams Prophylaxis (Cleaning) Fluoride Treatment Dental X-Rays Select type of benefit for Oral Exams: Anadatory Optional Is this benefit unlimited for Oral Exams: Nabelet unumber Indicate number Indicate number of visits for Oral Exams:	Select the Oral Exams periodicity:	Select type of benefit for Fluoride Treatment: Optional Is this benefit unlimited for Fluoride Treatment? Yeg No. indicate number of visits for Fluoride Treatment: Select the Fluoride Treatment periodicity: Curry troe years Curry troe years Curry tree	

	tion B-16, Contract X0001, Plan 001, Segment 000	
vious Next (Validate)	Go To: #16a Preventive Dental - Base 2 Exit (No Validate)	
ect type of benefit for Dental X-Rays:	Is there a service-specific Maximum Plan Benefit Coverage amount?	
Mandatory	O Yes	
Optional	C No	
his benefit unlimited for Dental X-Rays?	Does the Maximum Plan Benefit Coverage amount apply to In-	
Yes	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?	
No, indicate number	C In-network services only	
ndicate number of visits for Dental X-Rays:	C Both In-network and Out-of-network services	
	Indicate Maximum Plan Benefit Coverage amount:	
Select the Dental X-Rays periodicity:		
C Every three years C Every two years	Select the Maximum Plan Benefit Coverage periodicity:	
C Every year	C Every three years	
C Every six months C Every three months	C Every two years C Every year	
C Other, Describe	C Every year	
	C Every three months	
	C Other, Describe	

Help						
	Exit	Exit (No	Go To	#16a Preventive Dental - Base 3		
evious ivext	(Validate)	Validate)		_		_
evious Next here a service-specific Maxi Yes No dicate Maximum Enrollee O Select the Maximum Enrollee O Every three years Every three years Every two years Every six months Other, Describe there an enrollee Coinsurant Yes No Select which Preventive Der Select which Preventive Der Select which Cleaning) Fronplaxis (Cleaning) Fluoride Treatment Dental X-Rays	Exit (Validate)	Validate) ut-of-Pocket Co: ist amount: Cost periodicity	st?		Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning): Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning): Indicate Minimum Coinsurance percentage for Fluoride Treatment: Indicate Minimum Coinsurance percentage for Dental X-Rays: Indicate Minimum Coinsurance percentage for Dental X-Rays: Dental X-R	

evious	Next	Exit (Validate)	Exit (No Validate)	Go To:	#16a Preventive Dental - Base 4
there an enrol					
Yes	lee Deductibl	e?		-	Indicate Copayment amount for Office Visit:
No				2	
Indicate Ded	luctible Amou	nt:			Indicate Minimum Copayment amount for Oral Exams:
there an enrol	llee Copayme	ent?			Indicate Maximum Copayment amount for Oral Exams:
Yes No	200				Indicate Minimum Copayment amount for Prophylaxis (Cleaning):
Select all that Oral Exams	apply):	ntal Services ha	ve a Copayment		Indicate Maximum Copayment amount for Prophylaxis (Cleaning):
Prophylaxi Fluoride Tr Dental X-Ra	eatment				Indicate Minimum Copayment amount for Fluoride Treatment:
Office Visit?	ination of se	vices included i	n a single cost pe	er	Indicate Maximum Copayment amount for Fluoride Treatment:
O Yes O No					Indicate Minimum Copayment amount for Dental X-Rays:
Select which o cost per Offic	e Visit:	of services are in	cluded in a singl		Indicate Maximum Copayment amount for Dental X-Rays:
Prophylax	is (Cleaning) reatment				
Dental X-F	lays				

	stem - Section B-10	5, Contract X0001, Plan 001, Segr	ent 000	
Previous Next	Exit Exit (No (Validate) Validate)	Go To: #16a Preventive Dental - Base 5	.	
authorization required?				
Yes				
No				
referral required for Preven Yes	tive Dental Services?			
No				
ventive Dental Services Not				
te may include additional info egory. Do not repeat informa	ormation to describe benefit in tion captured in data entry.	this service		
tes:				
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CK FOR DESCRIPTION OF BENEFIT Select type of benefit for Non-routine Services: Select type of benefit for Diagnostic Services: Select type of benefit for Diagnostic Services: Select type of benefit for Restorative Services: If you do not offer enhanced benefits, you must complete this on for your Medicare-covered Benefits. Mandatory C Optional C Yes C Yes Select the No. indicate number Mandatory C Yes Mandatory C Yes Mandatory C Yes Indicate number Mandatory C Yes Indicate number of visits for Diagnostic Services: Indicate number of visits for Diagnostic Services Indicate number of visits for Diagnostic Services Indicate number of Visits for Diagnostic Services Indicate num	<u>H</u> elp							
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ndicate number of visits for Endodo	ntics: Indicate number of visits for Periodontics	Indicate number of visits for Extractions:	C Yes C No, indicate number	
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ect the Endodontics periodicity:	Select the Periodontics periodicity:	Select the Extractions periodicity:		
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there a servic Yes	ce-specific Ma	ximum Plan Ben	efit Coverage an	iount?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? C Yes	
Yes No					C No	
elect the Max	kimum Plan Be	nefit Coverage ty	/pe:		Select the Maximum Enrollee Out-of-Pocket Cost type:	
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e on the Mevi	imum Dian Bar	nefit Coverage an	austanski te k	natwork	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	
ervices only (ervices?	OR does it app	bly to both In-netv	vork and Out-of-	network		
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ndicate Max	timum Plan Be	nefit Coverage a	mount:		C Every year C Every six months	
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Is there an enrollee Coinsur	ance?		Is there an enrollee Deductible?	
C Yes C No			C Yes C No	
Select which Comprehensiv that apply): Medicare-covered Benefit Non-routine Services Restorative Services Endodontics Periodontics Endodontics Endodontics Endodontics Periodontics Prosthodontics, Other Other	its		Indicate Deductible Amount	
	Minimum Coinsurance	Maximum Coinsurance		
Medicare-covered Benefits				
Non-routine Services				
Diagnostic Services				
Restorative Services				
Endodontics				
Periodontics				
Extractions				
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:				

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there an enrollee Copayme	nt?		
) Yes) No			
elect which Comprehensive	Dental Services have a	payment (Select all	
at apply):			
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Non-routine Services Diagnostic Services			
Restorative Services			
Endodontics			
Periodontics			
Extractions			
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Diagnostic Services			
Restorative Services			
Endodontics			
Periodontics			
Extractions			
Prosthodontics, Other			
Oral/Maxillofacial Surgery.			
Other Services:			

#16b Comprehensive Dental – Base 6

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uthorization require	ed?				
Yes					
No					
referral required for Yes	r Comprehensive Dental	Services?			
No					
nprehensive Dental	I Services Notes				
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#17a Eye Exams – Base 1

evious	Next	Exit (Validate)	Exit (No Validate)	Go To: #17a Eye Exams - Base 1		
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LICK FOR E	ESCRIPTION	OF BENEFIT		Enter name of Other Service:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Or of-Pocket Cost?
es the plan p efit under P	orovide Eye Ex	ams as a suppl	emental	I	C Yes C No	C Yes C No
Yes	arro:			Select type of benefit for Other Service:		
No				C Mandatory C Optional	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?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:
lect enhanc Routine Ey Other				Is this benefit unlimited for Other Service?	C In-network services only C Both In-network and Out-of-network services	Select the Maximum Enrollee Out-of-Pocket
	(han a 64 fees D	outine Eye Exam		O Yes O No, indicate number	Indicate Maximum Plan Benefit Coverage amount:	Cost periodicity:
Mandato	ry	ourie cye cxam	5.	Indicate guantity for Other Service:		C Every three years C Every two years
ි Optional					Select the Maximum Plan Benefit Coverage periodicity:	O Every year O Every six months
Is this ber	nefit unlimited	for Routine Eye	Exams?	Select the Other Service periodicity:	C Every three years	C Every three months C Other, Describe
	dicate numbe	r		C Every three years C Every two years	C Every two years C Every year	
Indicate n	umber of ever	ns for Routine E	ve Evens	C Every year	C Every six months	
	umber of exal		ye Lxanis.	C Every six months	C Every three months	
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#17a Eye Exams – Base 2

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ere an enrollee Coinsurance? /es No	Is there an enrollee Copayment? C Yes C No	Is there an enrollee Deductible? C Yes C No
ct which Eye Exams have a Coinsurance (Select all that apply): ledicare-covered Benefits loutine Eye Exams ther	Select which Eye Exams have a Copayment (Select all that apply): Medicare-covered Benefits Routine Eye Exams Other	Indicate Deductible Amount:
dicate Minimum Coinsurance percentage for Medicare-covered nefits:	Indicate Minimum Copayment amount for Medicare-covered Benefits:	
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#17a Eye Exams – Base 3

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revious Next	(Validate) Validate)			
authorization required?		4		
Yes No				
referral required for Eye Exan	ns?			
Yes				
No				
Exams Notes e may include additional infor	mation to describe benefit in	bis service		
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e <u>H</u> elp	Go To: #17b Eyewear - Base 1	•	
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CLICK FOR DESCRIPTION OF BENEFIT	Select type of benefit for Contact lenses:	Select type of benefit for Eyeglasses (lenses and frames):	
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.	C Mandatory C Optional	C Mandatory C Optional	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Is this benefit unlimited for Contact lenses?	Is this benefit unlimited for Eyeglasses (lenses and frames)?	
C Yes	C No, indicate number	C Yes C No, indicate number	
O No Select enhanced benefits: Contact lenses	Indicate quantity (number of pairs) for Contact lenses:	Indicate quantity for Eyeglasses (lenses and frames):	
Eyeglasses (lenses and frames) Eyeglass lenses Eyeglass frames	Select Contact lenses periodicity:	Select Eyeglasses (lenses and frames) periodicity:	
Upgrades	C Every three years C Every two years C Every year	C Every three years C Every two years C Every two years C Every year	
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type of benefit for Eyeglass lenses:	Select type of benefit for Eyeglass frames:	
andatory otional	C Mandatory C Optional	
benefit unlimited for Eyeglass lenses?	Is this benefit unlimited for Eyeglass frames?	
s, indicate number	C Yes C No, indicate number	
ate quantity (number of pairs) for Eyeglass lenses:	Indicate quantity for Eyeglass frames:	
ect Eyeglass lenses periodicity:	Select Eyeglass frames periodicity:	
Every three years	C Every three years	
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Other, Describe	C Other, Describe	
	Select type of benefit for Upgrades:	
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there a service-specific Maximum Plan	Select the Combined Maximum Plan	Indicate Max Plan Benefit Coverage	Indicate Max Plan Benefit Coverage	
nefit Coverage amount?	Benefit Coverage periodicity:	amount for Eyeglasses (lenses and	amount for Eyeglass frames:	
Yes	C Every three years	frames):		
No	C Every two years			
Select the Maximum Plan Benefit	C Every year	Select the Individual Maximum Plan	Select the Individual Maximum Plan	
Coverage type:	C Every six months	Benefit Coverage periodicity for	Benefit Coverage periodicity for	
	C Every three months	Eyeglasses (lenses and frames):	Eyeglass frames:	
C Covered under Eye Exams Category 17a	O Other, Describe	C Every three years	C Every three years	
C Plan-specified amount per period	Select the type of Eyewear with	C Every two years	C Every two years	
C Plan-specified anount per period	Individual Max Plan Benefit Coverage amount:	C Every year	C Every year	
loes the Maximum Plan Benefit	Contact lenses	C Every six months	C Every six months	
Coverage amount apply to In-network	 Contact tenses Eyeglasses (lenses and frames) 	C Every three months	C Every three months	
ervices only OR does it apply to both In- etwork and Out-of-network services?	Eyeglasses (lenses and frames)	C Other, Describe	C Other, Describe	
C In-network services only	Eyeglass frames	Indicate Max Plan Benefit Coverage	Indicate Max Plan Benefit Coverage	
Both In-network and Out-of-network	Upgrades	amount for Eyeglass lenses:	amount for Upgrades:	
services	Indiante Meu Dian Dan 64 Carros			
	Indicate Max Plan Benefit Coverage amount for Contact lenses:			
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Eyewear?	Select the Individual Maximum Plan	C Every three years		
O Yes	Benefit Coverage periodicity for Contact lenses:	C Every two years	C Every three years	
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ndicate Maxir	num Enrollee (Out-of-Pocket Co	st amount:	Indicate Minimum Coinsurance percentage for Contact lenses:	Indicate Minimum Coinsurance percentage for Upgrades:	
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Yes]
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referral required for Eyewear?	
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LICK FOR DESCRIPTION OF BENEFIT	Select Routine Hearing Exams periodicity:	
en if you do not offer enhanced benefits, you must complete s section for your Medicare-covered Benefits. es the plan provide Hearing Exams as a supplemental	C Every three years C Every two years C Every year C Every six months C Every three months C Other, Describe	
nefit under Part C?	Select type of benefit for Fitting/Evaluation for Hearing Aid:	
Yes No	C Mandatory C Optional	
elect 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 Ald:	
s this benefit unlimited for Routine Hearing Exams?		
C Yes C No, indicate number	Select Fitting/Evaluation for Hearing Aid periodicity:	
Indicate number for Routine Hearing Exams:	C Every three years C Every two years C Every year C Every year C Every six months C Every three months C Other, Describe	

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e <u>H</u> elp			
Exit E	Go To: #18a Hearing Exams - Base 2 kit (No	▼	
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s there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:	
C Yes C No	C Yes C 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?	Indicate Maximum Enrollee Out-of-Pocket Cost amount:	Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:	
C In-network services only	-		
C Both In-network and Out-of-network services	Select Maximum Enrollee Out-of-Pocket Cost periodicity:	Indicate Minimum Coinsurance percentage for Routine Hearing Exams:	
Indicate Maximum Plan Benefit Coverage amount:	C Every three years C Every two years		
	C Every year C Every six months	Indicate Maximum Coinsurance percentage for	
Select the Maximum Plan Benefit Coverage periodicity:	C Every three months C Other, Describe	Routine Hearing Exams:	
C Every three years C Every two years	Is there an enrollee Coinsurance?		
C Every year	O Yes	Indicate Minimum Coinsurance percentage for	
C Every six months	O No	Fitting/Evaluation for Hearing Aid:	
C Every three months	C NO		
C Other, Describe	Select which Hearing Exam Benefits have a Coinsurance (Select all that apply):		
Is there an enrollee Deductible?	Medicare-covered Benefits	Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:	
C Yes	Routine Hearing Exams Fitting/Evaluation for Hearing Aid		
C No			
Indicate Deductible Amount:			

re an enrollee Copayment?		
es	Is authorization required?	
es o	C Yes C No	
lect which Hearing Exam Benefits have a Copayment (Select all that a Medicare-covered Benefits	apply): Is a referral required for Hearing Exams?	
Routine Hearing Exams	C Yes	
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licate Maximum Copayment amount for Medicare-covered Benefits:		
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icate Maximum Copayment amount for Fitting/Evaluation for Hearing	Aid:	

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ng Exams Notes						
may include additio	nal information to descri	be benefit in this service c	ategory. Do not repeat information c	aptured in data entry.		
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evious	Next	Exit	Exit (No	Go To: #18b Hearing Aids - Base 2	
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lect type of b	benefit for Hea	ring Aids - Over t	the Ear:	Does the Maximum Plan Benefit Coverage Amount apply per ear	
Mandatory	r			or for both ears combined?	
Optional				○ Per ear ○ One single ear	
this benefit	unlimited for H	Hearing Aids - Ov	ver the Ear?	C Bith ears combined	
Yes				Select the Maximum Plan Benefit Coverage type:	
No, indica	ate number			C Covered under Hearing Exams Category - 18a	
dicate quan	ntity for Hearing	g Aids - Over the	Ear:	C Plan-specified amount per period	
				Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?	
Select Heari	ing Aids - Over	r the Ear periodic	ity:	O In-network services only	
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here a serv verage amo	vice-specific M	aximum Plan Ben	nefit	C Every two years	
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PBP Data Entry System - Section B-18	, Contract X0001, Plan 001, Segme	ent 000	_ 8
e Help Previous Next Exit Exit (No (Validate)	Go To: #18b Hearing Aids - Base 3		
Previous Next Exit (Validate) Exit Validate) Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? \[\Period No Select the Maximum Enrollee Out-of-Pocket Cost type: \[Covered under Hearing Exams Category - 18a Plan-specified amount per period Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost amount: Select Waximum Enrollee Out-of-Pocket Cost Select Maximum Enrollee Out-of-Pocket Cost Select Waximum Enrollee Out-of-Pocket Cost Select Waximum Enrollee Out-of-Pocket Cost Select Whice wears Every three years Every three months Other, Describe Is there an enrollee Coinsurance? Yes No Select which Hearing Aids Benefits have a Coinsurance Select which Hearing Aids Senefits have a Coinsurance Select which Hearing Aids Dever Ear Hearing Aids - Over the Ear	Indicate Minimum Coinsurance percentage for Hearing Aids (all types): Indicate Maximum Coinsurance percentage for Hearing Aids (all types): Indicate Minimum Coinsurance percentage for Hearing Aids - Inner Ear: Indicate Maximum Coinsurance percentage for Hearing Aids - Inner Ear: Indicate Maximum Coinsurance percentage for Hearing Aids - Outer Ear: Indicate Maximum Coinsurance percentage for Hearing Aids - Outer Ear:	Indicate Minimum Coinsurance percentage for Hearing Aids - Over the Ear: Indicate Maximum Coinsurance percentage for Hearing Aids - Over the Ear:	

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es the plan provide Outpatient D plemental benefit under Part C?	rugs as a	C Yes C No	Indicate Max Plan Benefit Coverage amount semi-	
Yes No		Indicate type of Maximum Plan Benefit	annually for drugs:	
lect type of benefit:		Coverage: All drug groups covered by plan Combination of drug groups	Indicate Max Plan Benefit Coverage amount quarterly for	
Mandatory		Individual drug groups	drugs:	
Optional		Is the Maximum Plan Benefit Coverage	Indicate Max Plan Benefit Coverage amount monthly for	
licate the number of drug group ered:	ings that are	net of the enrollee copay?	drugs:	
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Vious Next Exit No Go To: 20 Outpatient Drugs - Base 2 any unused amounts be carried forward to the next period within the act period? any unused amounts be carried forward to the next period within the act period? Indicate Max Plan Benefit Coverage amount annually for combination of drug groups: t what combination of drug groups are included in the Maximum Plan fit. indicate Max Plan Benefit Coverage amount semi-annually for combination of drug groups: Indicate Max Plan Benefit Coverage amount quarterly for combination of drug groups: indicate Max Plan Benefit Coverage amount quarterly for combination of drug groups: Indicate Max Plan Benefit Coverage amount monthly for combination of drug groups: indicate Max Plan Benefit Coverage amount monthly for combination of drug groups: Indicate Max Plan Benefit Coverage amount monthly for combination of drug groups: indicate Max Plan Benefit Coverage amount monthly for combination of drug groups:	Help				
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a selected group unlimited after the combination Maximum Plan eneffi Coverage amount has been reached? Yes No Select the Maximum Enrollee Out-of-Pocket Cost amount: Select the Maximum Plan Benefit Group 1 Group 1 Group 2 Group 3 Group 4 Group 4 Group 4 Group 5 Select the Maximum Enrollee Coll-of-Pocket Cost periodicity: Generation of drug when a less expensive drug is solution to the Coinsurance or Copyr Select the Maximum Enrollee Out-of-Pocket Cost periodicity: Generation of drug when a less expensive drug is Select the Maximum Enrollee Coll-surance or Copyr Select the Maximum Enrollee Out-of-Pocket Cost? Yes No Select the Maximum Enrollee Out-of-Pocket Cost? Yes No Select the Maximum Enrollee Out-of-Pocket Cost? Yes No Select the Maximum Enrollee Out-of-Pocket Cost? Select the Maximum Enrollee Select t	Exit Exit (No		
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Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived: Group 1 Group 3 Group 3 Group 4 Group 4 Over service an enrollee Coinsurance for Medicare-covered Benefits? Cover service an enrollee Coinsurance or Copay or selecting a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is valiable? Cover service and a higher priced drug when a less expensive drug is stater a laximum Enrollee Out-of-Pocket Cost? Cover service and the minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs: Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs: Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs: Cover service and the minimum Coinsurance percentage for other Medicare Part B Drugs: Cover service and the discover service part B Chemotherapy Drugs: Cover service and the discover service percentage for other Medicare Part B Drugs: Cover service and the discover service percentage for other Medicare Part B Drugs: Cover service and the discover service percentage for other Medicare Part B Drugs: Cover service and the discover service percentage for other Medicare Part B Cover service and the discover service and the discov	O Yes O No	Palant No Mavimum Enzellan Out of Restat Cast enziediety	
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here an enrollee D <mark>e</mark> du	ctible?		Indicate Minimum Copayment amount for Medicare Part B	
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No			Latin to Maximum Community Marking Bard B	
Select what combination	on of drug groups ap	plies for Deductible:	Indicate Maximum Copayment amount for Medicare Part B Chemotherapy Drugs:	
Group 1 Group 2				
Group 3			Indicate Minimum Copayment for other Medicare Part B Drugs:	
Group 4				
Group 5			Indicate Maximum Copayment for other Medicare Part B Drugs:	
Medicare Covered				
ndicate Deductible an	nount:		Is authorization required?	
			C. Yes	
nere an enrollee Copa	yment for Medicare-	covered Benefits?	C No	
Yes				
No				
Select all that apply): Medicare Part B Ch Other Medicare Pa	emotherapy Drugs			

#20 Outpatient Drugs – Notes

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#20 Outpatient Drugs – Group 1 – Base 1

PBP Data Entry System - Section B-20, C	ontract X0001, Plah 001, Segment 000	
	o To: #20 Outpatient Drugs - Group 1 - Base 1	
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lect a label for Group 1:		
	Indicate Maximum Plan Benefit Coverage annual amount for Group 1:	
elect the drug type(s) covered for Group 1:	Indicate Maximum Plan Benefit Coverage semi-annual	
Generic	amount for Group 1:	
Preferred Brand		
Brand	Indicate Maximum Plan Benefit Coverage quarterly amount	
the second se	for Group 1:	
there a Maximum Plan Benefit Coverage amount for Group 1? Yes		
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	Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:	
dicate Maximum Plan Benefit Coverage for Group 1 periodicity: Annually		
Semi-annually	Indicate Maximum Plan Benefit Coverage amount per	
Quarterly Monthly	prescription for Group 1:	
Per Prescription		
Other, Describe		
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:	

#20 Outpatient Drugs – Group 1 – Base 2

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	llee Coinsura	nce for Group 1?		Is there an enrollee Copayment for Group	1?	
Yes No				O Yes O No		
dicate Coins armacy:	urance perce	ntage for Group 1	Designated Reta	ail Indicate Copayment amount for Group Designated Retail Pharmacy:	Up to a day supply covered for Group 1 Designated Retail Pharmacy:	
licate Coins armacy:	urance perce	ntage for Group 1	HMO-Owned	Indicate Copayment amount for Group 1 HMO-Owned Pharmacy:	Up to a day supply covered for Group 1 HMO-Owned Pharmacy:	
licate Coins	urance percer	tage for Group 1	Mail Order:	Indicate Copayment amount for Group 1 Mail Order:	Up to a day supply covered for Group 1 Mail Order:	
dicate Coins	urance percer	ntage for Group 1	Other:	Indicate Copayment amount for Group Other:	Up to a day supply covered for Group 1 Other:	
						

#20 Outpatient Drugs – Group 2 – Base 1

Exit Exit (No	Go To: #20 Outpatient Drugs - Group 2 - Base 1	
evious Next (Validate) Validate)		
lect a label for Group 2:	Indicate Maximum Plan Benefit Coverage annual amount for	
	Group 2:	
lect the drug type(s) covered for Group 2:	Indicate Maximum Plan Benefit Coverage semi-annual amount	
Generic Preferred Brand	for Group 2:	
Brand		
there a Maximum Plan Benefit Coverage amount for	Indicate Maximum Plan Benefit Coverage quarterly amount for	
oup 2? Yes	Group 2:	
No		
dicate Maximum Plan Benefit Coverage for Group 2 riodicity:	Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:	
Annually		
Semi-annually Quarterly		
Monthly	Indicate Maximum Plan Benefit Coverage amount per	
Per Prescription	prescription for Group 2:	
Other, Describe		
	Indicate Maximum Plan Benefit Coverage amount for Other for	
	Group 2:	

#20 Outpatient Drugs – Group 2 – Base 2

PBP Data Entry System - Section	n B-20, Contract X0001, Plan 001	l, Segment 000	
	Go To: #20 Outpatient Drugs - Group	2 - Base 2	
revious Next (Validate) V	alidate)		
elect from where Group 2 Drugs can be acquired Designated Retail Pharmacy HMO-Owned Pharmacy Mail Order Other, Describe			
there an enrollee Coinsurance for Group 2?	Is there an enrollee Copayment for Group 2?		
No	C Yes C No		
ndicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy:	Indicate Copayment amount for Group 2 Designated Retail Pharmacy:	Up to aday supply covered for Group 2 Designated Retail Pharmacy:	
ndicate Coinsurance percentage for Group 2 for MO-Owned Pharmacy:	Indicate Copayment amount for Group 2 HMO-Owned Pharmacy:	Up to a day supply covered for Group 2 HMO-Owned Pharmacy:	
dicate Coinsurance percentage for Group 2 for ail Order:	Indicate Copayment amount for Group 2 Mail Order:	Up to a day supply covered for Group 2 Mail Order:	
dicate Coinsurance percentage for Group 2 for ther:	Indicate Copayment amount for Group 2 Other:	Up to a day supply covered for Group 2 Other:	

#20 Outpatient Drugs – Group 3 – Base 1

BP Data Entry System - Section B	0, Contract X0001, Plan 001, Segment 000	
	Go To: #20 Outpatient Drugs - Group 3 - Base 1	
revious Next (Validate) Validate		
lect a label for Group 3:	Indicate Maximum Plan Benefit Coverage annual amount for Group 3:	
	Group 3:	
lect the drug type(s) covered for Group 3:	Indicate Maximum Plan Benefit Coverage semi-annual amount	
Generic Preferred Brand	for Group 3:	
Brand		
there a Maximum Plan Benefit Coverage amount for	Indicate Maximum Plan Benefit Coverage quarterly amount for	
oup 3?	Group 3:	
Yes No		
dicate Maximum Plan Benefit Coverage Group 3	Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:	
riodicity: Annually		
Semi-annually Quarterly		
Monthly	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 3:	
Per Prescription Other, Describe		
	Indicate Maximum Plan Benefit Coverage amount for Other for Group 3:	

#20 Outpatient Drugs – Group 3 – Base 2

PBP Data Entry System - Section B-20), Contract X0001, Plan 001, S	egment 000	
Exit Exit No	Go To: #20 Outpatient Drugs - Group 3 - E	ase 2	
Previous Next (Validate) Validate)			
elect from where Group 3 Drugs can be acquired:			
Designated Retail Pharmacy			
HMO-Owned Pharmacy Mail Order			
Other, Describe			
there an enrollee Coinsurance for Group 3?	Is there an enrollee Copayment for Group 3?		
Yes No	C Yes C No		
ndicate Coinsurance percentage for Group 3 Designated tetail Pharmacy:	Indicate Copayment amount for Group 3 Designated Retail Pharmacy:	Up to a day supply covered for Group 3 Designated Retail Pharmacy:	
dicate Coinsurance percentage for Group 3 HMO-Owned	Indicate Copayment amount for Group 3	Up to a day supply covered for Group 3 HMO-Owned Pharmacy:	
harmacy:	HMO-Owned Pharmacy:	Group 3 HMO-Owned Pharmacy:	
dicate 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:	
dicate 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

Help), Contract X0001, Plan 001, Segment 000	<u> </u>
revious Next (Validate) Validate)	Go To: #20 Outpatient Drugs - Group 4 - Base 1	
· · · · · · · · · · · · · · · · · · ·		
lect a label for Group 4:	Indicate Maximum Plan Benefit Coverage annual amount for Group 4:	
lect the drug type(s) covered for Group 4: Generic	Indicate Maximum Plan Benefit Coverage semi-annual	
Preferred Brand	amount for Group 4:	
Brand		
there a Maximum Plan Benefit Coverage amount for	Indicate Maximum Plan Benefit Coverage quarterly amount	
oup 4? Yes	for Group 4:	
No		
dicate Maximum Plan Benefit Coverage Group 4: Annually	Indicate Maximum Plan Benefit Coverage monthly amount	
Semi-annually	for Group 4:	
Quarterly		
Monthly Per Prescription	Indicate Maximum Plan Benefit Coverage amount per	
Other, Describe	prescription for Group 4:	
	Indicate Maximum Plan Benefit Coverage amount for Other	
	for Group 4:	

#20 Outpatient Drugs – Group 4 – Base 2

PBP Data Entry System - Section B-20 Help	, Contract X0001, Plan 001, Se	gment 000	
	Go To: #20 Outpatient Drugs - Group 4 - Ba	se 2	
evious Next (Validate) Exit (No (Validate) Validate)			
lect from where Group 4 Drugs can be acquired: Designated Retail Pharmacy			
HMO-Owned Pharmacy Mail Order			
Mall Order Other, Describe			
nere an enrollee Coinsurance for Group 4?	Is there an enrollee Copayment for Group 4?		
Yes	C Yes		
No	C No		
dicate Coinsurance percentage for Group 4 Designated etail Pharmacy:	Indicate Copayment amount for Group 4 Designated Retail Pharmacy:	Up to a day supply covered for Group 4 Designated Retail Pharmacy:	
an manuacy.	Designated Retail Pharmacy.	Group + Designated Retail Frianacy.	
dicate Coinsurance percentage for Group 4 HMO-Owned armacy:	Indicate Copayment amount for Group 4 HMO-Owned Pharmacy:	Up to a day supply covered for Group 4 HMO-Owned Pharmacy:	
dicate Coinsurance percentage for Group 4 Mail Order:		line has a second for	
	Indicate Copayment amount for Group 4 Mail Order:	Up to a day supply covered for Group 4 Mail Order:	
dicate Coinsurance percentage for Group 4 Other:	1. 1. 1. O	Unite a day symply asysted for	
	Indicate Copayment amount for Group 4 Other:	Up to a day supply covered for Group 4 Other:	

#20 Outpatient Drugs – Group 5 – Base 1

	, Contract X0001, Plan 001, Segment 000	<u></u>
Help Previous Next (Validate) Validate)	Go To: #20 Outpatient Drugs - Group 5 - Base 1	
elect a label for Group 5:	Indicate Maximum Plan Benefit Coverage annual amount for Group 5:	
Select the drug type(s) covered for Group 5: Generic Preferred Brand Brand	Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 5:	
s there a Maximum Plan Benefit Coverage amount for sroup 5?	Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:	
) Yes D No		
dicate Maximum Plan Benefit Coverage for Group 5 eriodicity: Annually Semi-annually	Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:	
Quarterly Monthly Per Prescription Other, Describe	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	_ 8
e Help	Go To: #20 Outpatient Drugs - Group 5	Base 2	
Previous Next (Validate) Validat	lo te)		
Select from where Group 5 Drugs can be acquired:			
Designated Retail Pharmacy			
HMO-Owned Pharmacy Mail Order			
Other, Describe			
s there an enrollee Coinsurance for Group 5? © Yes	Is there an enrollee Copayment for Group 5?		
⊖ Yes ⊃ No	C Yes C 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:	
ndicate 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

PBP Data	Entry Sy	/stem - Sec	tion B-20	, Contract X0	001, Plan 001, Segment 00	0			E
Telb		1	×	Go To: #20 Hor	ne Infusion Bundled Services		•		
revious	Next	Exit (Validate)	Exit (No Validate)	G0 10. [#2010]	ne imusion bundled Services				
remous	Heat	(validate)	validate)	_		_	_	_	 -
oes the plan pr	ovide Part D I	nome infusion dru	ugs as part of a l	oundled service					
s a supplement	tal benefit?			1.1					
) Yes) No									
bundled servic	e as a supple	plan provide Part mental benefit?, y must be uploader , June 09, 2017 at	ou must indica	n drugs as part of te these specific ormulary rn Time.					
ou must also er t any services Iministration.	nsure that you and supplies	r benefit includes associated with th	not only the ho he home infusio	me infusion drug, n drug's					
indled service ascribed in the	then those se CY 2010 Call ing for the bur	provide Part D hor ervices must be pr Letter this waiver i ndle of home infus	ovided at \$0 co. is conditioned of	st sharing. As					
apremental De	areat								