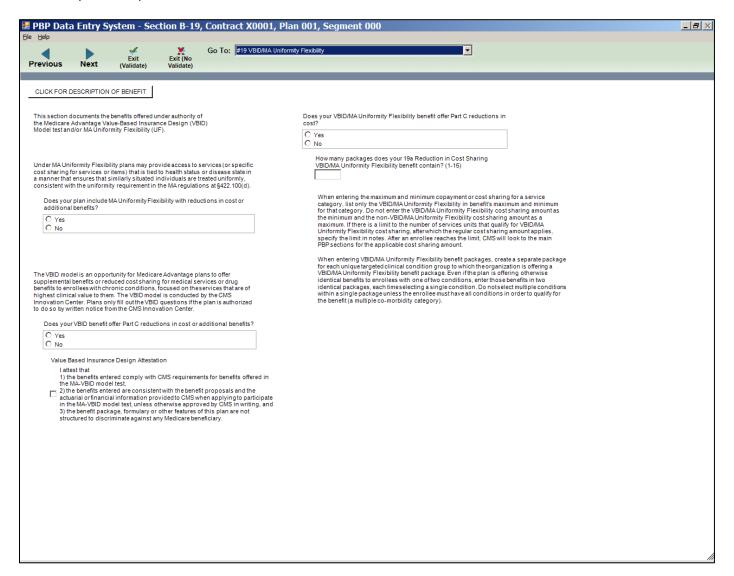
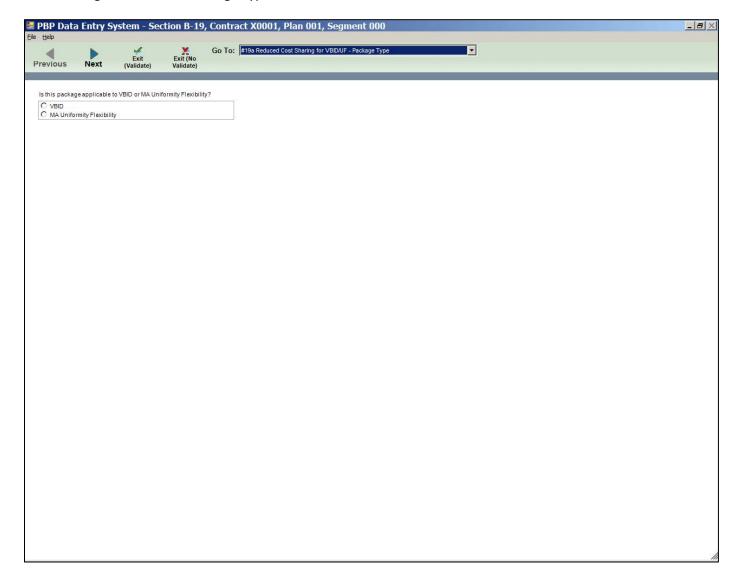
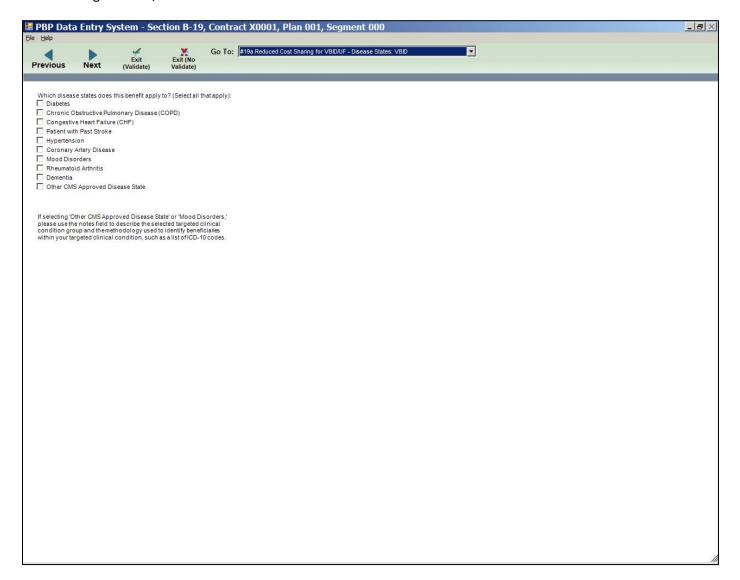
#19 VBID/MA Uniformity Flexibility



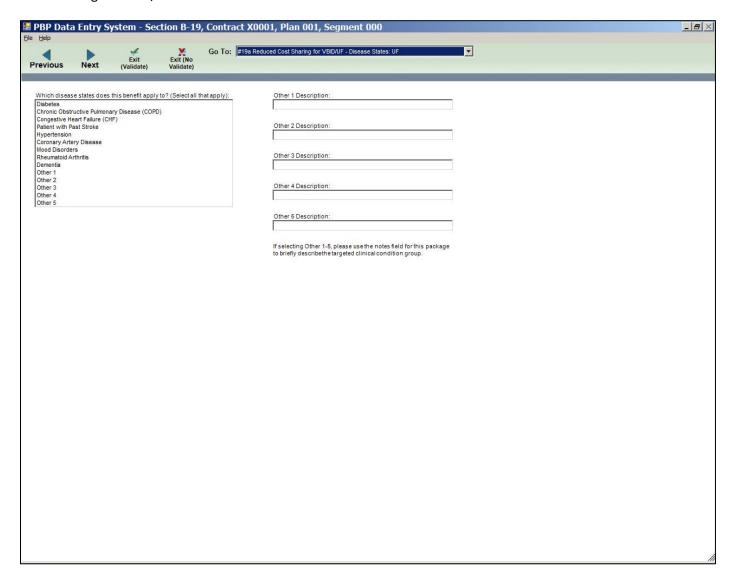
#19a Reduced Cost Sharing for VBID/UF – Package Type



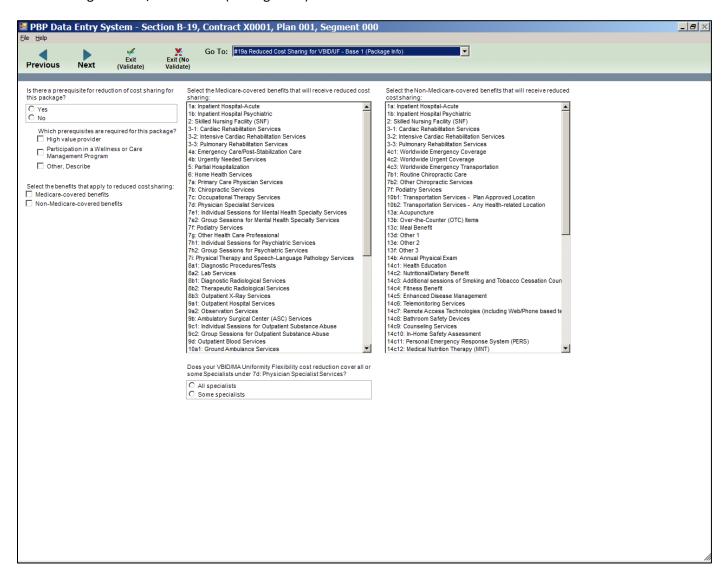
#19a Reduced Cost Sharing for VBID/UF - Disease States: VBID



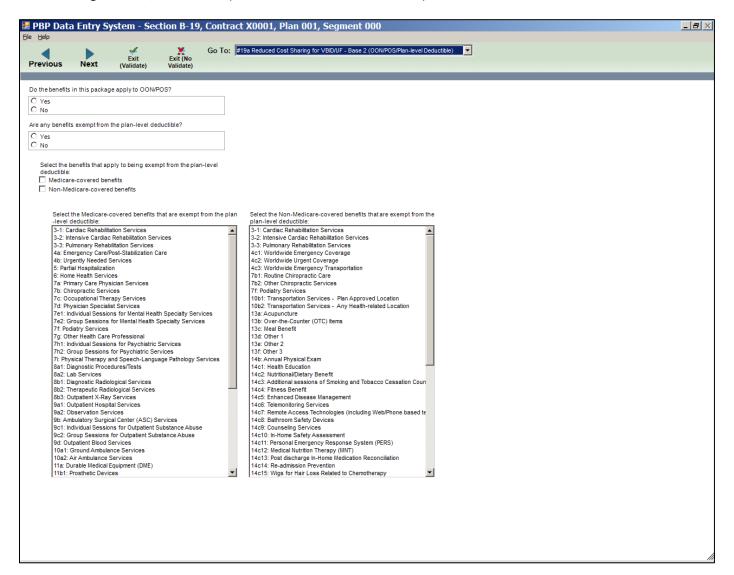
#19a Reduced Cost Sharing for VBID/UF - Disease States: UF



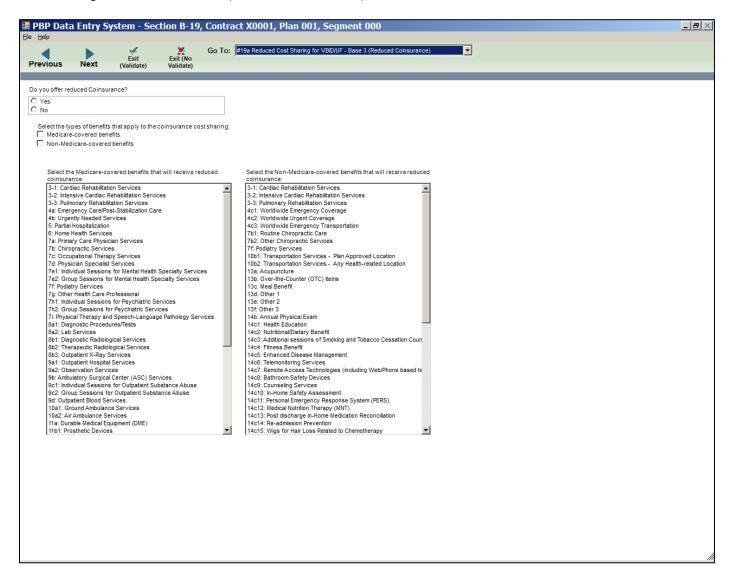
#19a Reduced Cost Sharing for VBID/UF - Base 1 (Package Info)



#19a Reduced Cost Sharing for VBID/UF - Base 2 (OON/POS/Plan-level Deductible)



#19a Reduced Cost Sharing for VBID/UF - Base 3 (Reduced Coinsurance)



#19a Reduced Cost Sharing for VBID/UF – Base 4 (Reduced Coinsurance)

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Indicate Coins	surance for one	ormore of the fol	llowing Medicare	-covered servi	ces:			
			Minimum Coinsurance	Maximum Coinsurance		Minimum Coinsurance	Maximum coinsurance	
Cardiac Reha	bilitation Servic	ces			Podiatry Services			
Intensive Card	diac Rehabilitat	ion Services			Other Health Care Professional			
Pulmonary Re	habilitation Se	rvices			Individual Sessions for Psychiatric Services			
Emergency C	are/Post-Stabili	zation Care			Group Sessions for Psychiatric Services			
Urgently Need	ded Services				Physical Therapy and Speech-Language Pathology Services			
Partial Hospit	alization				Diagnostic Procedures/Tests			
Home Health	Services				Lab Services			
Primary Care	Physician Serv	ices			Diagnostic Radiological Services			
Chiropractic S	Services				Therapeutic Radiological Services			
Occupational	Therapy Service	ces			Outpatient X-Ray Services			
Physician Spe	ecialist Service	s			Outpatient Hospital Services			
Individual Ses Specialty Serv	sions for Ment rices	al Health			Observation Services			
Group Sessio Services	ns for Mental H	ealth Specialty			Ambulatory Surgical Center (ASC) Services			

#19a Reduced Cost Sharing for VBID/UF – Base 5 (Reduced Coinsurance)

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Elle Help Previous Next (Validate)	Exit (No Validate)		9a Reduced Cost Sharing for VBID/UF - Base 5 (Red		
Indicate Coinsurance for one or more of the fol	llowing Medicare	-covered service	es.		
marcate comparance for one or more or are to	nowing incurcan				
	Minimum Coinsurance	Maximum Coinsurance		Minimum Maximum Coinsurance Coinsurance	
Outpatient Substance Abuse			Glaucoma Screening		
Group Sessions for Outpatient Substance Abuse			Diabetes Self-Management Training		
Outpatient Blood Services			Barium Enemas		
Ground Ambulance Services			Digital Rectal Exams		
Air Ambulance Services			EKG following Welcome Visit		
Durable Medical Equipment (DME)			Other Medicare-covered Preventive Services		
Prosthetic Devices			Medicare Part B Chemotherapy Drugs		
Medical Supplies			Other Medicare Part B Drugs		
Diabetic Supplies			Comprehensive Dental		
Diabetic Therapeutic Shoes/Inserts			Eye Exams		
Dialysis Services			Eyewear		
Kidney Disease Education Services			Hearing Exams		

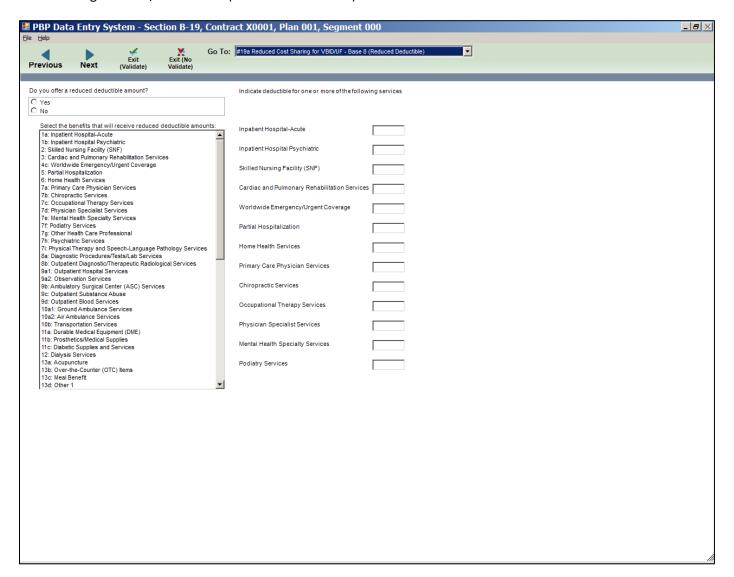
#19a Reduced Cost Sharing for VBID/UF – Base 6 (Reduced Coinsurance)

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rievious	Next	(Validate)	Validate)	_		
Indicate Coinsu	urance for one (or more of the follo	wing Non-Med	dicare-covered	s ervices:	
			Minimum Coinsurance	Maximum e Coinsurance		Minimum Maximum Coinsurance Coinsurance
Additional Care	diac Rehabilitat	ion Services			Other 2	
Additional Inte Services	nsive Cardiac F	Rehabilitation			Other 3	
Additional Puln	monary Rehabii	itation Services			Annual Physical Exam	
WorldwideEm	ergency Cover	age			Health Education	
Worldwide Urg	gent Coverage				Nutritional/Dietary Benefit	
WorldwideEm	ergency Trans	portation			Additional sessions of Smoking and Tobacco Cessation Counseling	•
Chiropractic S	ervices - Routi	ne Care			Fitness Benefit	
Chiropractic S	ervices - Other	Services			Enhanced Disease Management	
Podiatry Service	ces - Routine F	oot Care			Telemonitoring Services	
Transportation Location	Services - Pla	n Approved			Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)	g
Transportation related Location		y Health-			Bathroom Safety Devices	
Acupuncture					Counseling Services	
Over-the-Coun	nter (OTC) Item	S			In-Home Safety Assessment	
Meal Benefit					Personal Emergency Response System (PERS)	
Other 1					Medical Nutrition Therapy (MNT)	

#19a Reduced Cost Sharing for VBID/UF – Base 7 (Reduced Coinsurance)

■ PBP Data Entry S	ystem - Sec	tion B-19,	, Contract	t X0001, Plan 001, Segment 0	00	. 🗗 🗴
File Help Previous Next	Exit (Validate)	Exit (No Validate)		19a Reduced Cost Sharing for VBID/UF - Base 7 (f		
Indicate Coinsurance for one		usina Nan Mad				
Indicate Coinsulance for one	or more or the folio	wing Non-Med	icare-covered	SELVICES.		
		Minimum Coinsurance	Maximum Coinsurance		Minimum Maximum Coinsurance Coinsurance	
Post discharge In-Home Me Reconciliation	dication			Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services		
Re-admission Prevention				Routine Eye Exams		
Wigs for Hair Loss Related to	Chemotherapy			Other Eye Exam Services		
Weight Management Progra	ms			Contact Lenses		
Alternative Therapies				Eyeglasses (lenses and frames)		
Oral Exams				Eyeglass lenses		
Prophylaxis (Cleaning)				Eyeglass frames		
Fluoride Treatment				Upgrades		
Dental X-Rays				Routine Hearing Exams		
Non-routine Services				Fitting/Evaluation for Hearing Aid		
Diagnostic Services				Hearing Aids (all types)		
Restorative Services				Hearing Aids - Inner Ear		
Endodontics				Hearing Aids - Outer Ear		
Periodontics				Hearing Aids - Over the Ear		
Extractions						

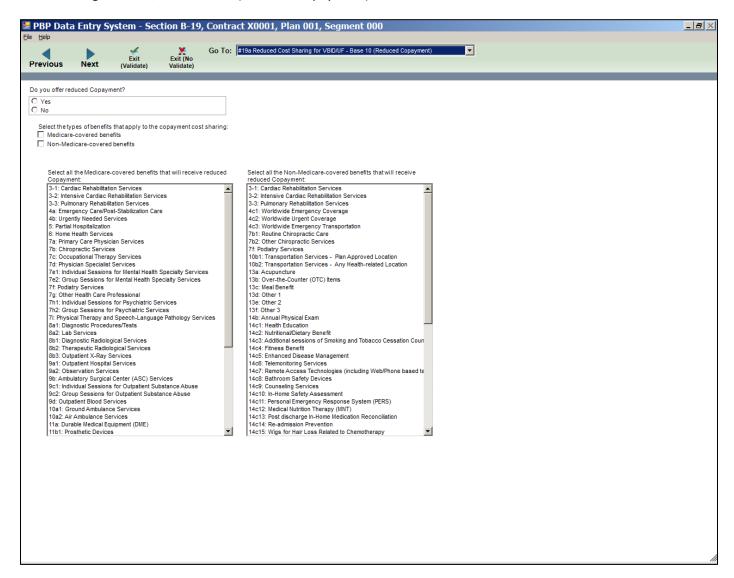
#19a Reduced Cost Sharing for VBID/UF - Base 8 (Reduced Deductible)



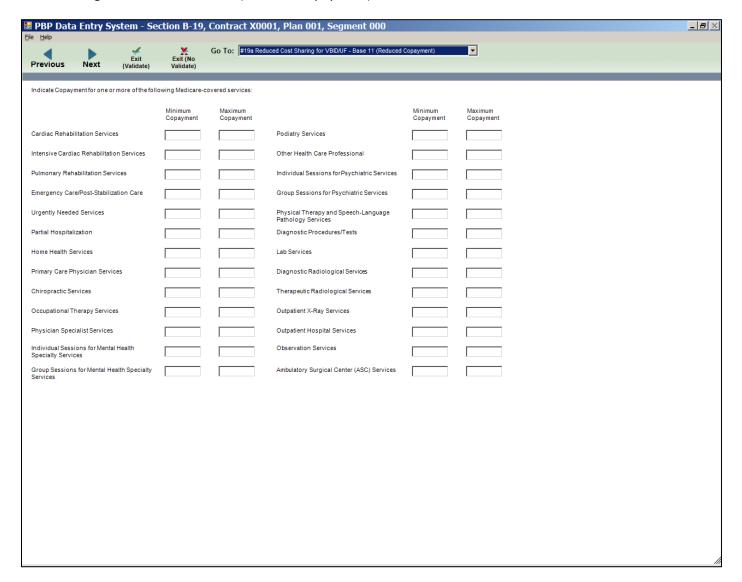
#19a Reduced Cost Sharing for VBID/UF – Base 9 (Reduced Deductible)

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■		Exit	Exit (Mo	Go To:	#19a Reduced C	ost Sharing	for VBID	/UF - Base 9 (Reduced Deductible)		▼			
Previous	Next	(Validate												
Indicate deducti	ible for one or mo	re of the f	ollowing servi	ces										
		De	eductible				Dedu	ctible		De	eductible		Deductible	
			nount				Amou				nount		Amount	
Other Health Ca	are Professional			Prosth	etic Device	s			Enhanced Disease Management			Glaucoma Screening		
Psychiatric Serv	vices			Diabet	ic Supplies	and Services			Telemonitoring Services			Diabetes Self-Management Training		
Physical Therap Language Patho	oy and Speech- plogy Services			Dialys	is Services				Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline	e)		Barium Enemas		
Diagnostic Prod Services	cedures/Tests/La	b [Acupu	ncture				Bathroom Safety Devices			Digital Rectal Exams		
Outpatient Diag Radiological Se	nostic/Therapeu ervices	tic _		Over-t	he-Counter	(OTC) Items			Counseling Services			EKG following Welcome Visit		
Outpatient Hosp	oital Services			Meal B	enefit				In-Home Safety Assessment			Other Medicare-covered Preventive Services		
Observation Se	rvices			Other	1				Personal Emergency Response System (PERS)			Medicare Part B Rx Drugs		
Ambulatory Surg Services	gical Center (ASC	C) [Other	2				Medical Nutrition Therapy (MNT)			Preventive Dental		
Outpatient Subs	tance Abuse			Other	3				Post discharge In-Home Medication Reconciliation			Comprehensive Dental		
Outpatient Bloo	d Services			Annua	l Physical E	Exam			Re-admission Prevention			Eye Exams		
Ground Ambula	nce Services			Health	Education				Wigs for Hair Loss Related to Chemotherapy			Eyewear		
Air Ambulance S	Services			Nutritio	onal/Dietary	Benefit			Weight Management Programs			Hearing Exams		
Transportation	Services					ns of Smoking an on Counseling	d		Alternative Therapies			Hearing Aids		
Durable Medical	l Equipment (DM	E)		Fitnes	s Benefit				Kidney Disease Education Service	ces				

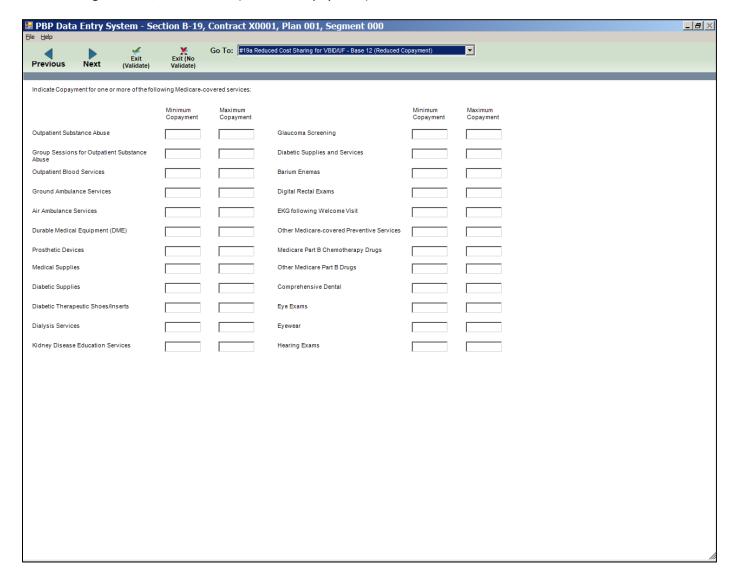
#19a Reduced Cost Sharing for VBID/UF - Base 10 (Reduced Copayment)



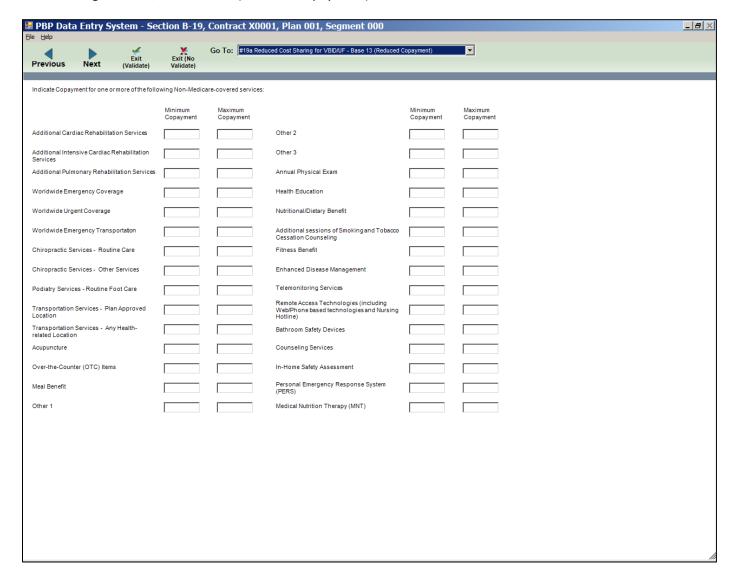
#19a Reduced Cost Sharing for VBID/UF - Base 11 (Reduced Copayment)



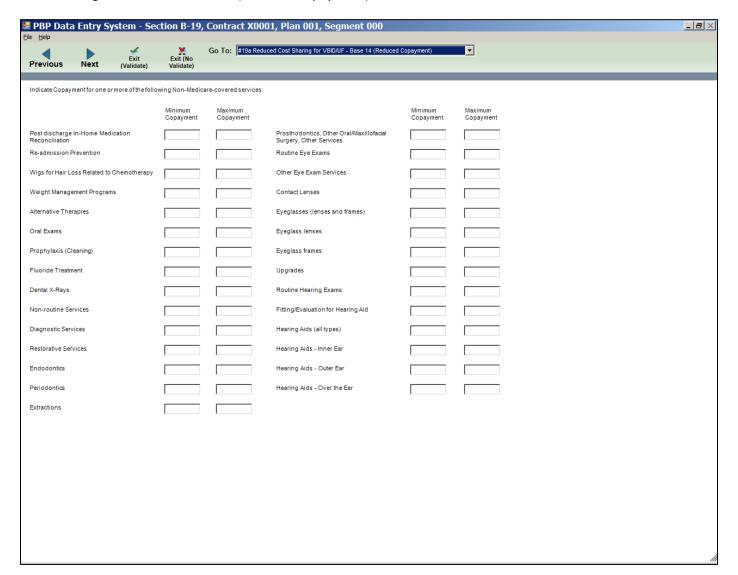
#19a Reduced Cost Sharing for VBID/UF - Base 12 (Reduced Copayment)



#19a Reduced Cost Sharing for VBID/UF - Base 13 (Reduced Copayment)



#19a Reduced Cost Sharing for VBID/UF - Base 14 (Reduced Copayment)



#19a Reduced Cost Sharing for VBID/UF – Base 15 (Reduced Specialist Coinsurance)

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Previous	Next	(Validate) V	alidate)						
Select all Specia Geriatrics	alists with a redu	uced coinsurance:	Indicate Coinsurance for on	e or more of the	e following Sp	ecialists:			
Allergy and Immu	unology			Minimum	Maximum		Minimum	Maximum	
Cardiology Dermatology				Coinsurance	Coinsurance	•	Coinsurance	Coinsurance	
Endocrinology			Geriatrics			Oncology - Medical, Surgical			
ENT/Otolaryngoli Gastroenterolog	у					Oncology - Radiation/			
General Surgery Gynecology, OB			Allergy and Immunology			Radiation Oncology			
Infectious Diseas			Cardiology			Ophthalmology			
Nephrology Neurology						-			
Neurosurgery Oncology - Medi	inal Curainal		Dermatology			Orthopedic Surgery			
Oncology - Radia		Incology	Endocrinology			Physiatry, Rehabilitative			
Ophthalmology Orthopedic Surg	ery		2.1000.111009)			Medicine			
Physiatry, Rehat Plastic Surgery		•	ENT/Otolaryngology			Plastic Surgery			
Pulmonology			Gastroenterology			Pulmonology			
Rheumatology Urology			Gastroenterology			Pallionology			
Vascular Surger Cardiothoracic S			General Surgery			Rheumatology			
Other*	surgery								
* Diana Hattha		-1	Gynecology, OB/GYN			Urology			
* Please list the specialty in the	Notes	ai	Infectious Diseases			Vascular Surgery			
			Nephrology			Cardiothoracic Surgery			
			Neurology			Other			
			Neurosurgery						
1									
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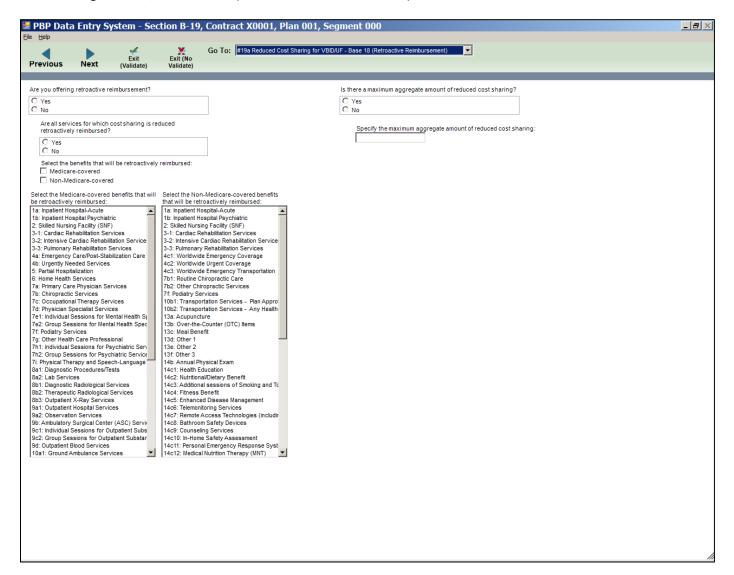
#19a Reduced Cost Sharing for VBID/UF – Base 16 (Reduced Specialist Deductible)

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ile <u>H</u> elp	∀ Go To: #49a Pa	educed Cost Sharing for V	/BID/UF - Base 16 (Reduced Spec	cialist Deductible)	
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(Validate)	validate)				
Select all Specialists with a reduced deductible:	Indicate Deductible for one	or more of the following	Specialists:		
Geriatrics Allergy and Immunology		Deductible		Deductible	
Cardiology Dermatology		Amount		Amount	
Endocrinology	Geriatrics		Oncology - Medical, Surgical		
ENT/Otolaryngology Gastroenterology			Oncology - Radiation/		
General Surgery	Allergy and Immunology		Radiation Oncology		
Gynecology, OB/GYN Infectious Diseases	Cardiology		Ophthalmology		
Nephrology Neurology	,				
Neurosurgery	Dermatology		Orthopedic Surgery		
Oncology - Medical, Surgical Oncology - Radiation/Radiation Oncology	Endocrinology		Physiatry, Rehabilitative		
Ophthalmology Orthopedic Surgery	Endodiniology		Medicine		
Physiatry, Rehabilitative Medicine Plastic Surgery	ENT/Otolaryngology		Plastic Surgery		
Pulmonology	Gastroenterology		Pulmonology		
Rheumatology Urology	Casa conto crogy		amonology		
Vascular Surgery Cardiothoracic Surgery	General Surgery		Rheumatology		
Other*	Gynecology, OB/GYN		Urology		
* Please list the provider's actual	ojiioologj, ozioiii		o.o.o.gy		
specialty in the Notes	Infectious Diseases		Vascular Surgery		
	Nephrology		Cardiothoracic Surgery		
	Neurology		Other		
	Neurosurgery				

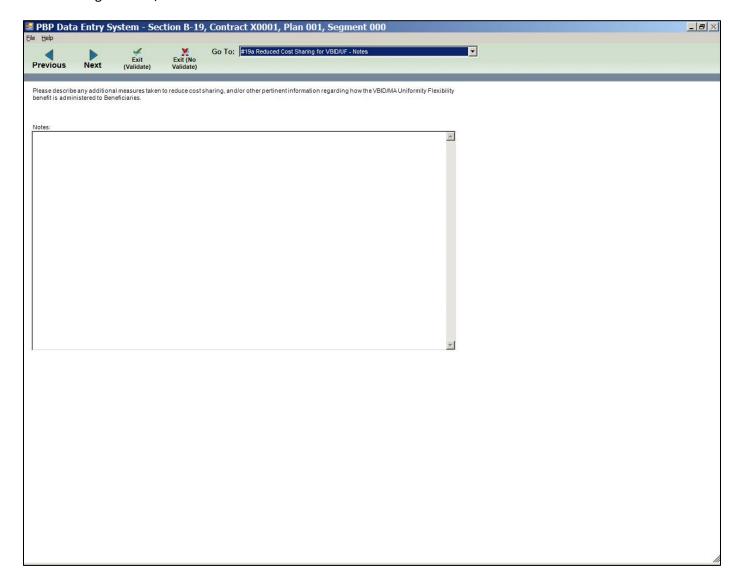
#19a Reduced Cost Sharing for VBID/UF – Base 17 (Reduced Specialist Copayment)

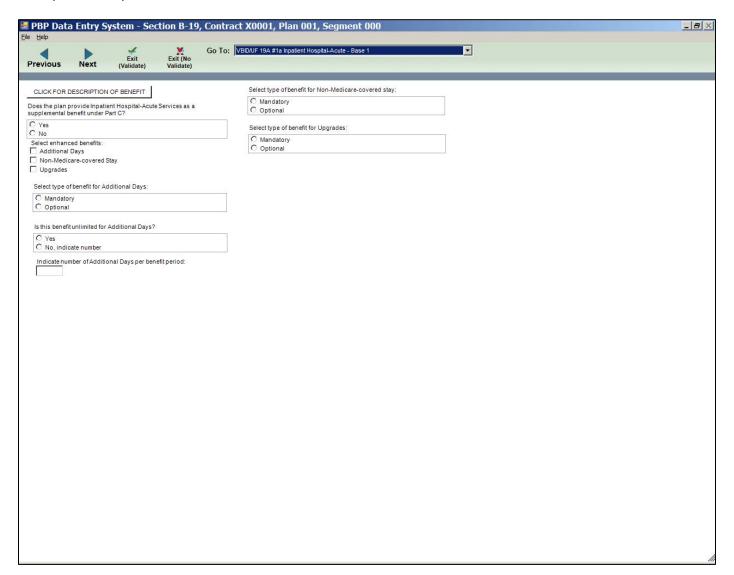
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Select all Specialists with a reduced copayment:	Indicate Copayment for one	e or more of the	following Specialists:			
Geriatrics Allergy and Immunology		Minimum	Maximum	Minimum	Maximum	
Cardiology Dermatology			Copayment		t Copayment	
Endocrinology	Geriatrics		Oncology - Medical	, Surgical		
ENT/Otolaryngology Gastroenterology			Oncology - Radiatio	in/		
General Surgery Gynecology, OB/GYN	Allergy and Immunology		Radiation Oncology			
Infectious Diseases	Cardiology		Ophthalmology			
Nephrology Neurology						
Neurosurgery Oncology - Medical, Surgical	Dermatology		Orthopedic Surgery			
Oncology - Radiation/Radiation Oncology	Endocrinology		Physiatry, Rehabilit	ative		
Ophthalmology Orthopedic Surgery			Medicine			
Physiatry, Rehabilitative Medicine Plastic Surgery	ENT/Otolaryngology		Plastic Surgery			
Pulmonology Rheumatology	Gastroenterology		Pulmonology			
Urology	2,					
Vascular Surgery Cardiothoracic Surgery	General Surgery		Rheumatology			
Other*	Gynecology, OB/GYN		Urology			
* Please list the provider's actual	27,					
specialty in the Notes	Infectious Diseases		Vascular Surgery			
	Nephrology		Cardiothoracic Surg	gery		
	Neurology		Other			
	Neurosurgery					

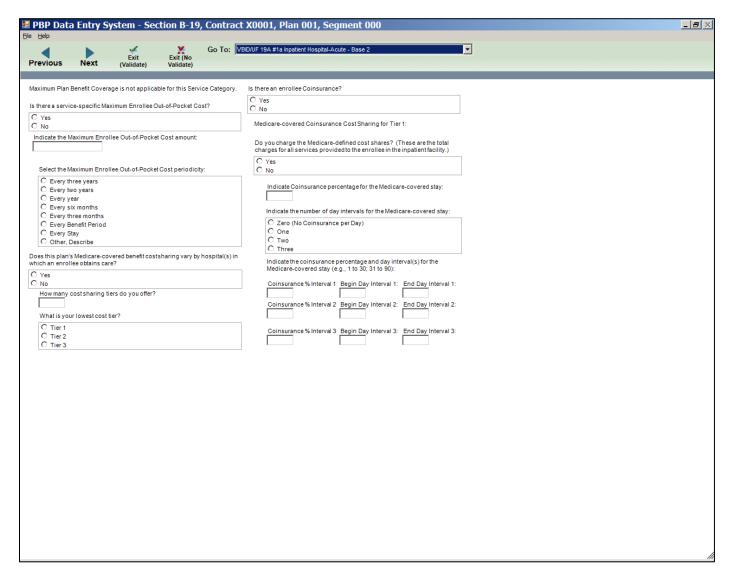
#19a Reduced Cost Sharing for VBID/UF - Base 18 (Retroactive Reimbursement)

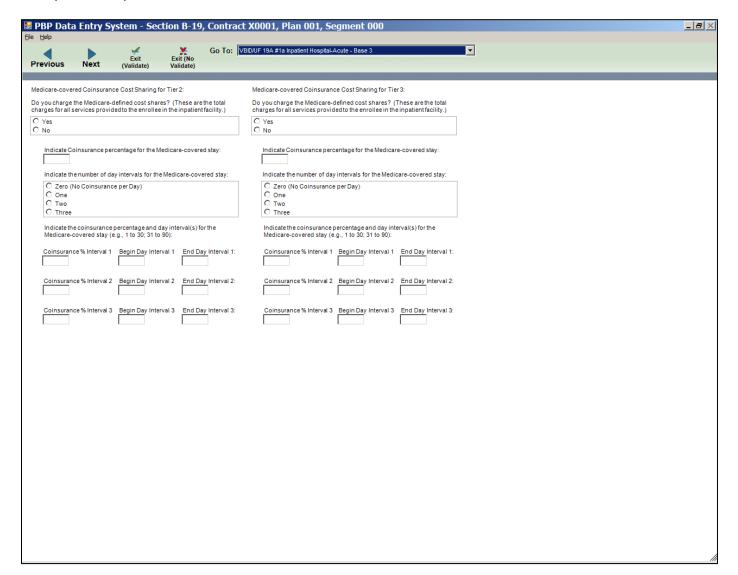


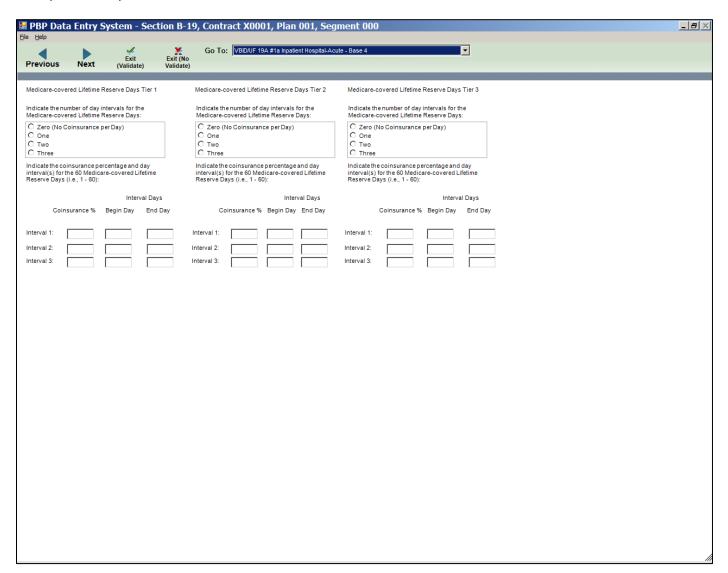
#19a Reduced Cost Sharing for VBID/UF - Notes

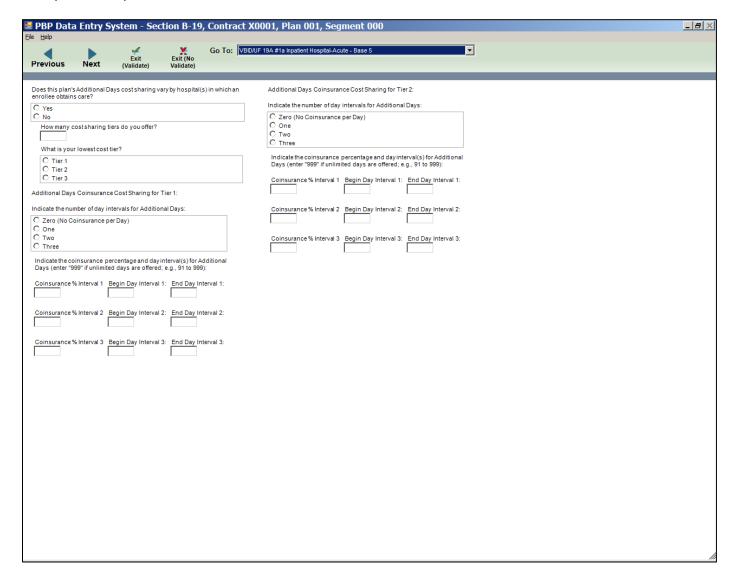


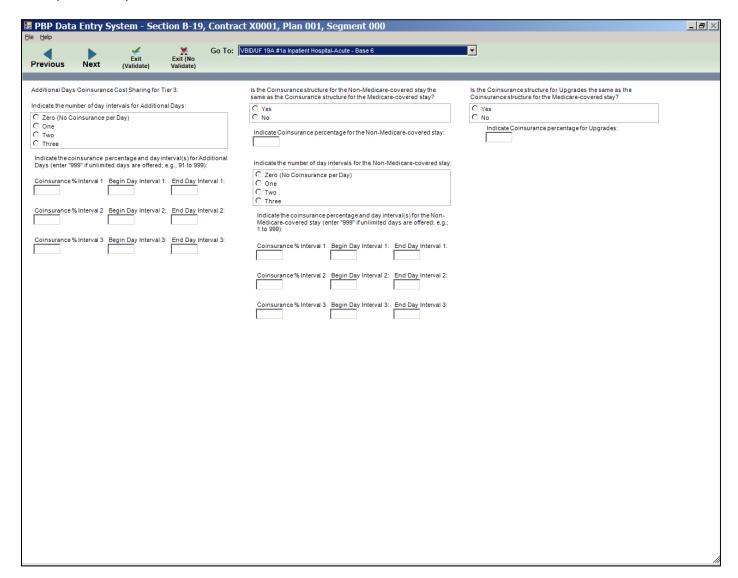


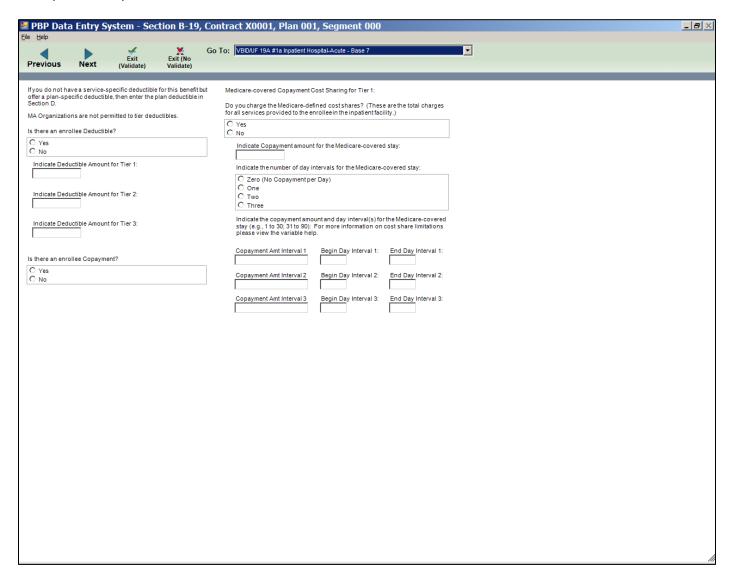


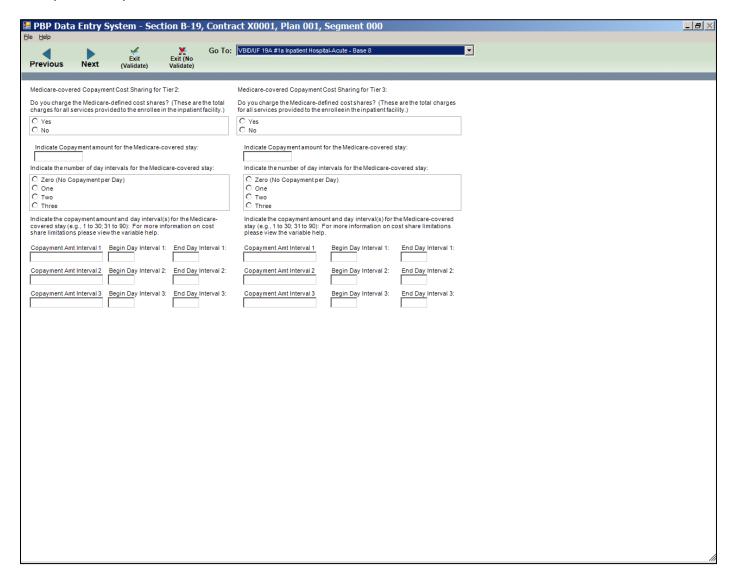


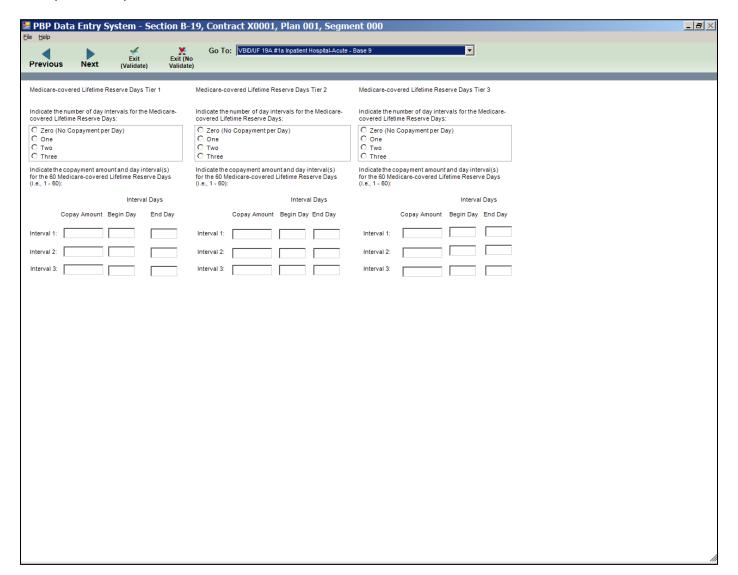


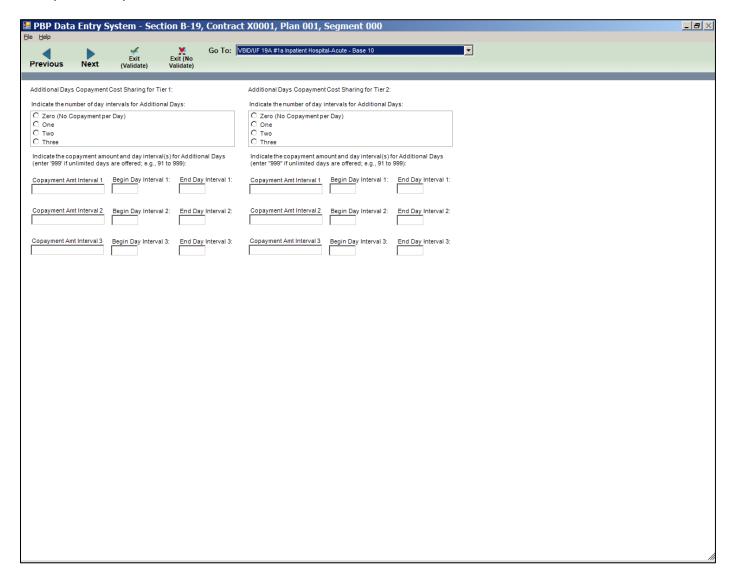


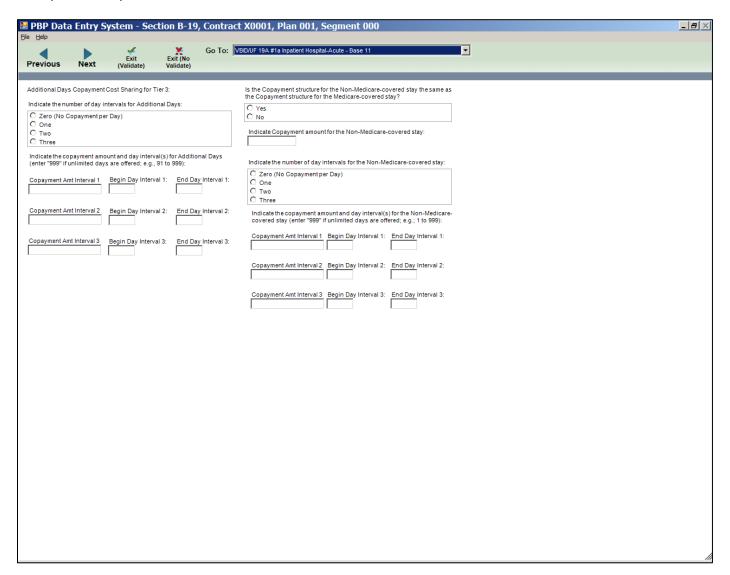


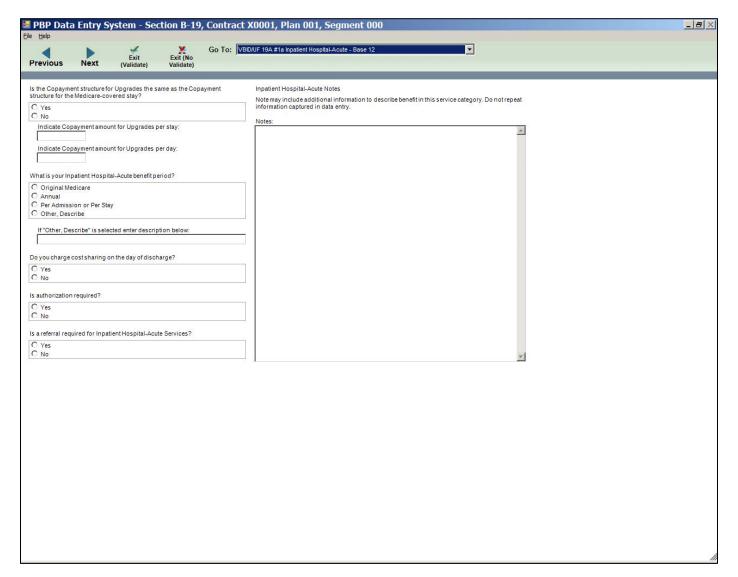




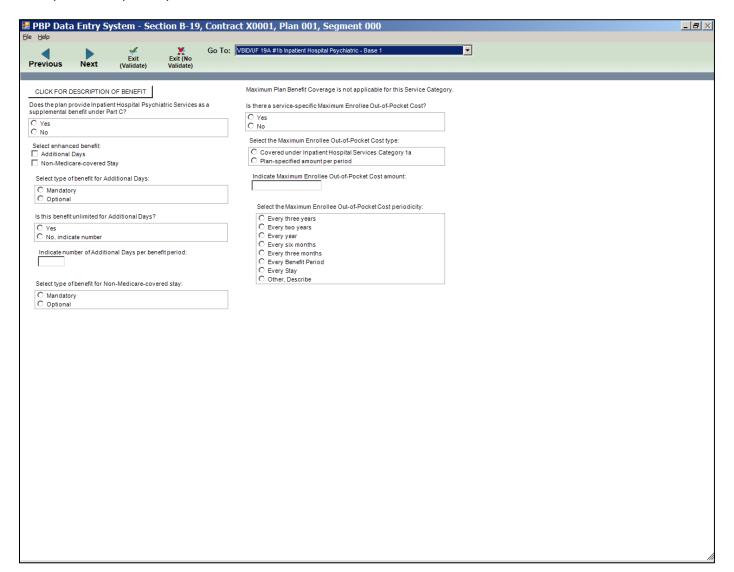


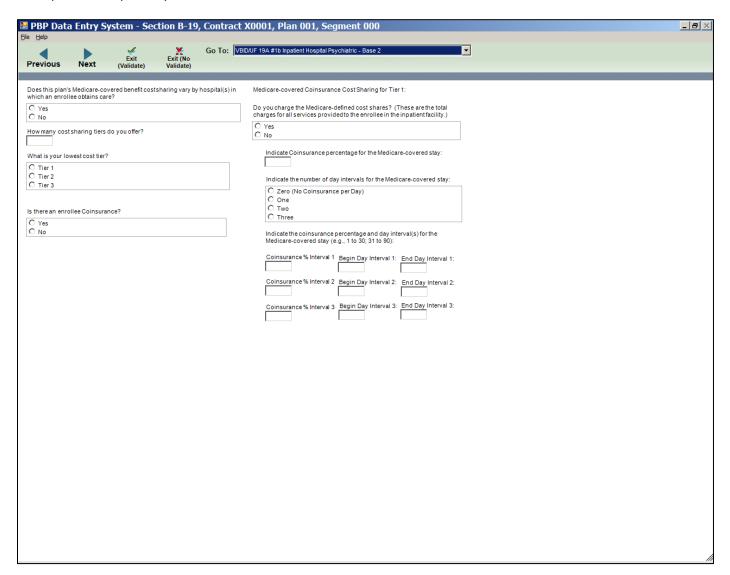


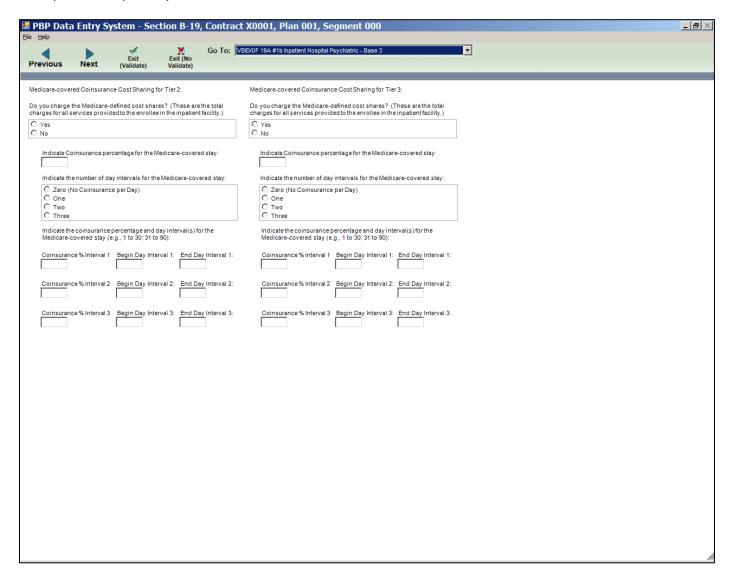




VBID/UF 19A #1b Inpatient Hospital Psychiatric – Base 1

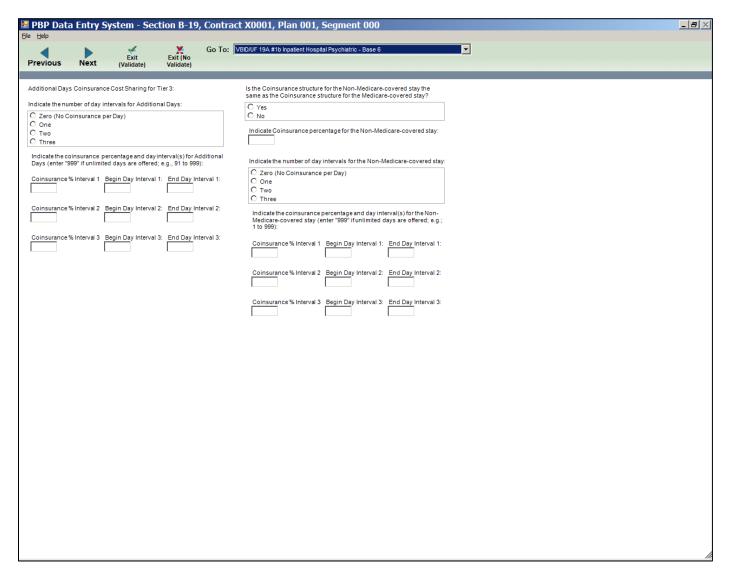


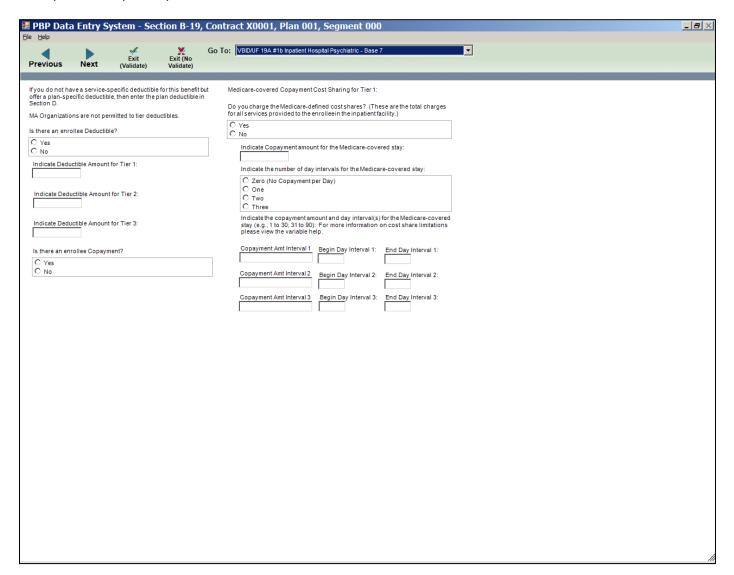


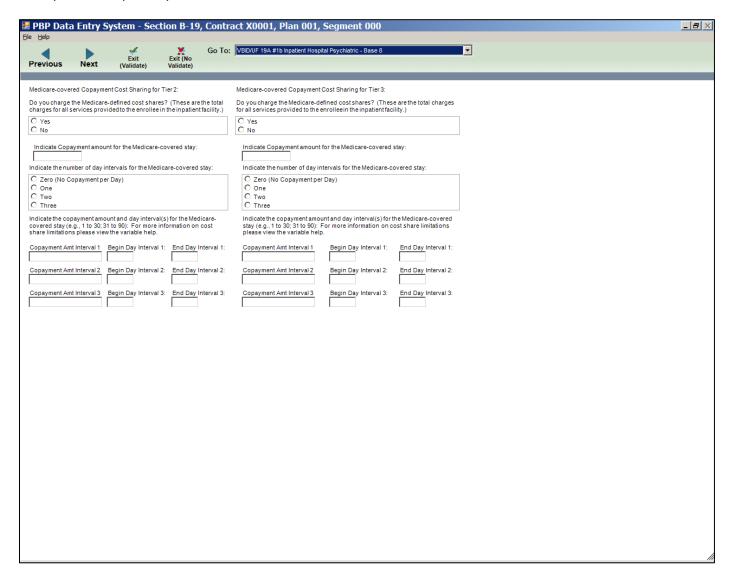


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Previous	Next	(Validate)	e) Validate)			
Medicare-co	vered Lifetime	Reserve Days 1	Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3	
Indicate the Medicare-co	number of day vered Lifetime	intervals for the Reserve Days:	В	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	
C Zero (No	Coinsurance	per Day)		C Zero (No Coinsurance per Day) C One	C Zero (No Coinsurance per Day) C One	
O One				O Two	C Two	
O Three				C Three	C Three	
interval(s) fo	coinsurance p r the 60 Medic s (i.e., 1 - 60):	ercentage and d care-covered Life	fay etime	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 50 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	
		Interval	ıl Days	Interval Days	Interval Days	
Co	insurance %	Begin Day	End Day	Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day	
Interval 1:				Interval 1:	Interval 1:	
Interval 2:				Interval 2:	Interval 2:	
Interval 3:				Interval 3:	Interval 3:	

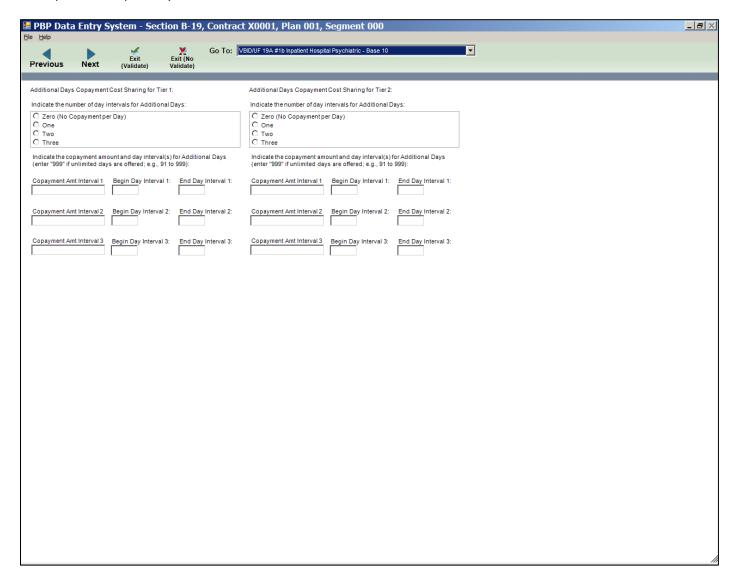
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ile <u>H</u> elp		J.	y .	Go To: VBI	D/UF 19A #1b Inpatient Hospital Psychiatric - Base 5	
Previous	Next	Exit (Validate)	Exit (No Validate)			
Does this plar enrollee obtai	n's Additional D ins care?	ays cost sharing	ary by hospital((s) in which an	Additional Days Coinsurance Cost Sharing for Tier 2:	
O Yes O No					Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day)	
	cost sharing t	iers do you offer?			C One	
)A/b -4 i	our lowest cost	#i2			C Two	
C Tier 1	our lowest cost	lier?			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 2 C Tier 3						
		e Cost Sharing for	Tier 1:		Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1:	
		ntervals for Addition			Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2:	
C Zero (No	Coinsurance p		•			
O One O Two					Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	
C Three						
Indicate the	coinsurance p	ercentage and day ed days are offere	rinterval(s) for A	Additional 9):		
		Begin Day Interva				
Comsulance	e 76 III.Lei Vali I	Degin Day interva	I I. Elid Day II	itervar i.		
Coinsurance	e % Interval 2	Begin Day Interva	12: End Day In	nterval 2:		
		,				
Coinsurance	e % Interval 3	Begin Day Interva	13: End Day In	nterval 3:		
	I					

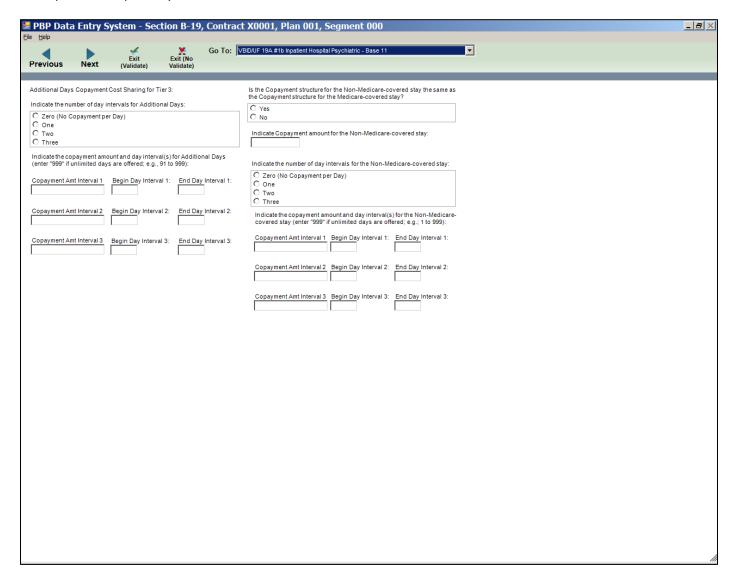


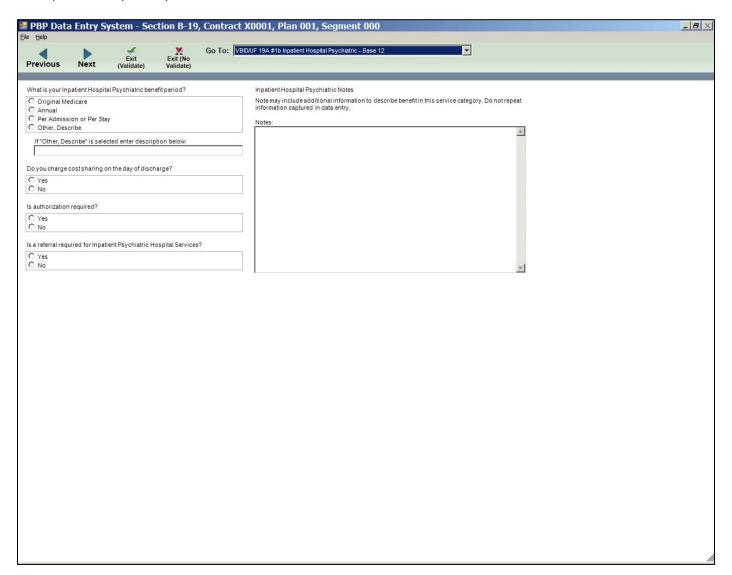


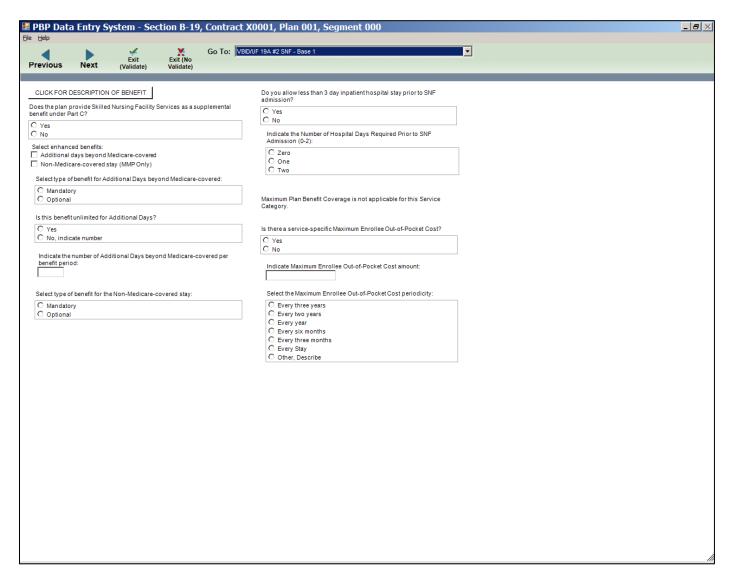


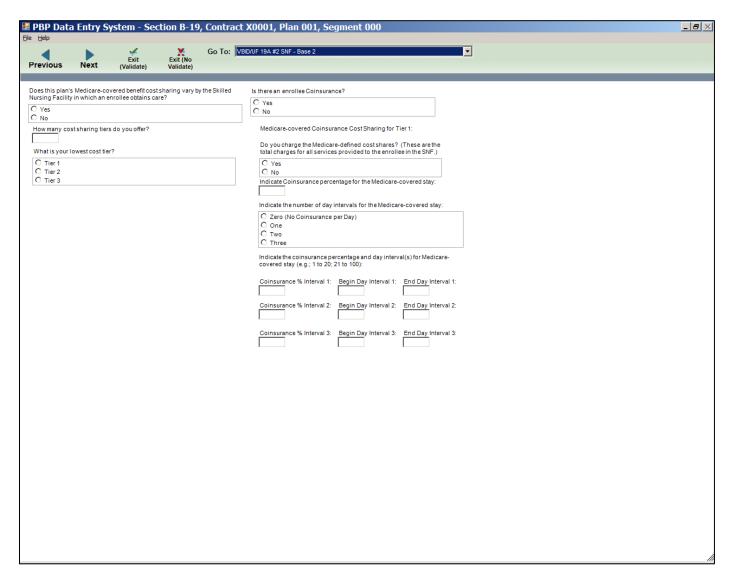
⊞ PBP D	ata Entry	System -	- Section B	3-19, Contract X0001, Plan 001, Segr	nent 000	_ 5 X
<u>File</u> <u>H</u> elp						
•		Exit		Go To: VBID/UF 19A #1b Inpatient Hospital Psyc	hiatric - Base 9 ▼	
Previou	s Next	(Valida	ite) Valida	ate)		
Medicare-	overed Lifetime	Reserve Day	s lier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3	
Indicate th	e number of day fetime Reserve (intervals for t Days:	he Medicare-	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	
O Zero (1	lo Copayment p	er Day)		C Zero (No Copayment per Day) C One	C Zero (No Copayment per Day) C One	
O Two	O One			C Two	C Two	
C Three				C Three	C Three	
Indicate the for the 60 P (i.e., 1 - 60)	e copayment am Medicare-covere I:	ount and day ed Lifetime Re	interval(s) serve Days	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):	
		Inter	val Days	Interval Days	Interval Days	
	Copay Amount	Begin Day	End Day	Copay Amount Begin Day End Day	Copay Amount Begin Day End Day	
Interval 1:				Interval 1:	Interval 1:	
Interval 2:				Interval 2:	Interval 2:	
Interval 3:				Interval 3:	Interval 3:	

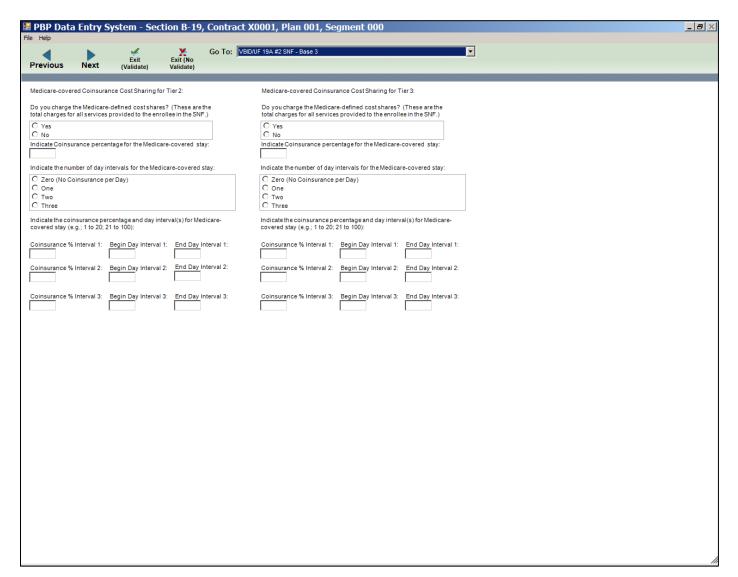




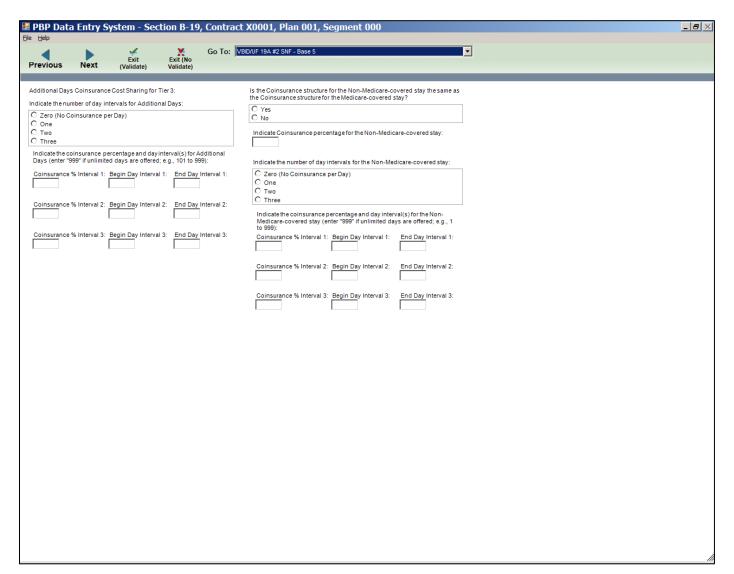


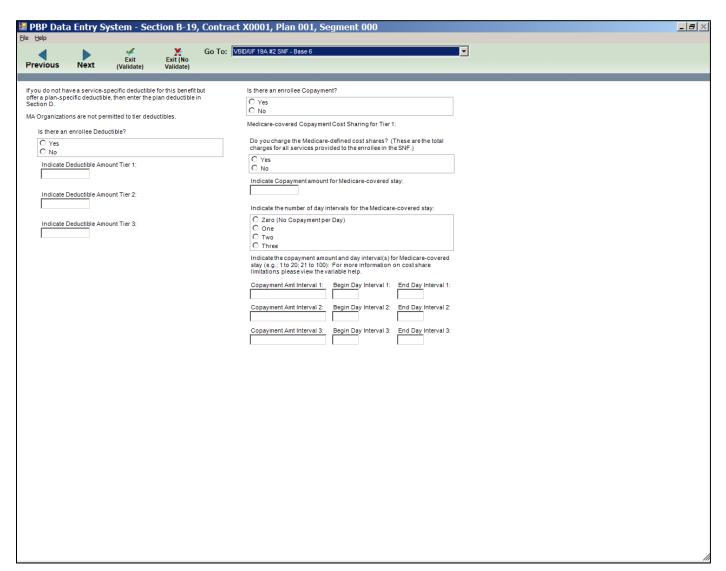


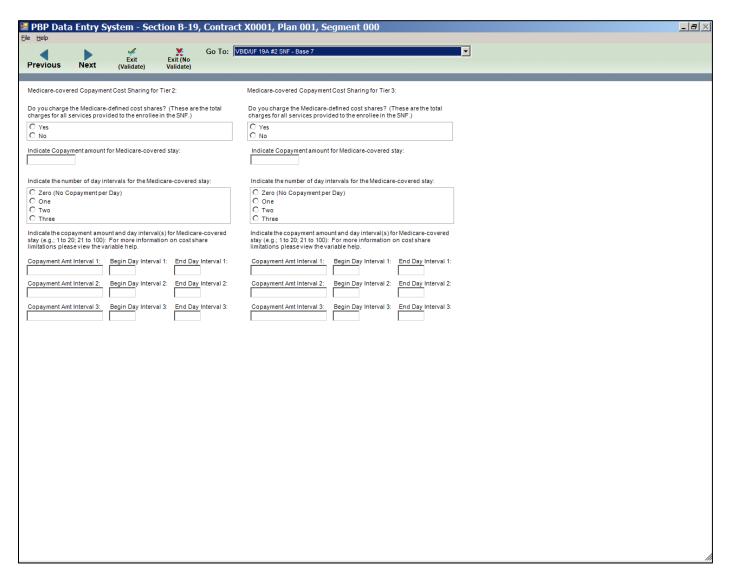


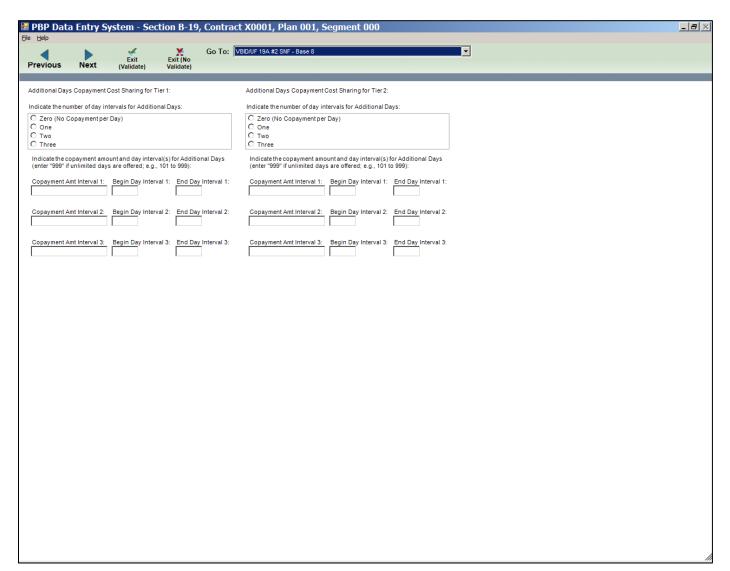


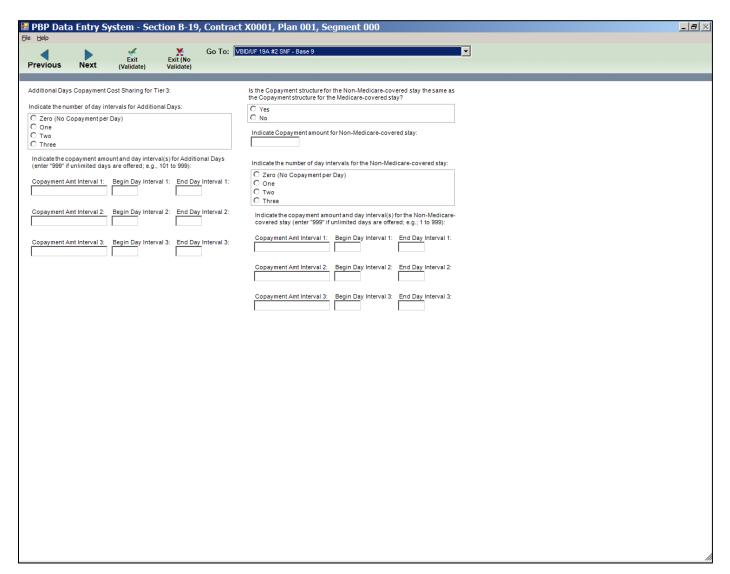
BPBP Data Entry System - Section B-19, Contract	X0001, Plan 001, Segment 000	_ B X
File Help ✓ ✓ Go To: VB	D/UF 19A #2 SNF - Base 4 ▼	
Exit Exit (No Previous Next (Validate) Validate)		
Previous Next (Validate) Does this plan's Additional Days cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care? C Yes C No How many cost sharing tiers do you offer? What is your lowest cost tier? C Tier 1 C Tier 2 C Tier 2 C Tier 3 Additional Days Coinsurance Cost Sharing for Tier 1: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One	Additional Days Coinsurance Cost Sharing for Tier 2: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 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:	
C Two 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): 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:	Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	

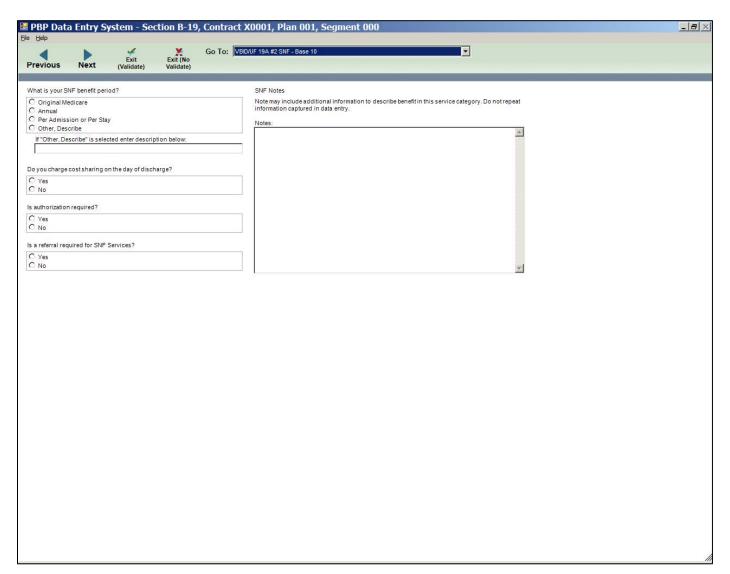




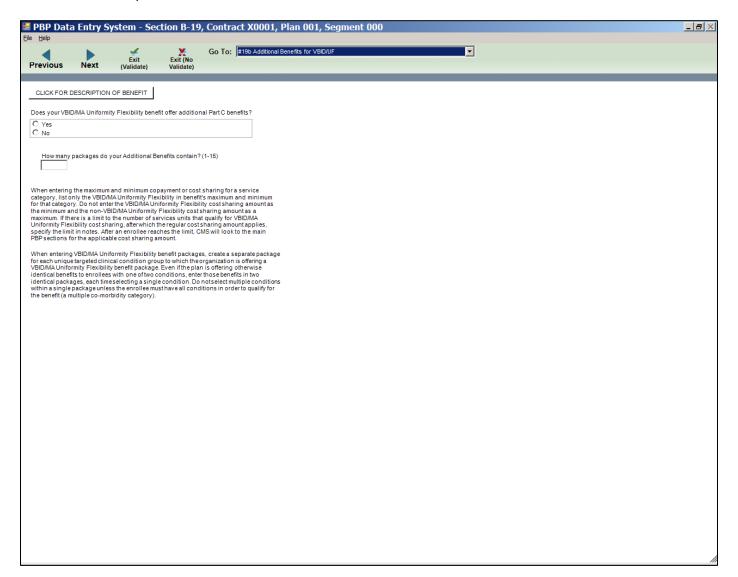




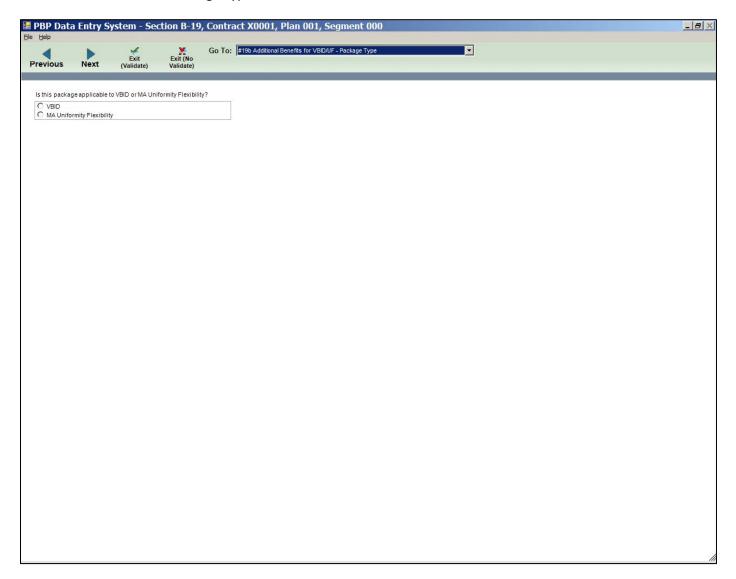




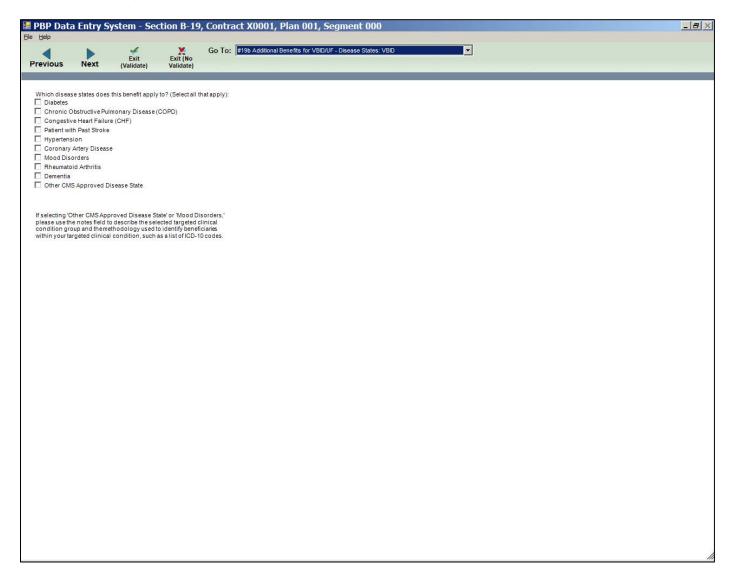
#19b Additional Benefits for VBID/UF



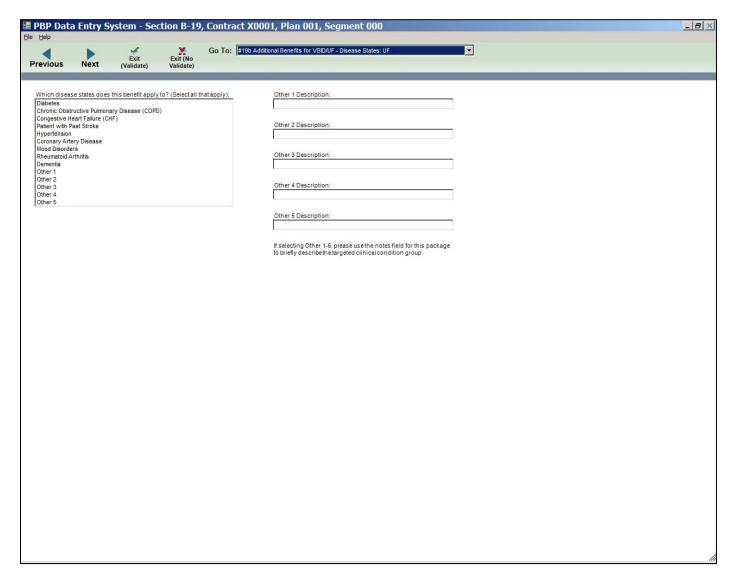
#19b Additional Benefits for VBID/UF - Package Type



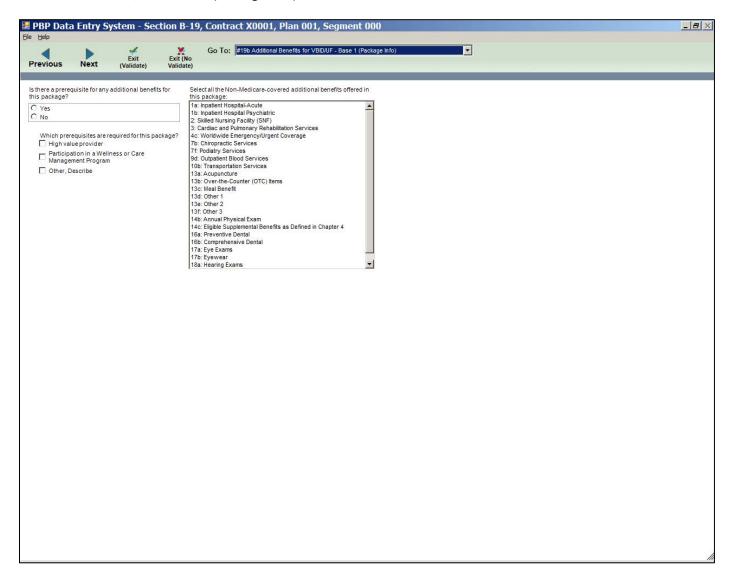
#19b Additional Benefits for VBID/UF - Disease States: VBID



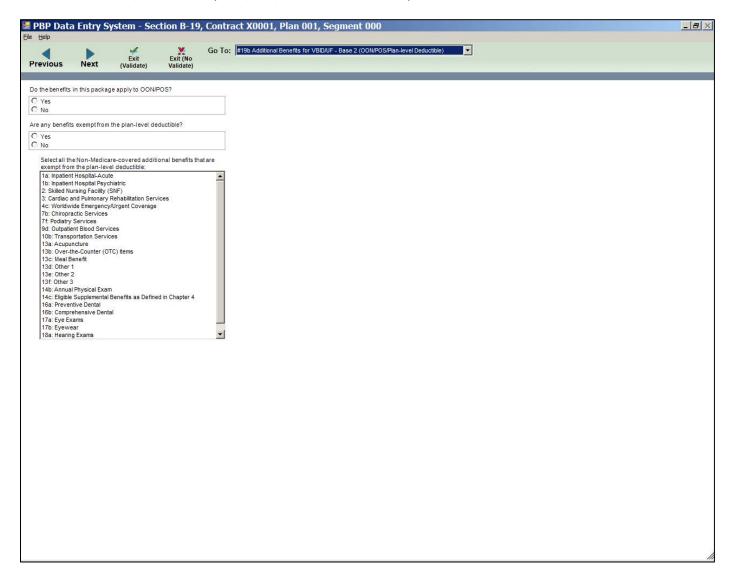
#19b Additional Benefits for VBID/UF - Disease States: UF



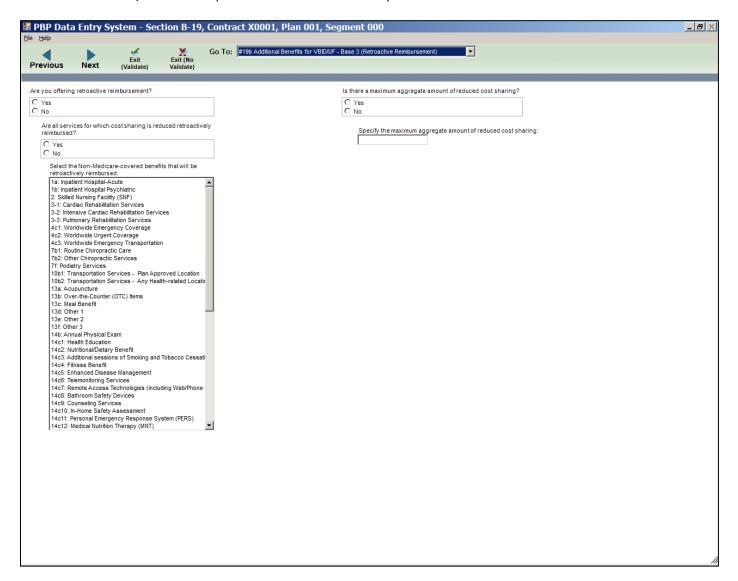
#19b Additional Benefits for VBID/UF - Base 1 (Package Info)



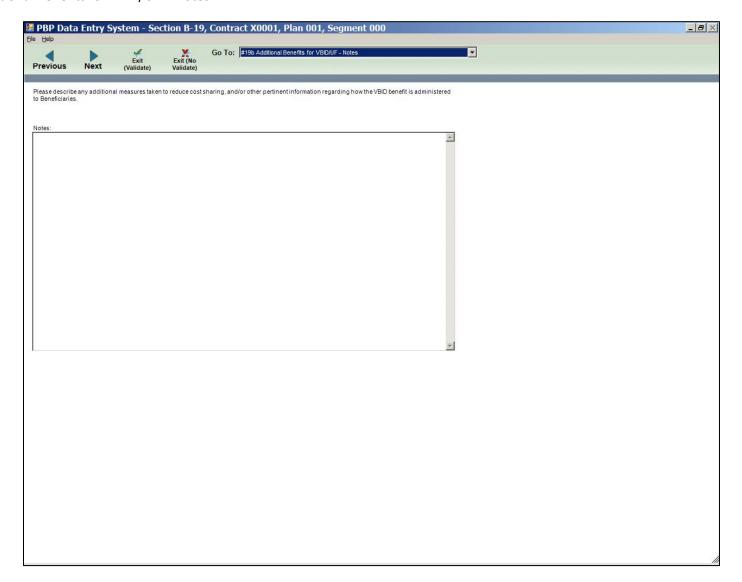
#19b Additional Benefits for VBID/UF - Base 2 (OON/POS/Plan-level Deductible)

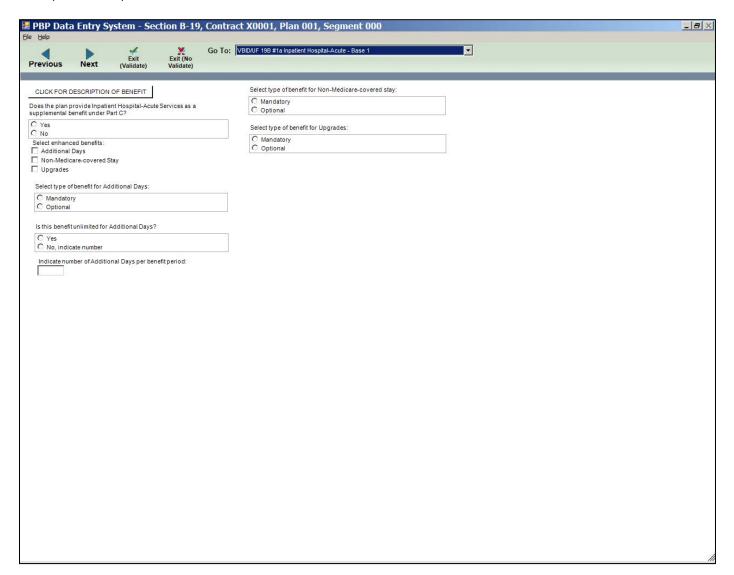


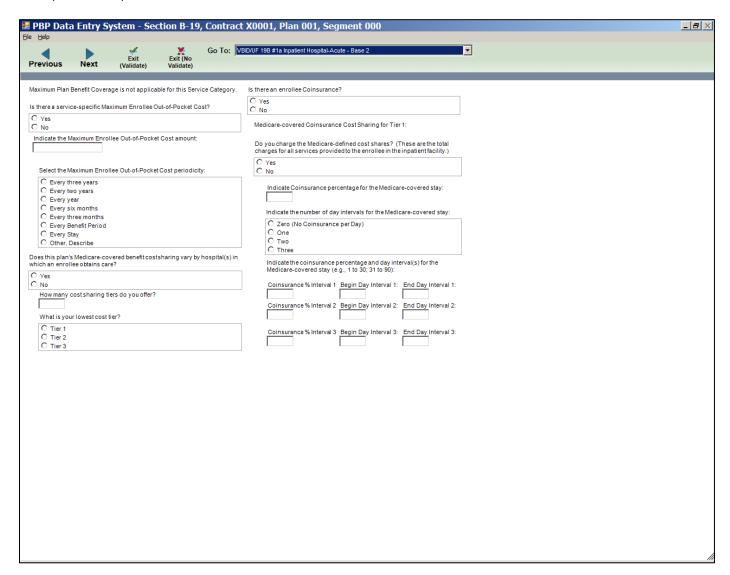
#19b Additional Benefits for VBID/UF - Base 3 (Retroactive Reimbursement)

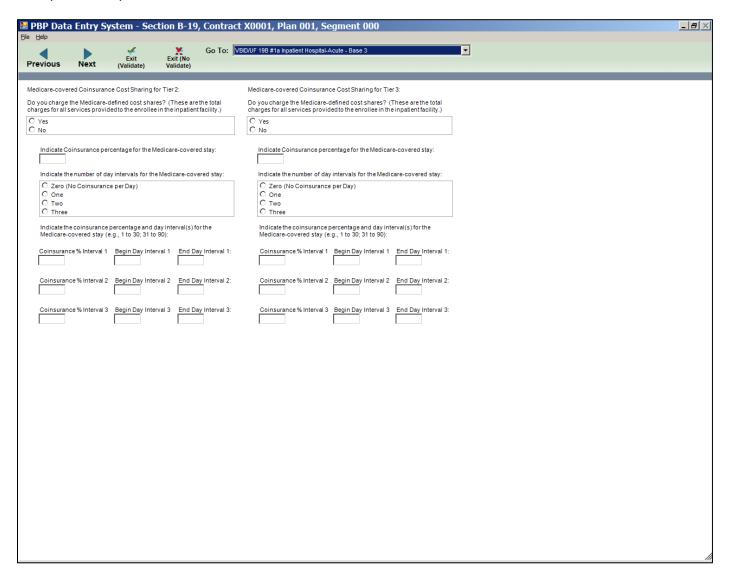


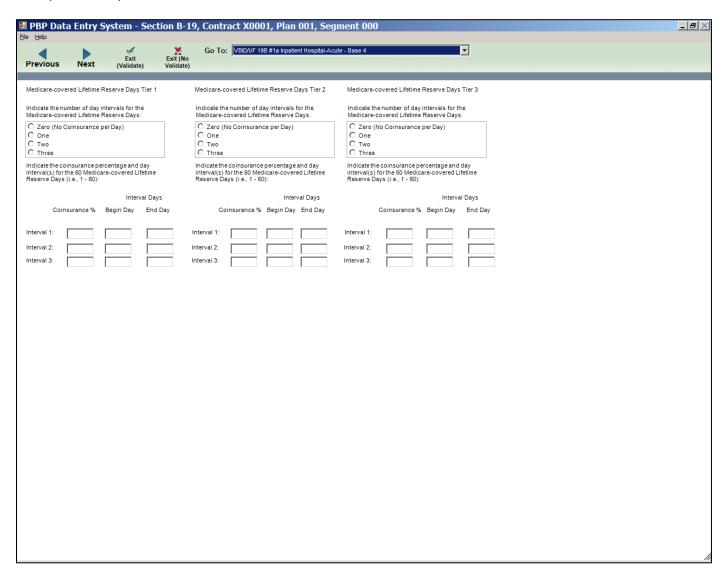
#19b Additional Benefits for VBID/UF - Notes

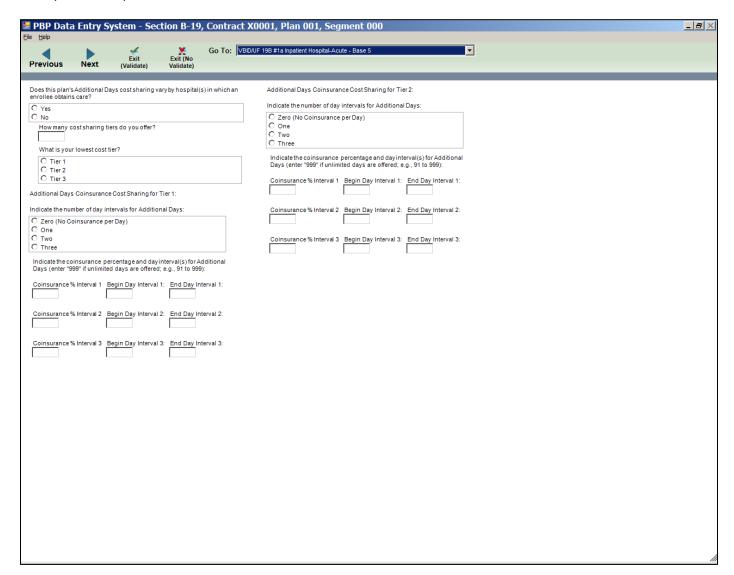


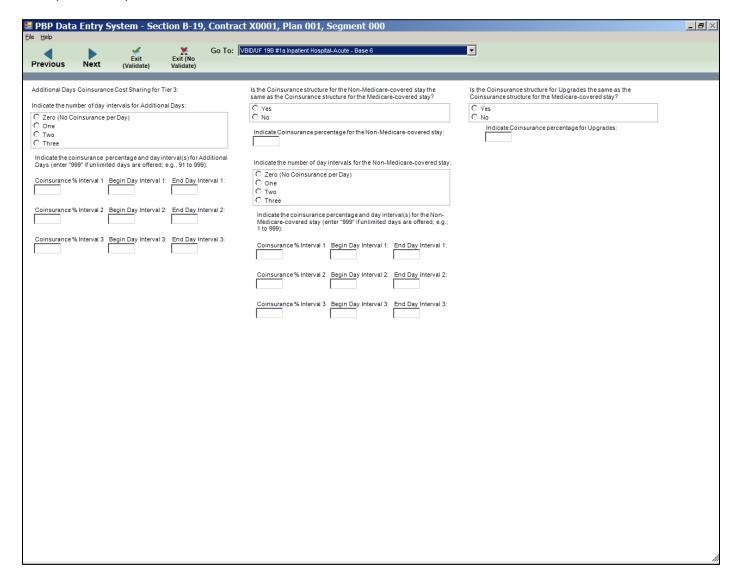


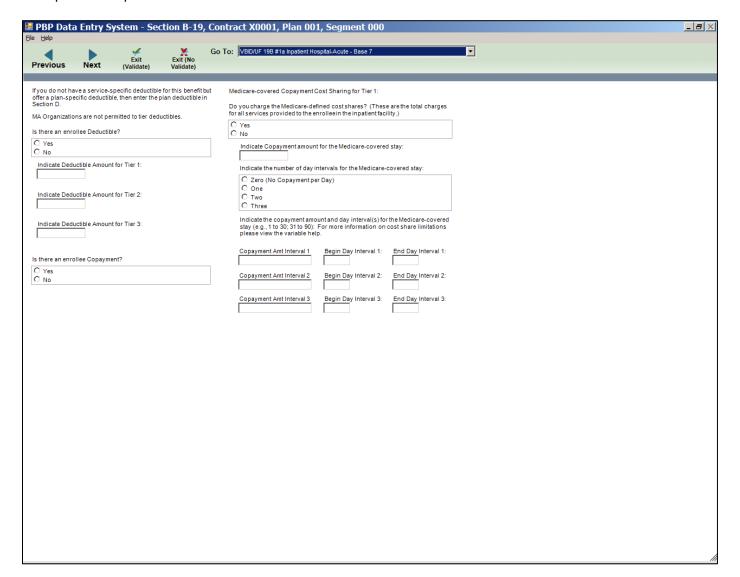




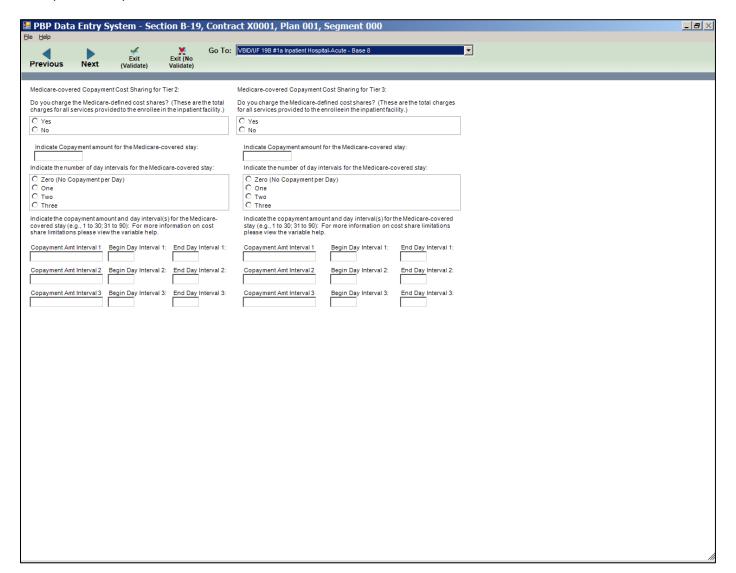




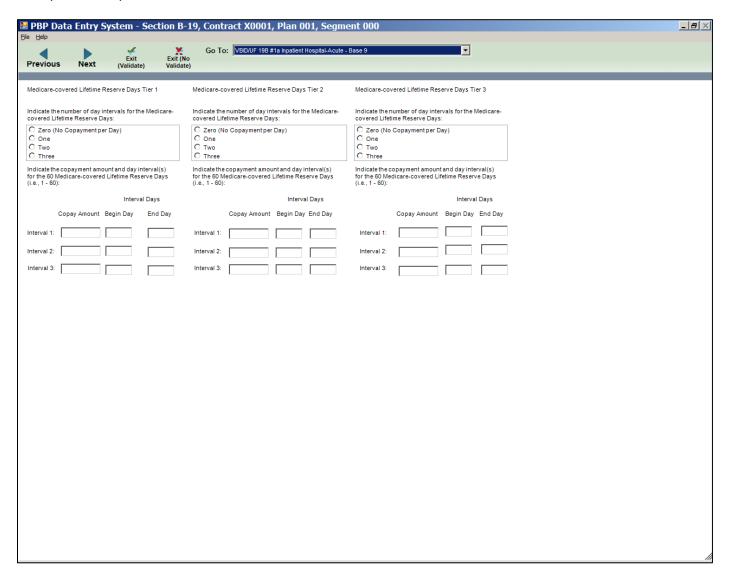




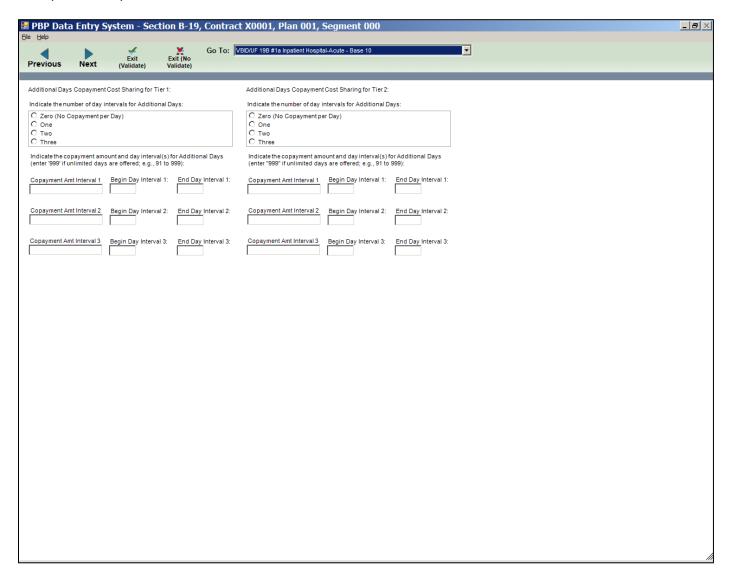
VBID/UF 19B #1a Inpatient Hospital-Acute - Base 8



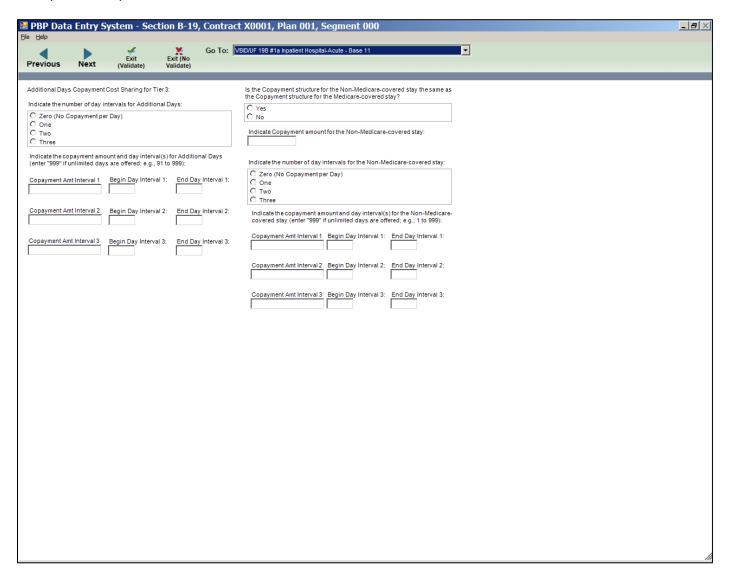
VBID/UF 19B #1a Inpatient Hospital-Acute - Base 9



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

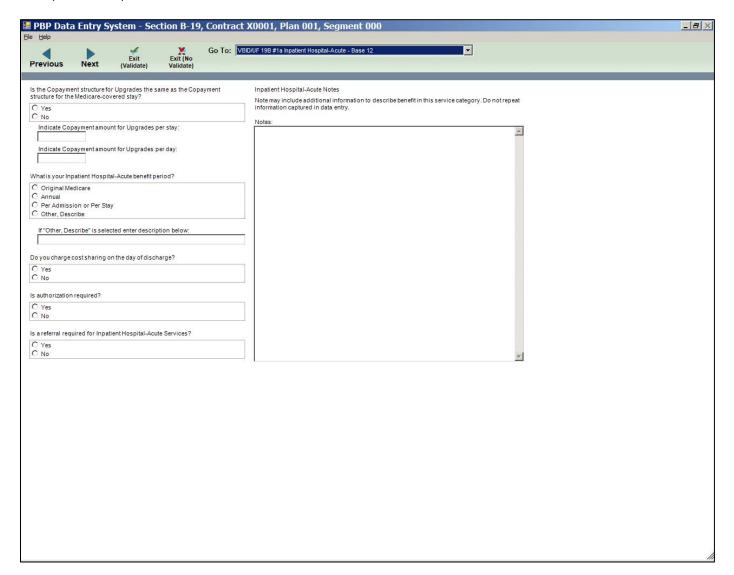


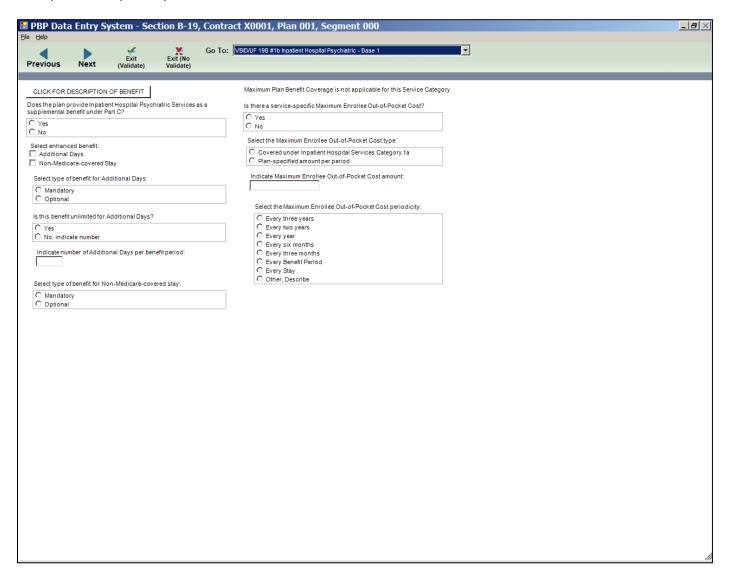
VBID/UF 19B #1a Inpatient Hospital-Acute - Base 11

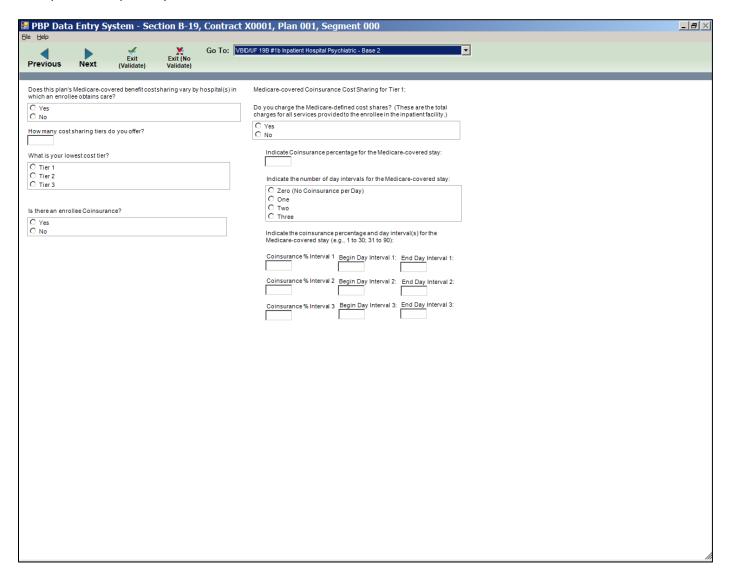


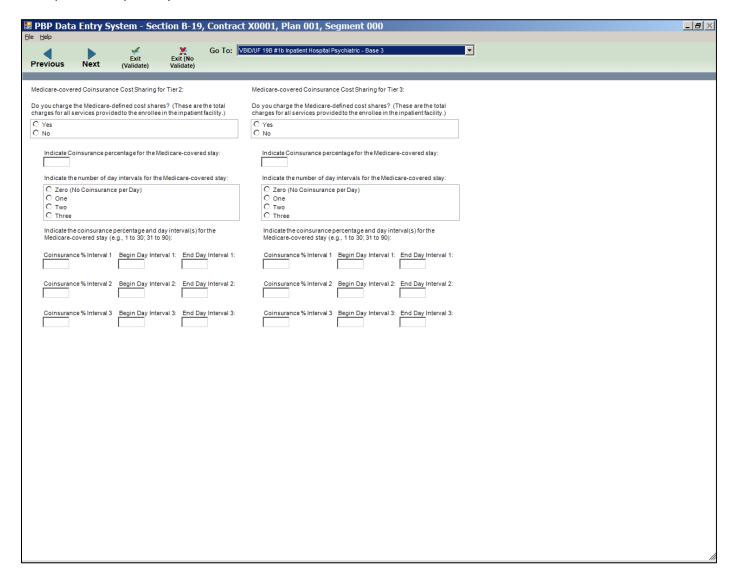
Page 76 of 178

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

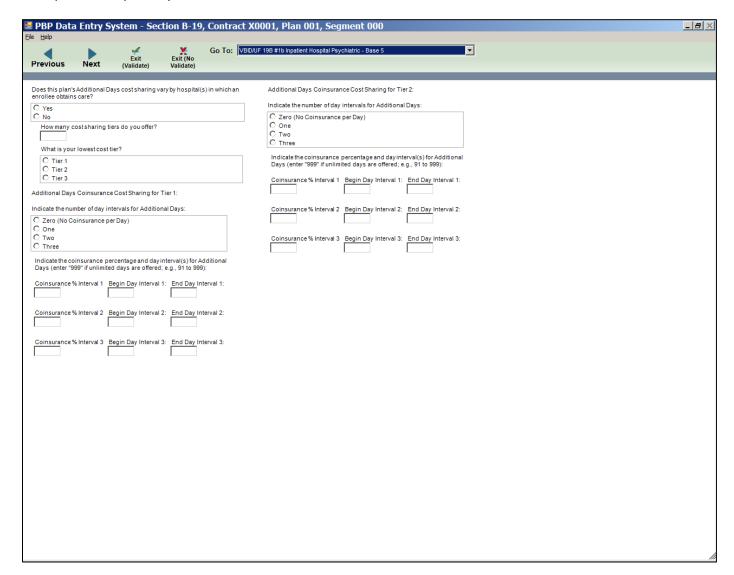


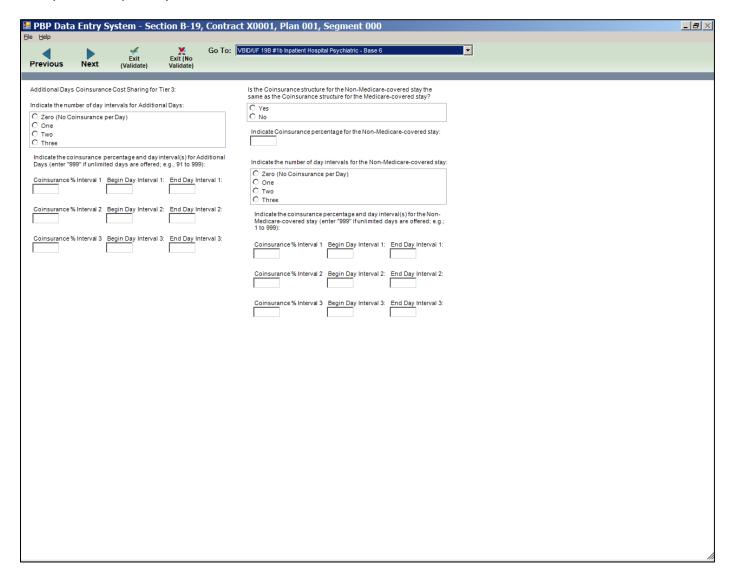


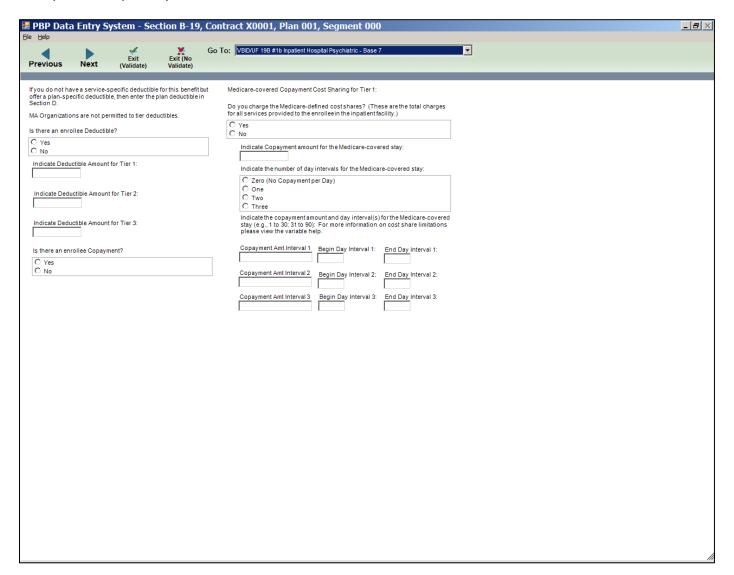


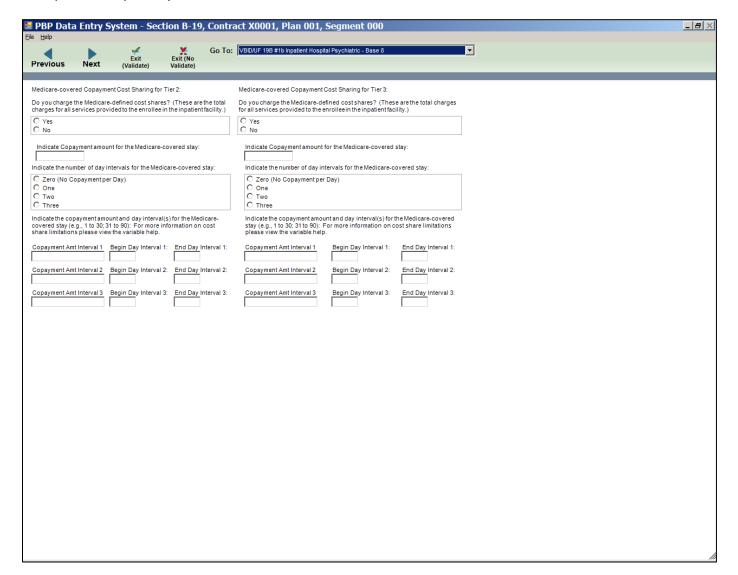


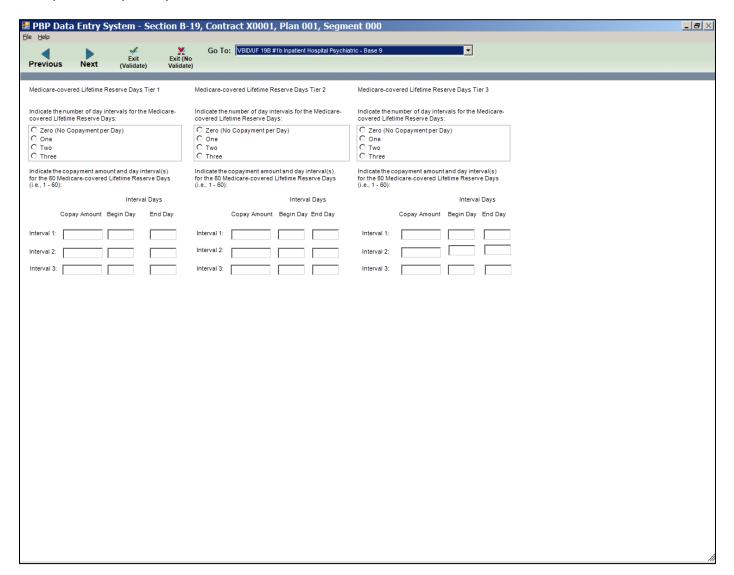
🔛 PBP Da	ta Entry :	System -	Section B-1	19, Contract X0001, Plan 001, Seg	gment 000	_ & X			
<u>File</u> <u>H</u> elp									
4		Exit	Exit (No	Go To: VBID/UF 19B #1b Inpatient Hospital Ps	ychiatric - Base 4				
Previous	Next	(Validate	e) Validate						
Medicare-covered Lifetime Reserve Days Tier 1				Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3				
Indicate the r Medicare-co	number of day vered Lifetime	intervals for th Reserve Days:	e	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:				
C Zero (No	Coinsurance	per Day)		C Zero (No Coinsurance per Day) C One	C Zero (No Coinsurance per Day) C One				
O One O Two				C Two	O Two				
C Three				C Three	C Three				
Indicate the o interval(s) fo Reserve Day	rthe 60 Medic	ercentage and (are-covered Lif	day fetime	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):				
		Interva	al Days	Interval Days	Interval Days				
Coi	nsurance %	Begin Day	End Day	Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day				
Interval 1:				Interval 1:	Interval 1:				
Interval 2:				Interval 2:	Interval 2:				
Interval 3:				Interval 3:	Interval 3:				

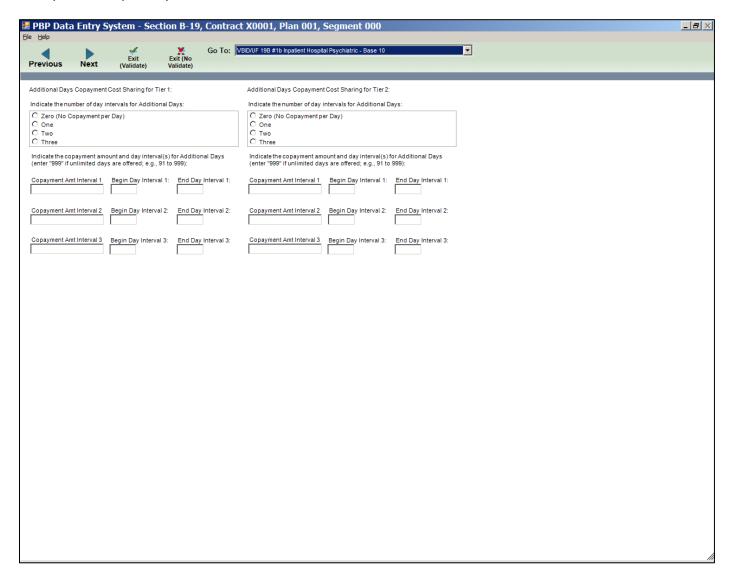


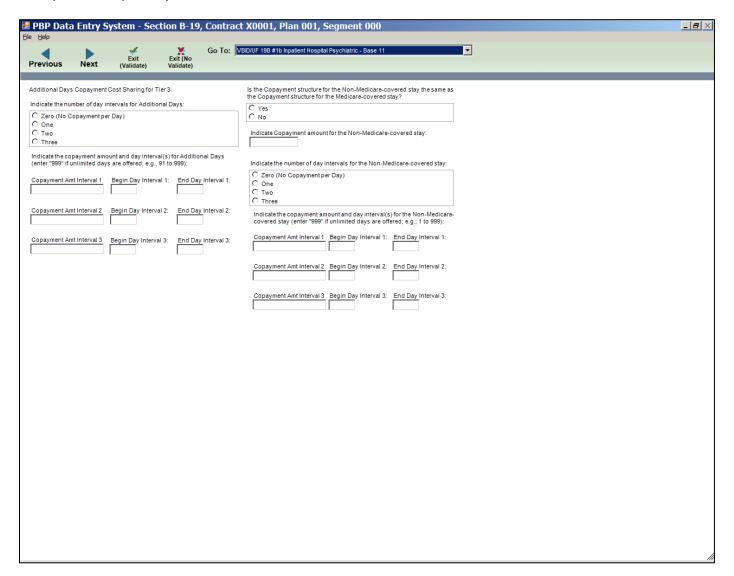


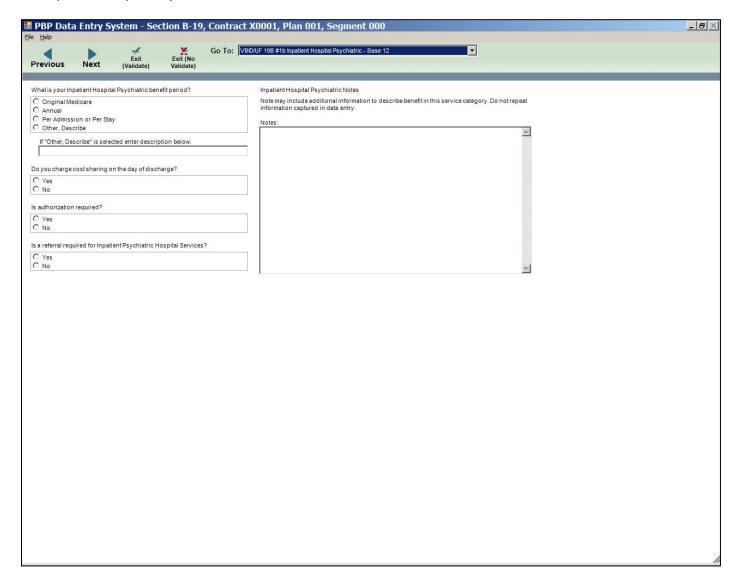


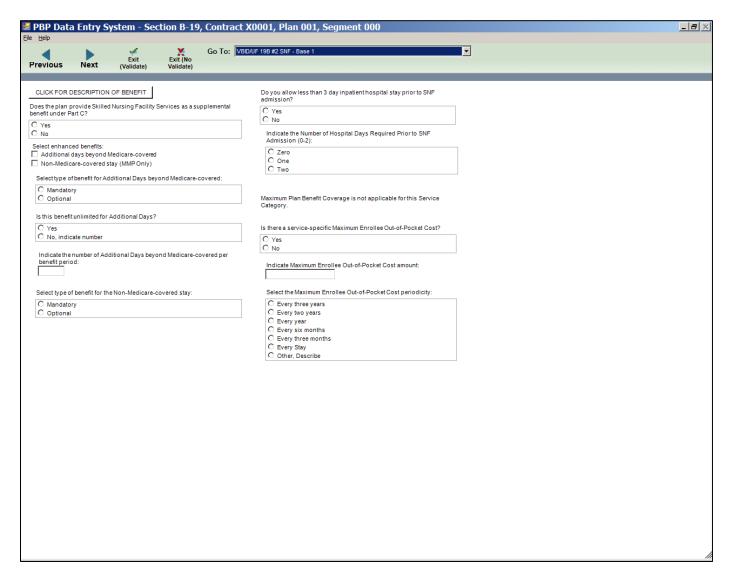


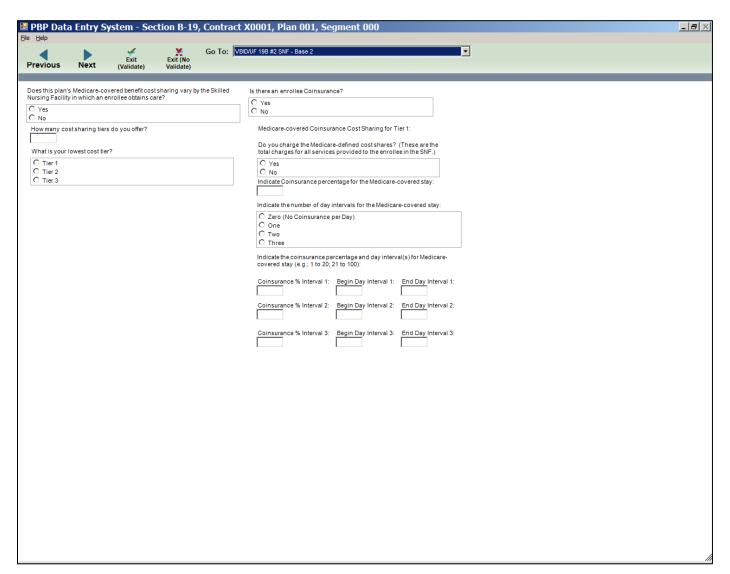


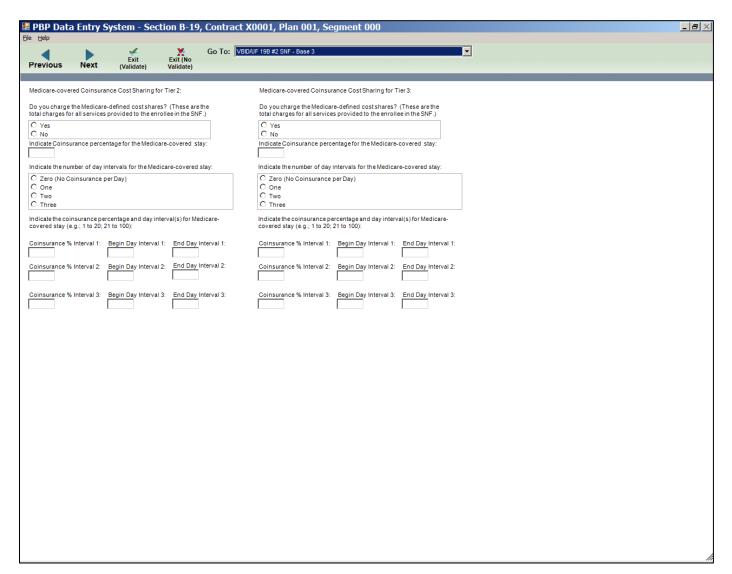


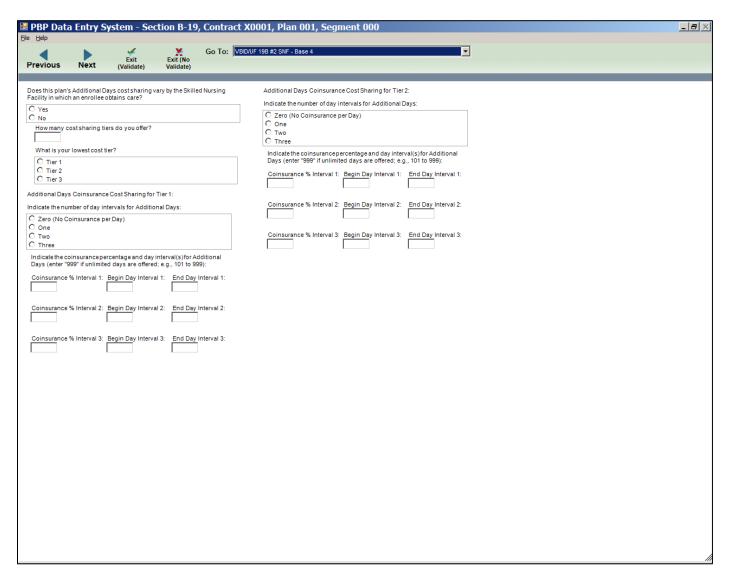


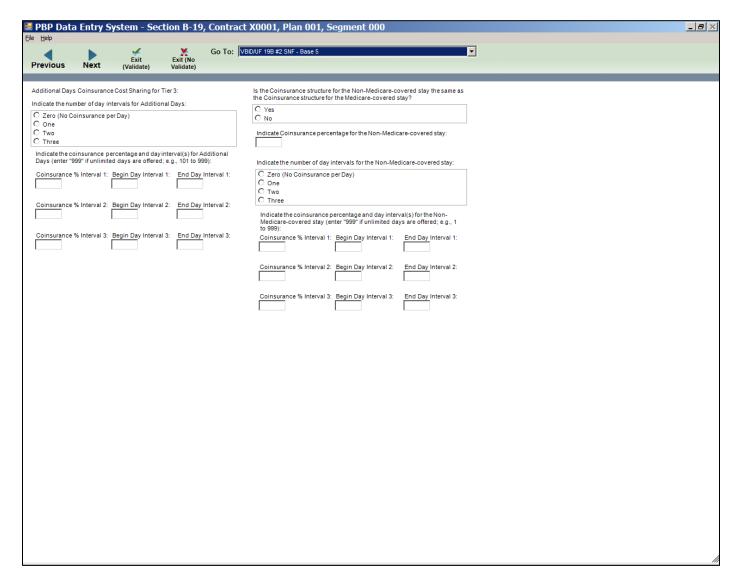


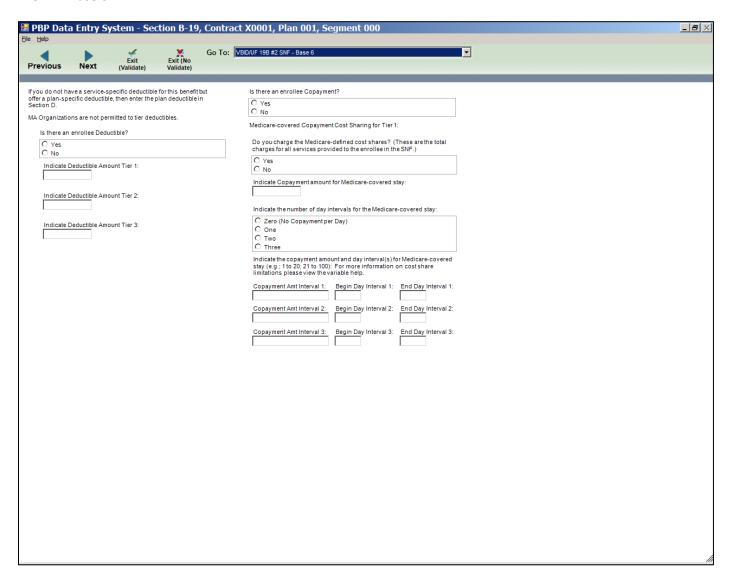


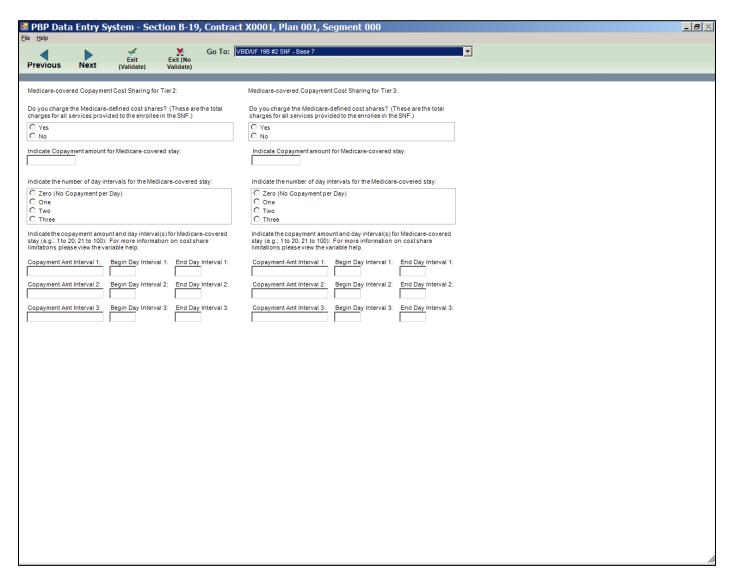


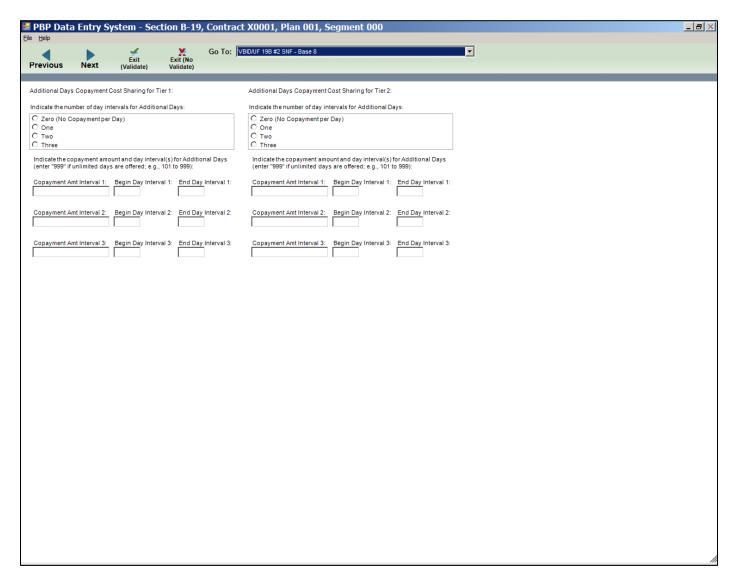




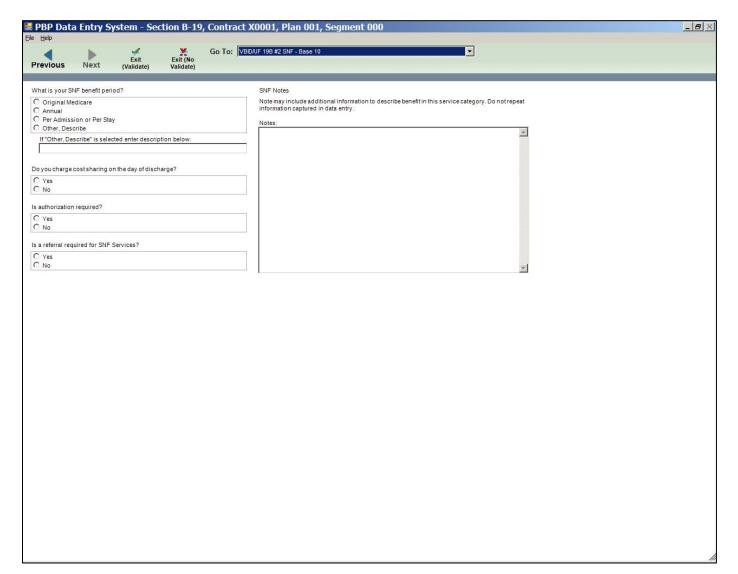








🖪 PBP Data Entry System - Section B-19, Contrac	act X0001, Plan 001, Segment 000	_ & ×				
File <u>H</u> elp						
	VBID/UF 19B #2 SNF - Base 9 ▼					
Previous Next (Validate) Validate)						
Additional Days Copayment Cost Sharing for Tier 3:	Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay?					
Indicate the number of day intervals for Additional Days:	C Yes					
C Zero (No Copayment per Day)	C No					
C One C Two	Indicate Copayment amount for 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., 101 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 Copayment per Day)					
Copayment Amt Interval 1. Begin Day Interval 1. End Day Interval 1.	C One C Two					
	O 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: Begin Day Interval 3: End Day Interval 3:					



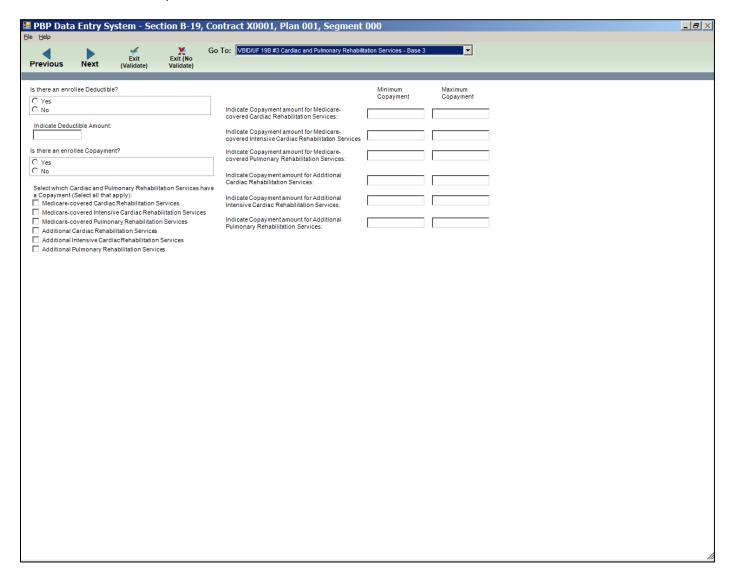
VBID/UF 19B #3 Cardiac and Pulmonary Rehabilitation Services – Base 1

	a Entry S	ystem - Se	ction B-19	, Contrac	X0001, Plan 001, Segment 000	_ B ×
File Help		4	~	Go To:	BID/UF 198 #3 Cardiac and Pulmonary Rehabilitation Services - Base 1	
Previous	Next	Exit (Validate)	Exit (No Validate)	G0 10. j	Services - Base 1	
		, , , , , , , , , , , , , , , , , , , ,				
CLICK FOR	DESCRIPTION	OF BENEFIT			Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services?	
Does the plan supplemental	provide Cardia	ac and Pulmonary	y Rehabilitation :	Services as a	C Yes	
C Yes	Derreilt under F	-ait O:			C No, indicate number	
C No					Indicate number of visits for Additional Intensive Cardiac Rehabilitation Services:	
	al Cardiac Reh	abilitation Service				
		rdiacRehabilitatio ehabilitation Serv			Select the Additional Intensive Cardiac Rehabilitation Services periodicity: C Every three years	
		ditional Cardiac		ervices:	C Every two years	
O Mandato					C Every year C Every six months	
C Optional		Additional Cardia	c Rehabilitation	Services?	C Every three months C Other, Describe	
O Yes						
C No, indic					Select type of benefit for Additional Pulmonary Rehabilitation Services: C Mandatory	
Indicate	e number of vis	its for Additional	Cardiac Rehabil	litation Services	C Optional	
Sele	ect the Addition	al Cardiac Rehab	oilitation Service:	s periodicity:	Is this benefit unlimited for Additional Pulmonary Rehabilitation Services?	
	Every three ye				C Yes C No, indicate number	
	Every two year Every year	'S			Indicate number of visits for Additional Pulmonary Rehabilitation Services:	
	Every six mon Every three mo					
	Other, Describ				Select the Additional Pulmonary Rehabilitation Services periodicity:	
		ditional Intensive	Cardiac Rehabi	litation Services	C Every three years C Every two years	
C Mandator C Optional	У				C Every year C Every six months	
					C Every three months	
					C Other, Describe	

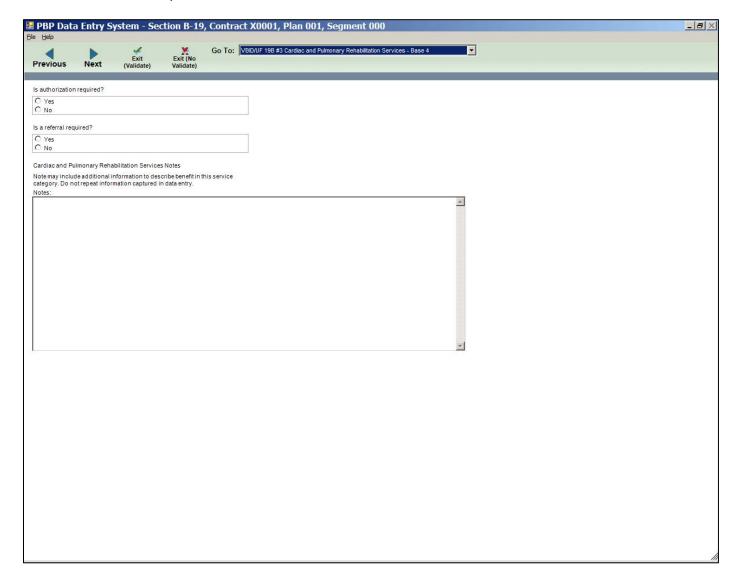
VBID/UF 19B #3 Cardiac and Pulmonary Rehabilitation Services – Base 2

■ PBP Dat	a Entry Sy	stem - Sec	tion B-19,	Contra	ct X0001, Plan 001, Segment 000					_	B X	
File Help			<u> </u>									
4		✓	v .	Go To:	VBID/UF 19B #3 Cardiac and Pulmonary Rehabilitation Se	rvices - Base 2	Ţ					
_ •		Exit	Exit (No	G0 10.	V DID/OT 13D #3 Cardiac and Familionary (Condomination Sci	Vices - Buse 2						
Previous	Next	(Validate)	Validate)									
Maximum Plan	Benefit Covera	ge is not applicat	ble for this Service	ce Category.	Select which Cardiac and Pulmonary Rehabilitation	Services have a	a					
					Coinsurance (Select all that apply):							
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?					☐ Medicare-covered Cardiac Rehabilitation Services ☐ Medicare-covered Intensive Cardiac Rehabilitation Services							
C Yes					Medicare-covered Unionary Rehabilitation Services Medicare-covered Pulmonary Rehabilitation Services							
C No					Medical economic Political Relational Certification (Certification Certification							
Indicate Ma	aximum Enrollee	Out-of-Pocket C	ost amount:		Additional Intensive Cardiac Rehabilitation Services							
					Additional Pulmonary Rehabilitation Services							
'						Minimum Maximum						
Select Max	ximum Enrollee	Out-of-Pocket Co	st periodicity:			Coinsurance	Coinsurance					
	three years				Indicate Coinsurance percentage for Medicare-							
	two years				covered Cardiac Rehabilitation Services:							
O Every					Indicate Coinsurance percentage for Medicare-							
	six months three months				covered Intensive Cardiac Rehabilitation Services:							
	Describe				Indicate Coinsurance percentage for Medicare-							
		haring to the bene	eficiary, includin	g anv	covered Pulmonary Rehabilitation Services:							
facility cost s	sharing. If you h	ave a variety of co	ost sharing, plea	se utilize	Indicate Coinsurance percentage for Additional							
	a beneficiary m	ields to reflect the av pav.	e lowest and nig	nest cost	Cardiac Rehabilitation Services:							
	•				Indicate Coinsurance percentage for Additional							
Is there an e	nrollee Coinsur	ance?			Intensive Cardiac Rehabilitation Services:							
O Yes					Indicate Coinsurance percentage for Additional							
C No					Pulmonary Rehabilitation Services:							
											/	

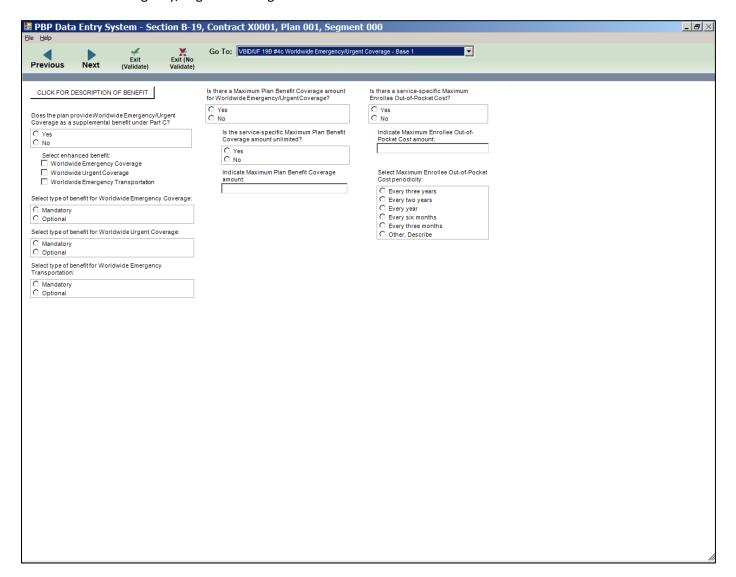
VBID/UF 19B #3 Cardiac and Pulmonary Rehabilitation Services - Base 3



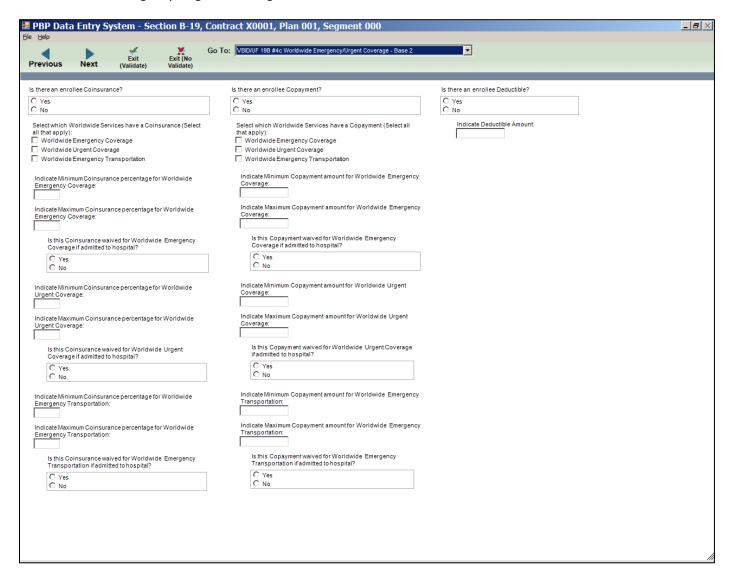
VBID/UF 19B #3 Cardiac and Pulmonary Rehabilitation Services - Base 4



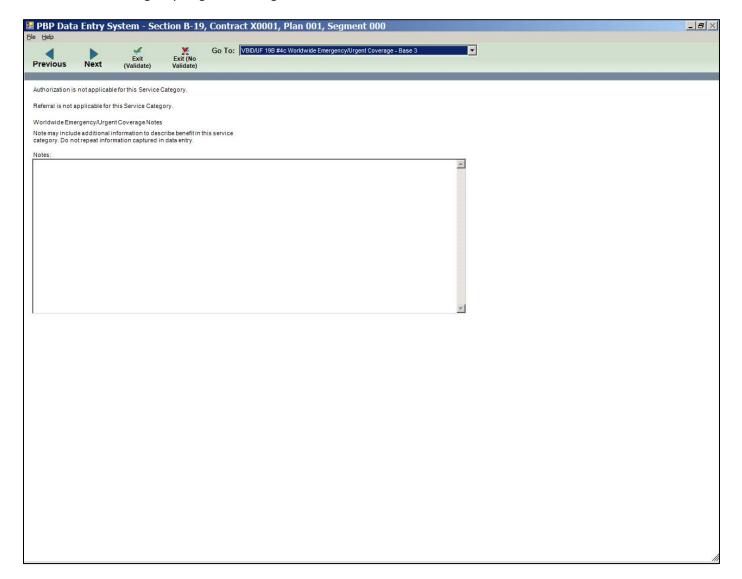
VBID/UF 19B #4c Worldwide Emergency/Urgent Coverage - Base 1



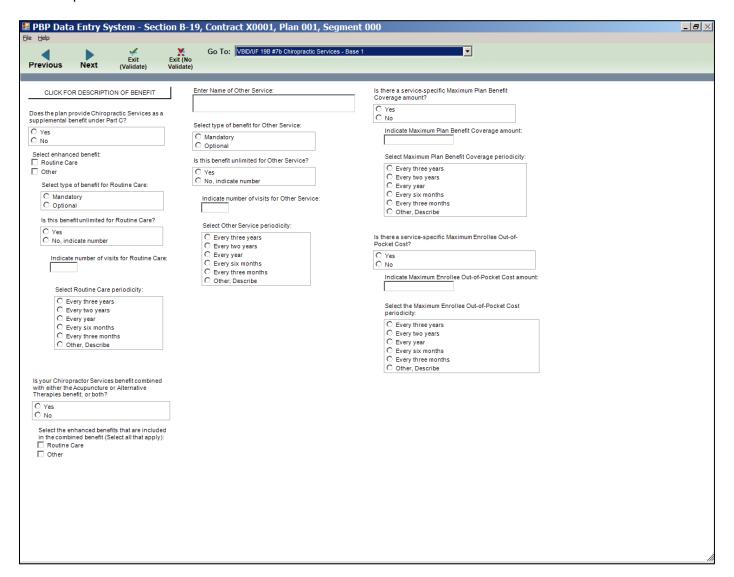
VBID/UF 19B #4c Worldwide Emergency/Urgent Coverage – Base 2



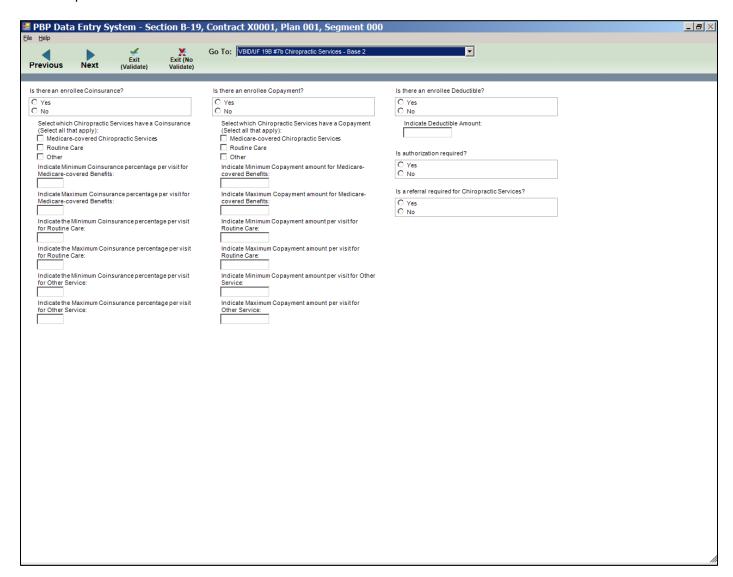
VBID/UF 19B #4c Worldwide Emergency/Urgent Coverage - Base 3



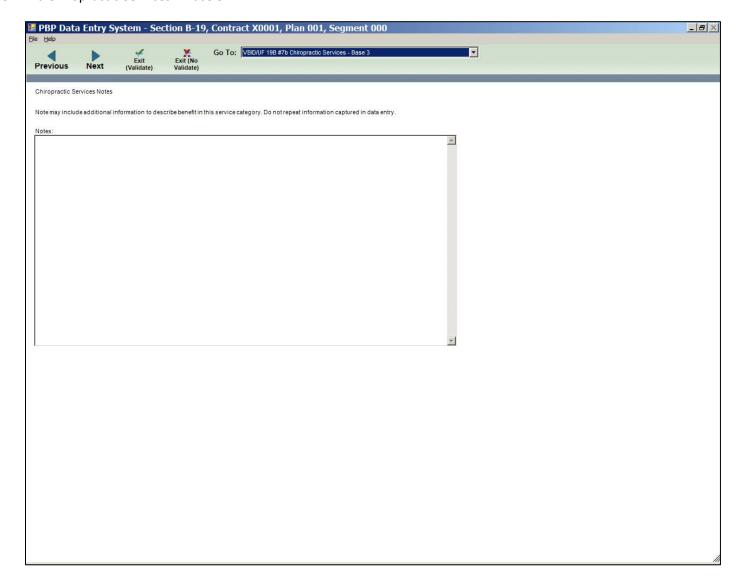
VBID/UF 19B #7b Chiropractic Services – Base 1



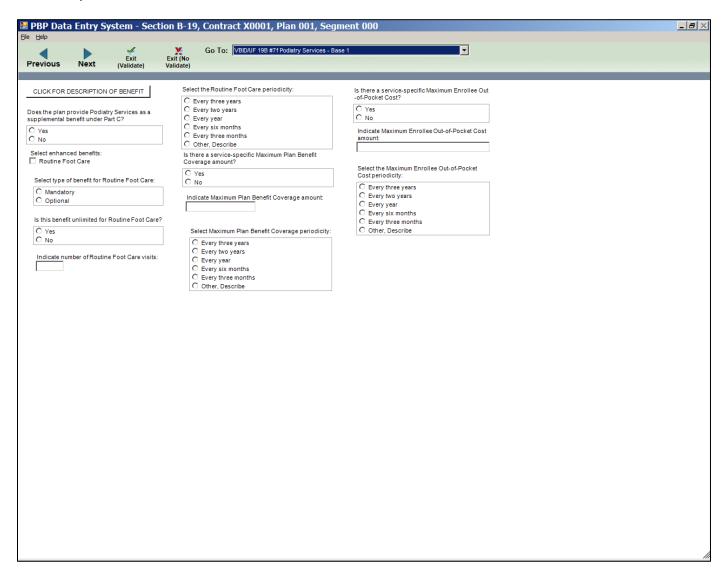
VBID/UF 19B #7b Chiropractic Services – Base 2



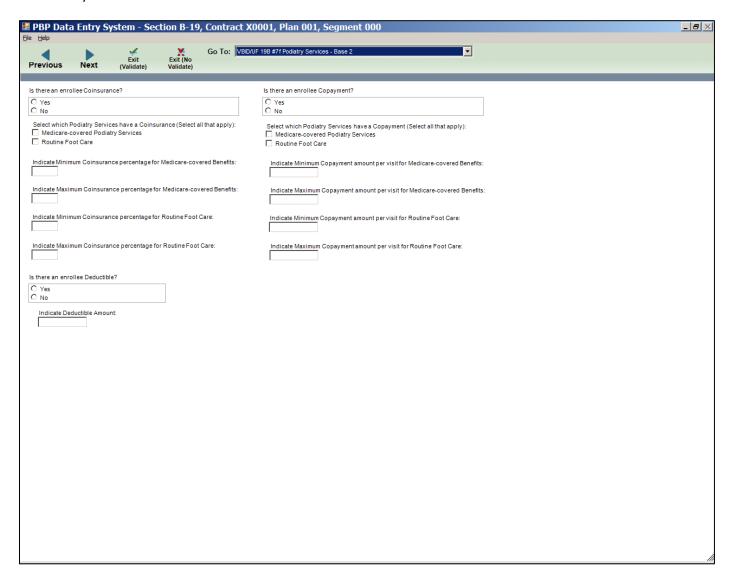
VBID/UF 19B #7b Chiropractic Services – Base 3



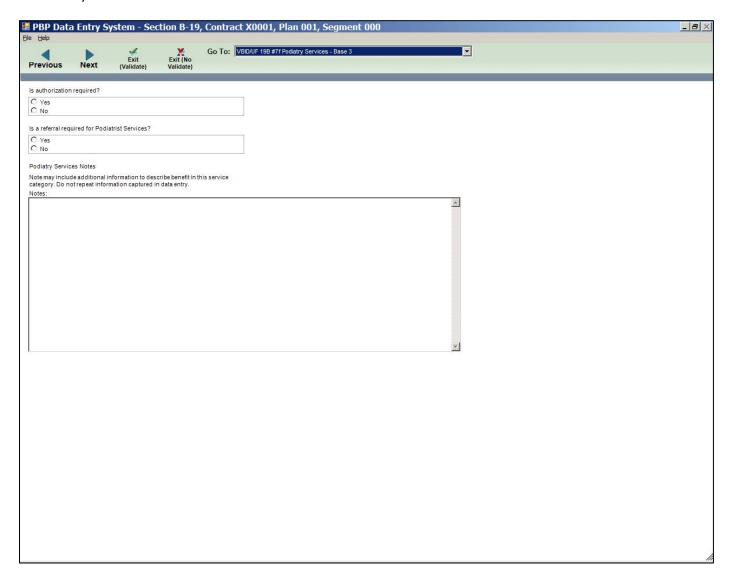
VBID/UF 19B #7f Podiatry Services - Base 1



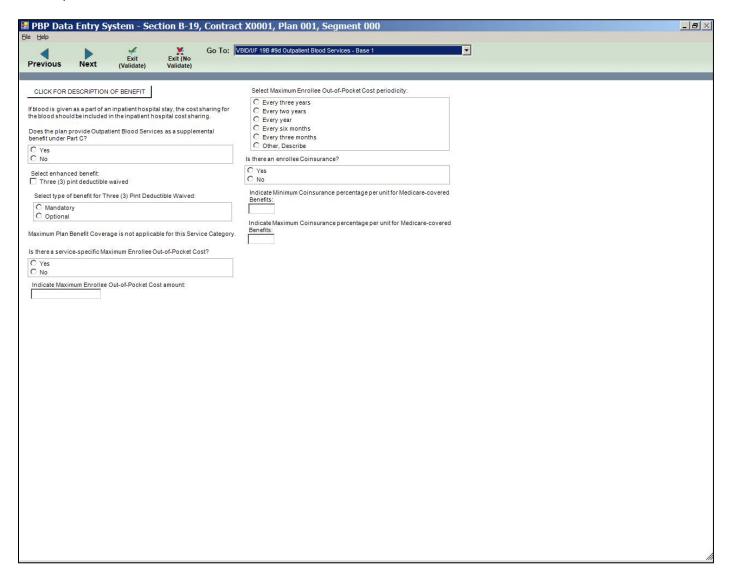
VBID/UF 19B #7f Podiatry Services - Base 2



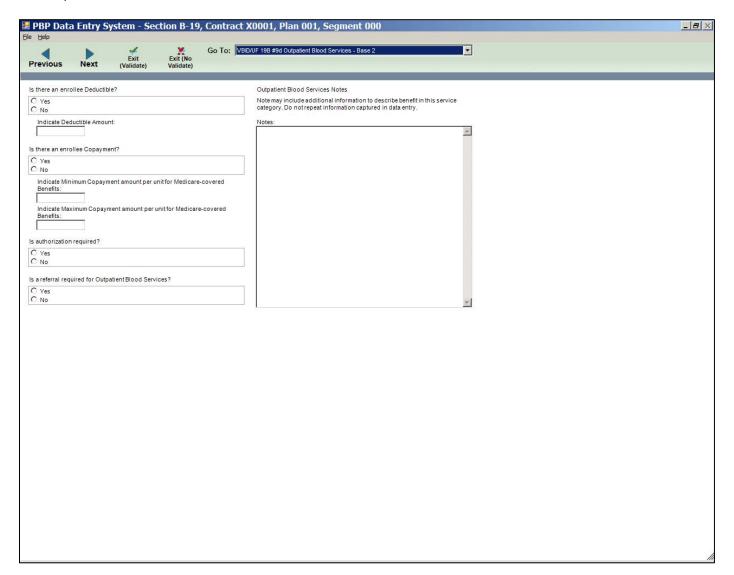
VBID/UF 19B #7f Podiatry Services - Base 3



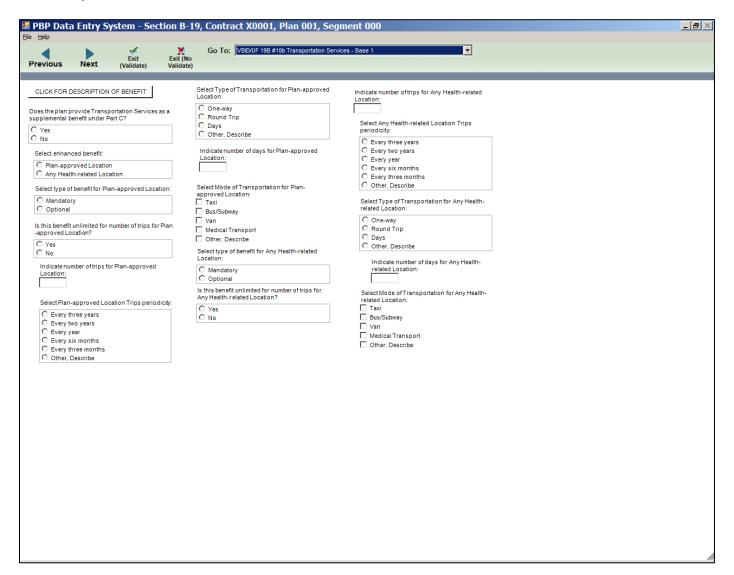
VBID/UF 19B #9d Outpatient Blood Services - Base 1



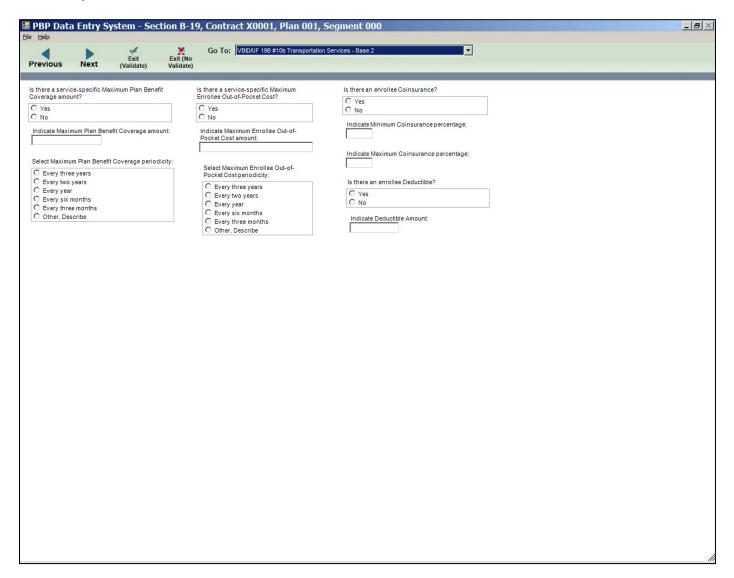
VBID/UF 19B #9d Outpatient Blood Services – Base 2



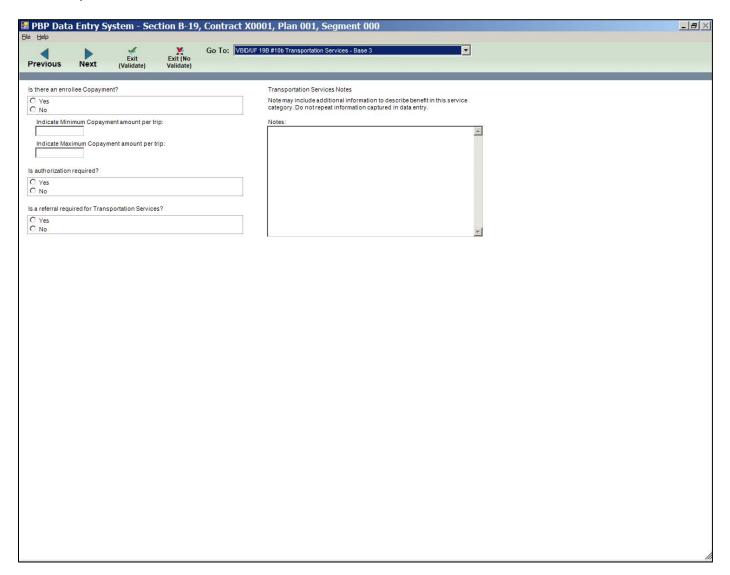
VBID/UF 19B #10b Transportation Services - Base 1



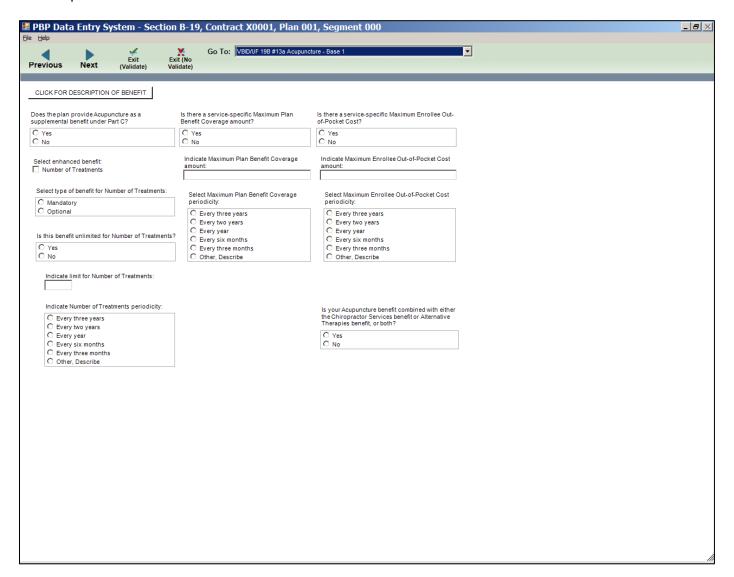
VBID/UF 19B #10b Transportation Services – Base 2



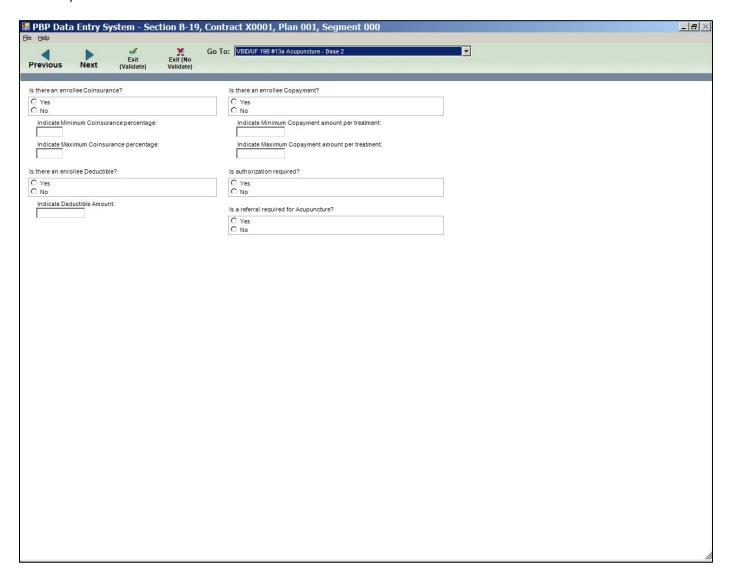
VBID/UF 19B #10b Transportation Services - Base 3



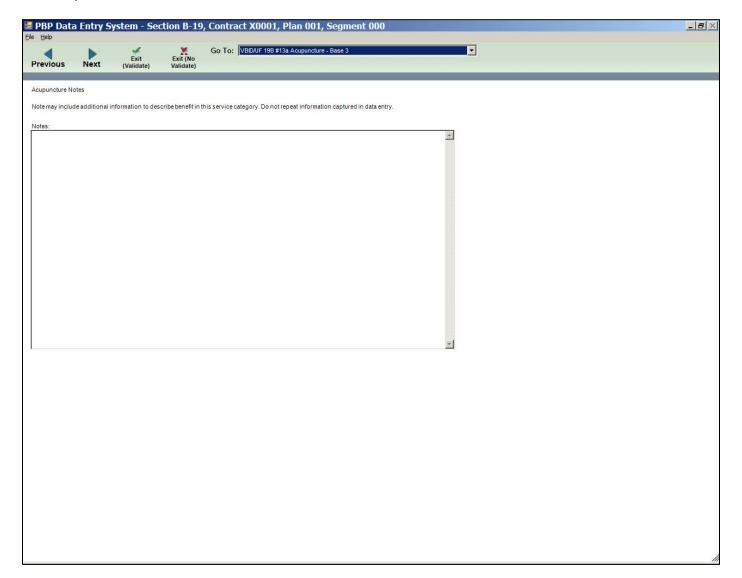
VBID/UF 19B #13a Acupuncture - Base 1



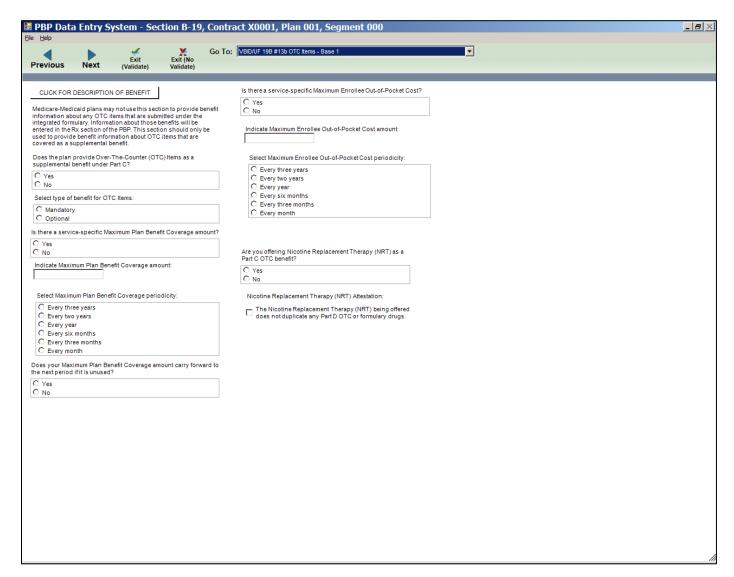
VBID/UF 19B #13a Acupuncture - Base 2



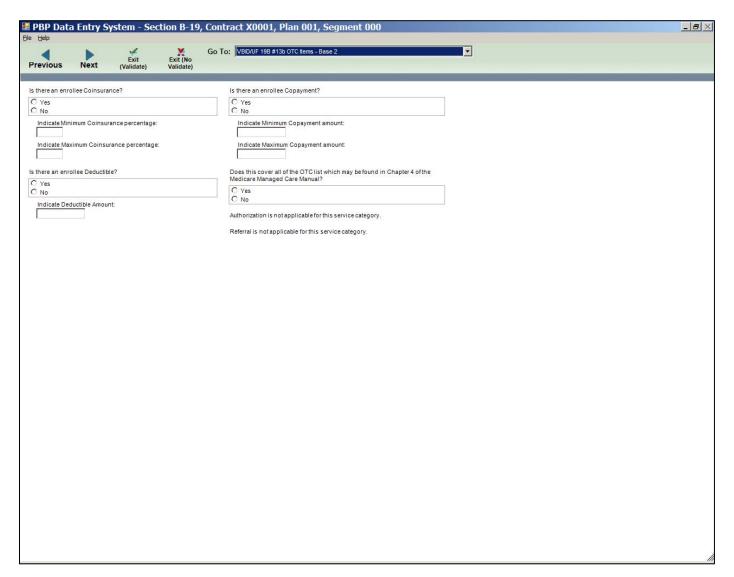
VBID/UF 19B #13a Acupuncture - Base 3



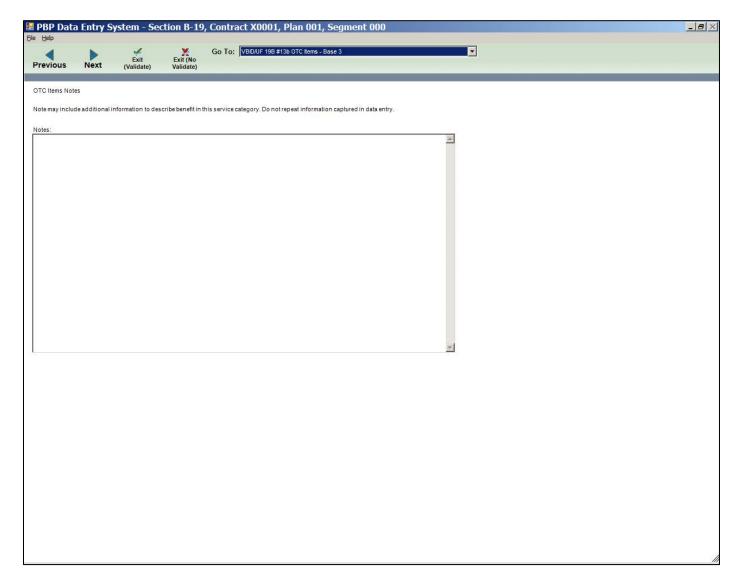
VBID/UF 19B #13b OTC Items - Base 1



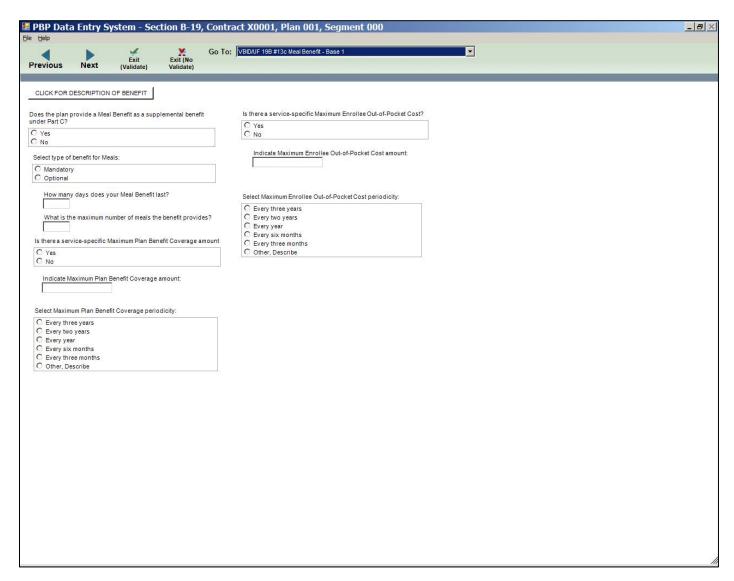
VBID/UF 19B #13b OTC Items - Base 2



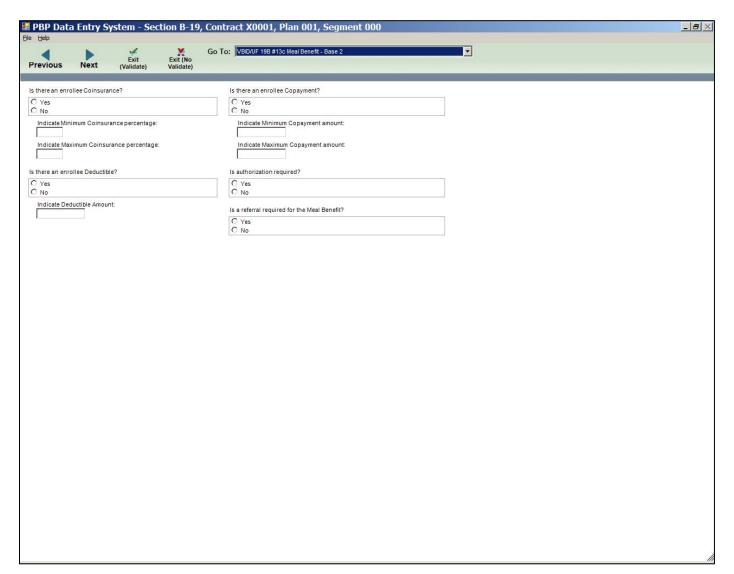
VBID/UF 19B #13b OTC Items - Base 3



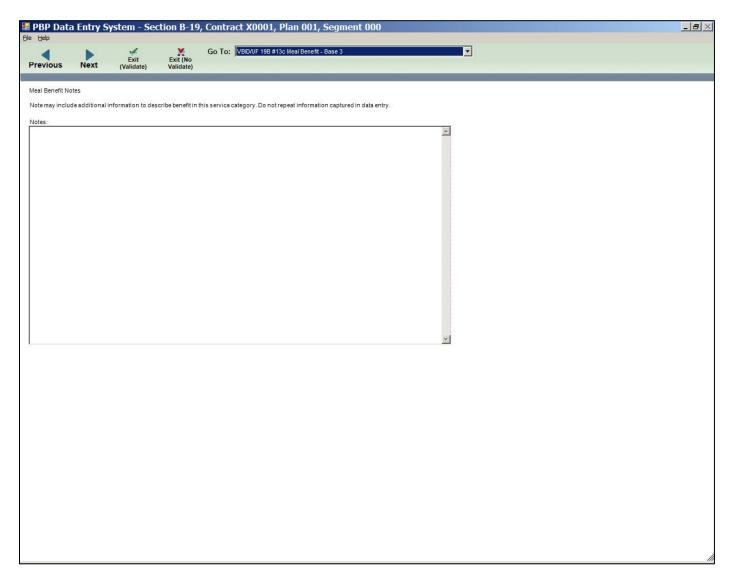
VBID/UF 19B #13c Meal Benefit - Base 1



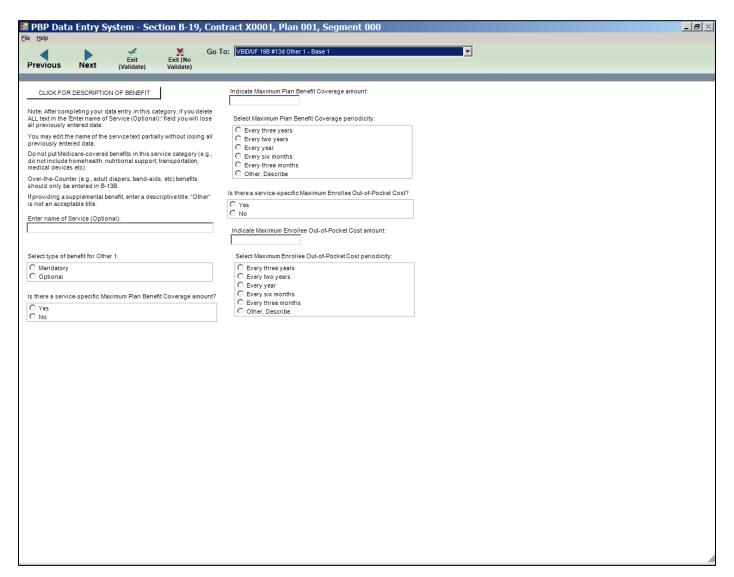
VBID/UF 19B #13c Meal Benefit - Base 2



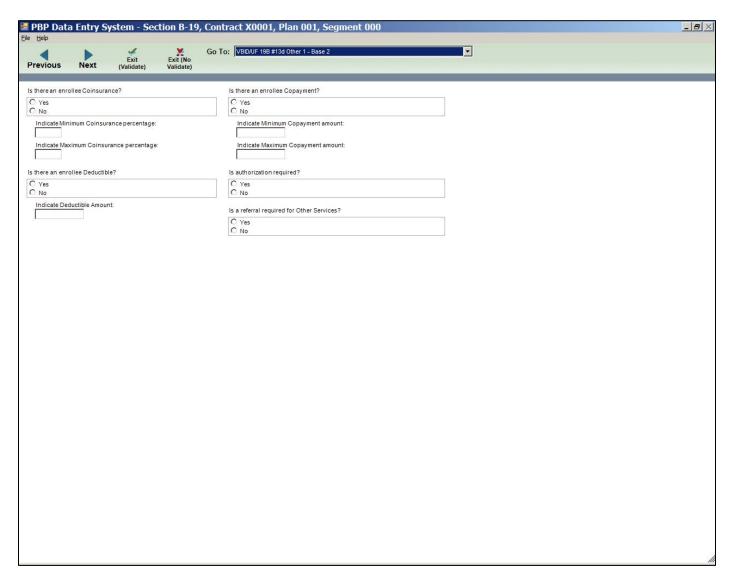
VBID/UF 19B #13c Meal Benefit - Base 3



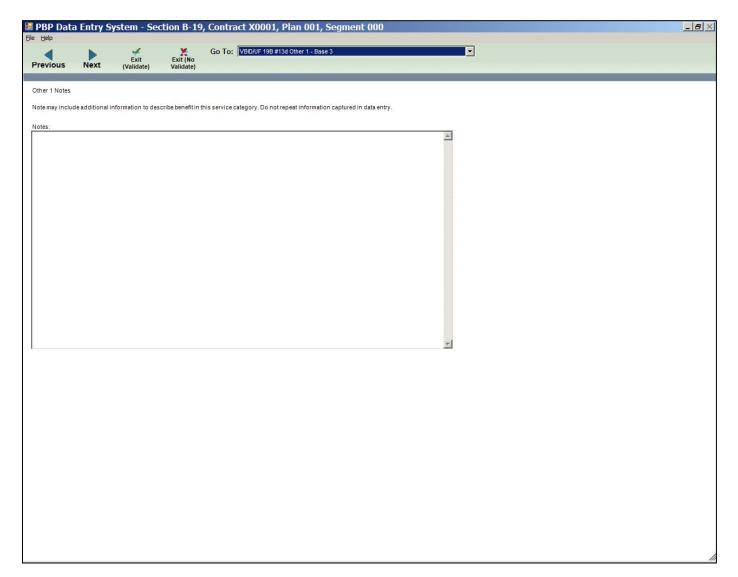
VBID/UF 19B #13d Other 1 - Base 1



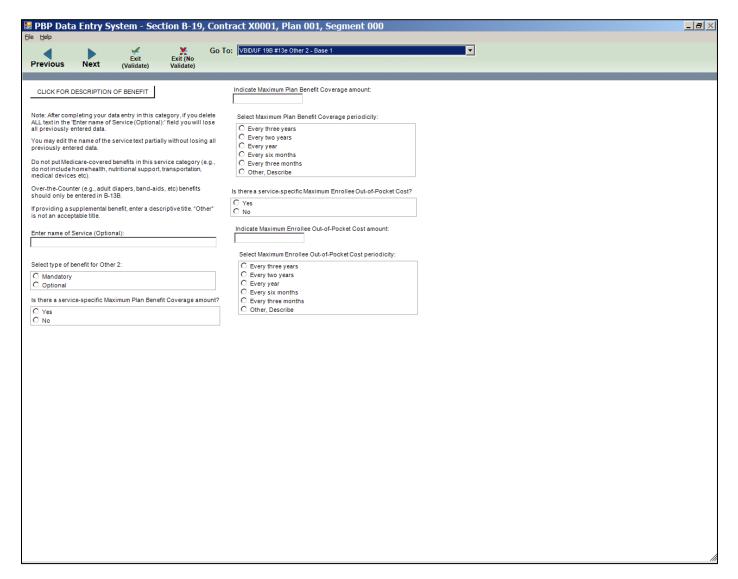
VBID/UF 19B #13d Other 1 – Base 2



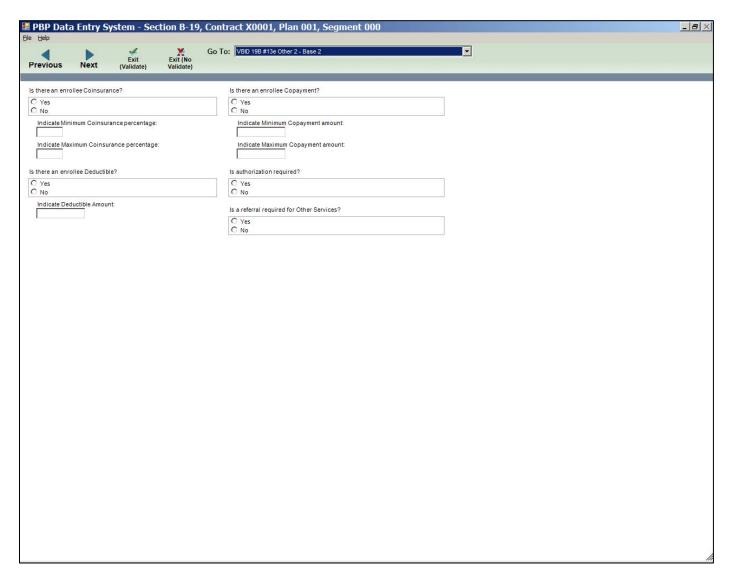
VBID/UF 19B #13d Other 1 - Base 3



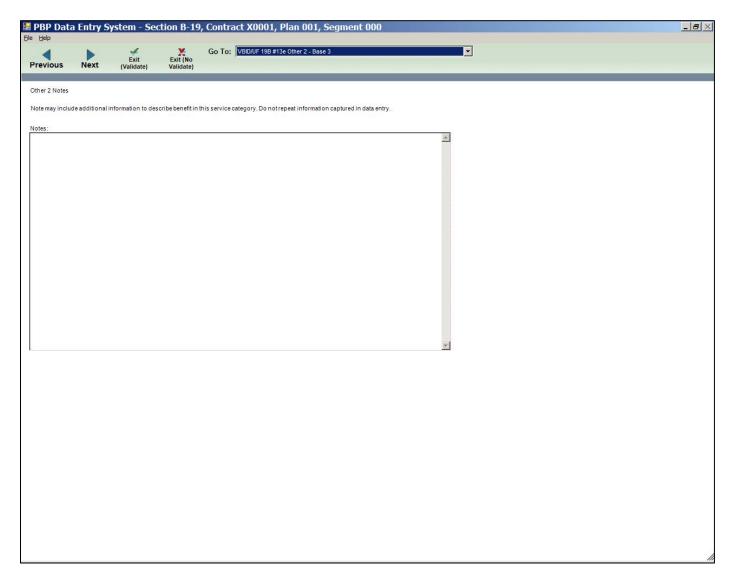
VBID/UF 19B #13e Other 2 - Base 1



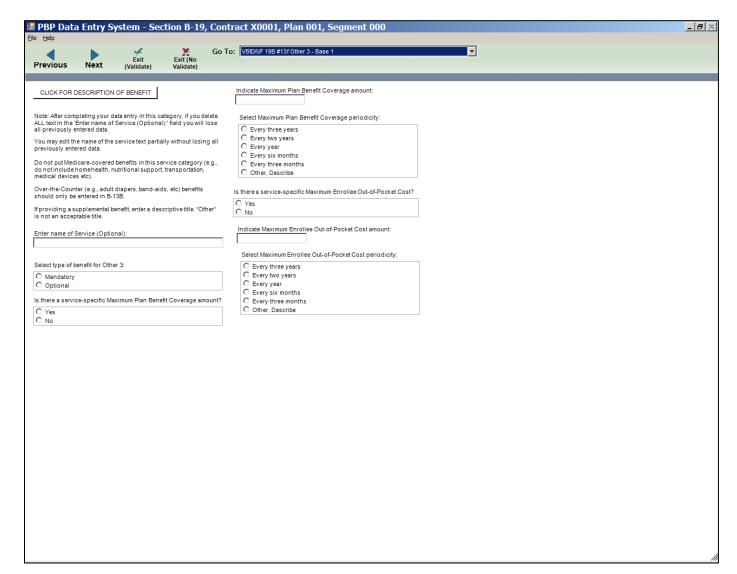
VBID/UF 19B #13e Other 2 - Base 2



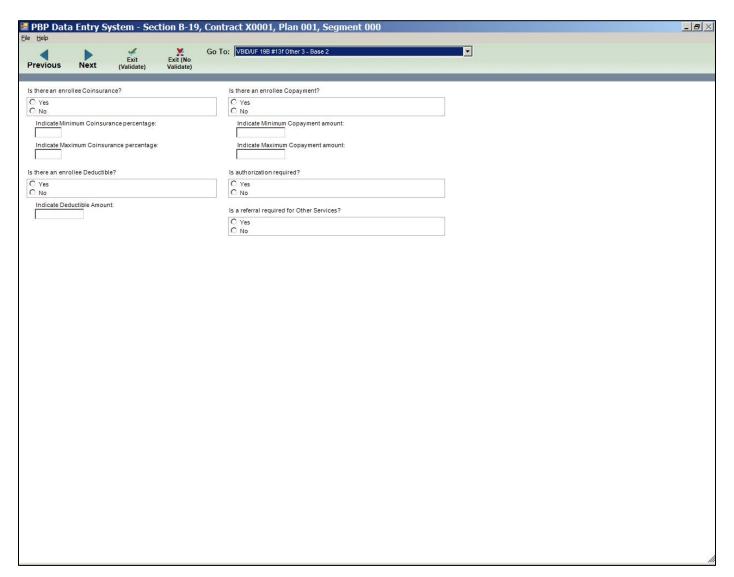
VBID/UF 19B #13e Other 2 - Base 3



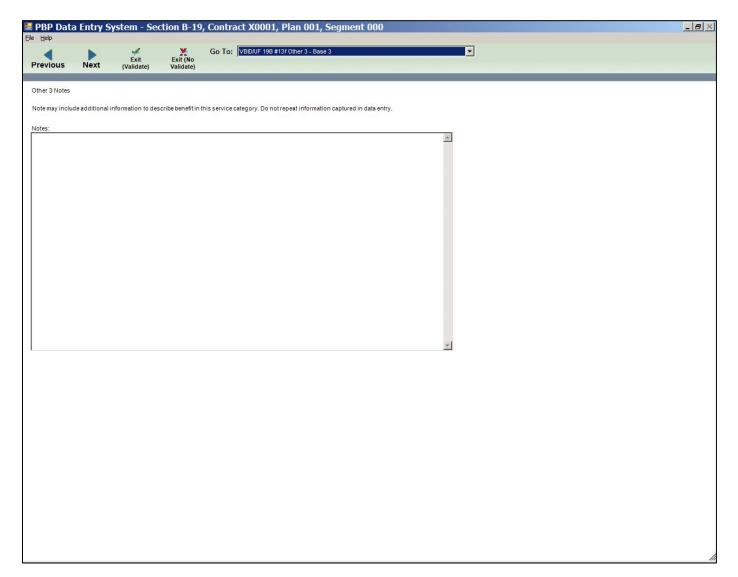
VBID/UF 19B #13f Other 3 - Base 1



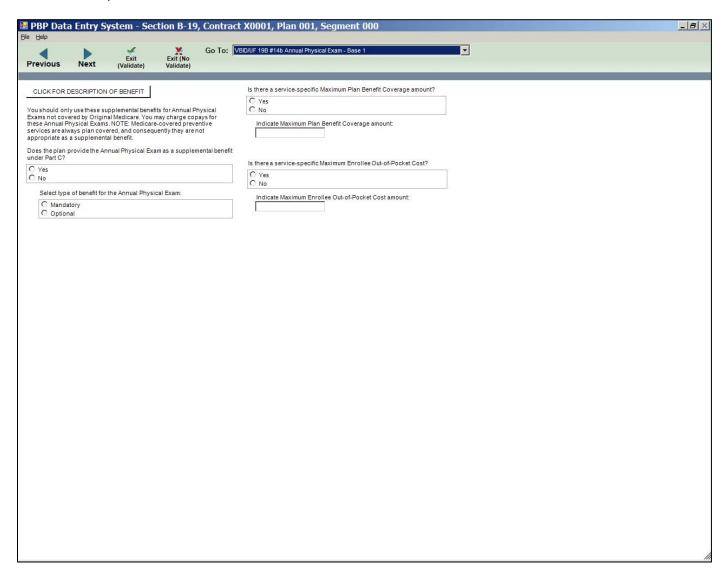
VBID/UF 19B #13f Other 3 – Base 2



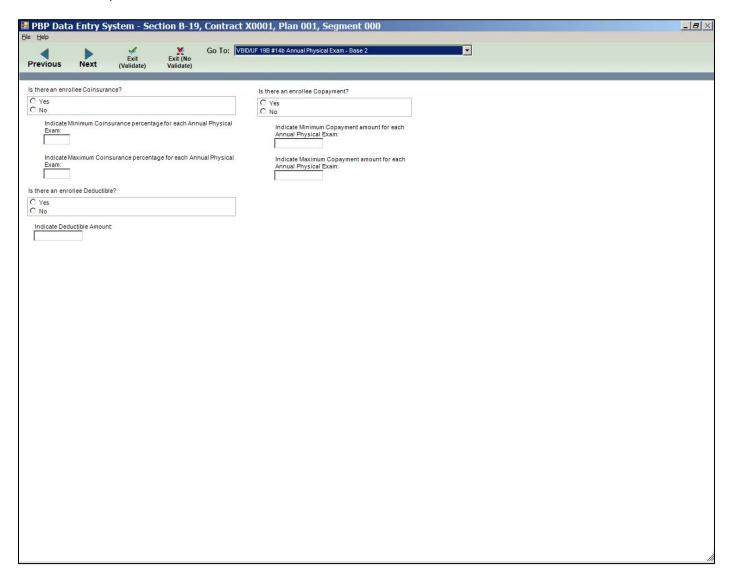
VBID/UF 19B #13f Other 3 – Base 3



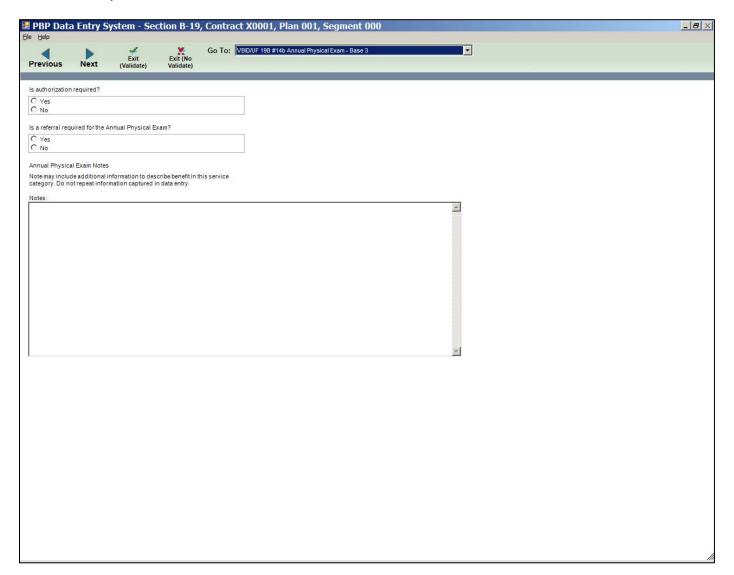
VBID/UF 19B #14b Annual Physical Exam – Base 1

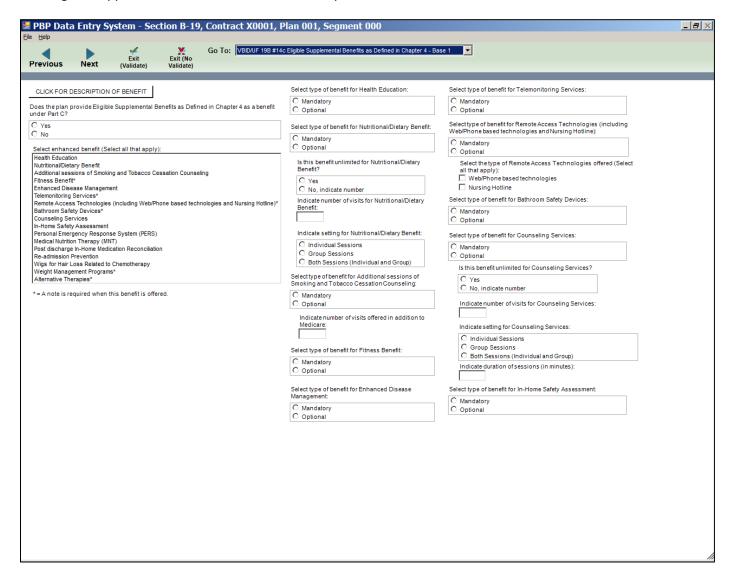


VBID/UF 19B #14b Annual Physical Exam – Base 2



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





CY 2019 PBP Data Entry System Screens

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Previous Next (Validate) Validate)	Complete 19th #14¢ Eligible Supplemental Benetits as Defined in Chapter 4 - Base 2	<u> </u>	
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Select type of benefit for Personal Emergency Response System (PERS):	Select type of benefit for Re-admission Prevention:	Select type of benefit for Alternative Therapies:	
C Mandatory C Optional	C Mandatory C Optional	C Mandatory C Optional	
Select type of benefit for Medical Nutrition Therapy (MNT):	What does your Re-admission Prevention benefit include (check all that apply):	Is this benefit unlimited for Alternative Therapies?	
O Mandatory O Optional	☐ Meals ☐ Medication Reconciliation	C Yes C No, indicate number	
Do you offer Additional Sessions for Medicare-covered diseases?	☐ In-Home Safety Assessment☐ Other, Describe	Indicate number of visits offered for Alternative Therapies:	
O No	Enter name of Service:		
Indicate the limit for Additional Sessions: C Visits C Hours	Please describe the Meal benefit included in Re-admission Prevention:	Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	
Indicate numerical limit on the services provided for Additional Sessions:	How many days does your Meal Benefit last?	C Yes C No	
Sessions.	What is the maximum number of meals the benefit provides?		
Do you offer Coverage for Non-Medicare-covered diseases? (Specify the diseases and describe the coverage in the notes field)	Select type of benefit for Wigs for Hair Loss Related to Chemotherapy: C Mandatory		
C Yes	C Optional		
Indicate units a limit will be provided in for Coverage for Non- Medicare covered diseases:	Select type of benefit for Weight Management Programs: O Mandatory		
C Visits C Hours	C Optional		
Indicate numerical limit on the services provided for Coverage for Non-Medicare covered diseases:			
Select type of benefit for Post discharge In-Home Medication Reconciliation:			
C Mandatory C Optional			

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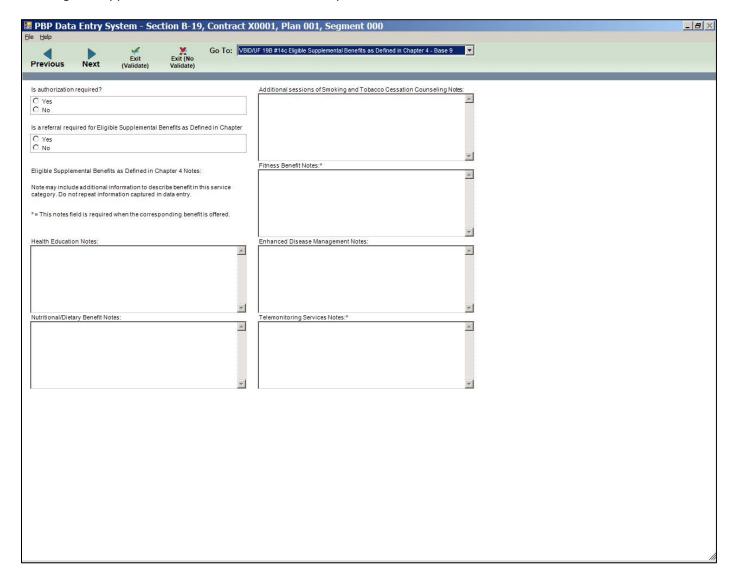
CY 2019 PBP Data Entry System Screens

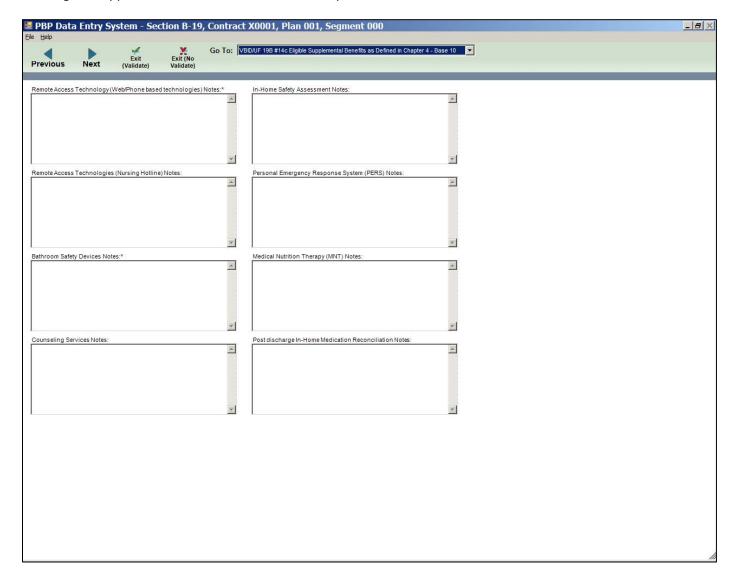
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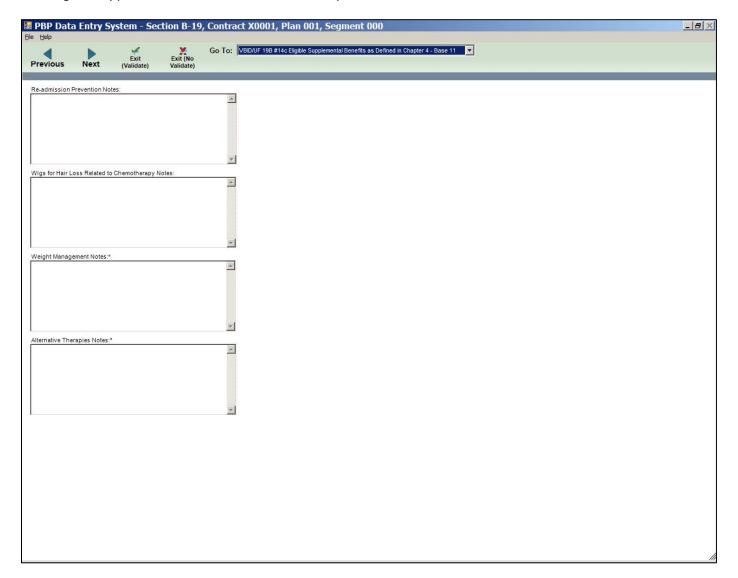
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Nutritional/Dietary Benefit Additional sessions of Smoking and Tobacco Cessation Counseli Fitness Benefit Enhanced Disease Management	Indicate Minimum Coinsurance percentage for Enhanced Disease Management:	Indicate Minimum Coinsurance percentage for In-Home Safety Assessment:	Indicate Minimum Coinsurance percentage for Weight Management Programs:		
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In-Home Safety Assessment Personal Emergency Response System (PERS) Medical Nutrition Therapy (MNT) Post discharge In-Home Medication Reconciliation	Indicate Minimum Coinsurance percentage for Telemonitoring Services:	Indicate Minimum Coinsurance percentage for Personal Emergency Response System (PERS):	Indicate Minimum Coinsurance percentage for Alternative Therapies:		
Re-admission Prevention Wigs for Hair Loss Related to Chemotherapy	Indicate Maximum Coinsurance percentage for Telemonitoring Services:	Indicate Maximum Coinsurance percentage for Personal Emergency Response System (PERS):	Indicate Maximum Coinsurance percentage for Alternative Therapies:		
Indicate Minimum Coinsurance percentage for Health Education:	Indicate Minimum Coinsurance percentage for Remote Access Technologies (Web/Phone based technologies):	Indicate Minimum Coinsurance percentage for Medical Nutrition Therapy (MNT):			
Indicate Maximum Coinsurance 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 costsharing to the beneficiary, including any facility costsharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest costsharing that a beneficiary may pay.		
Indicate Minimum Coinsurance percentage for Nutritional/Dietary Benefit:	Indicate Minimum Coinsurance percentage for Remote Access Technologies (Nursing Hotline):	Indicate Minimum Coinsurance percentage for Post discharge In-Home Medication Reconciliation:			
Indicate Maximum Coinsurance percentage for Nutritional/Dietary Benefit:	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Nursing Hotline):	Indicate Maximum Coinsurance percentage for Post discharge In-Home Medication Reconciliation:			
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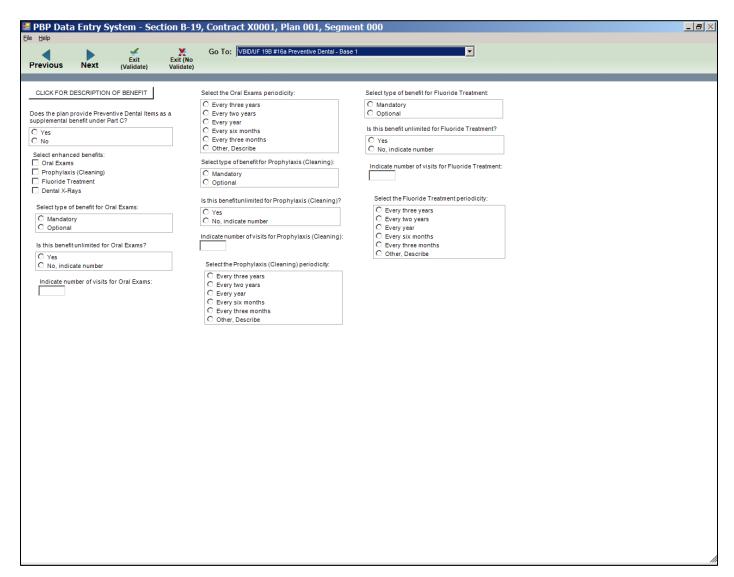
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Elle Help Go To: VBID/UF 198 #14c Eligible Supplemental Benefits as Defined in Chapter 4 - Base 8 ▼				
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Is there an enrollee Copayment?	Indicate Minimum Copayment amount for Fitness Benefit:	Indicate Minimum Copayment amount for Counseling Services:	Indicate Minimum Copayment amount for Wigs for Hair Loss Related to Chemotherapy:	
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Chapter 4 have a Copayment (Select all that apply): Health Education Nutritional/Dietary Benefit	Indicate Minimum Copayment amount for Enhanced Disease	Indicate Minimum Copayment amount for In-Home Safety	Indicate Minimum Copayment amount for Weight Management	
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In-Home Safety Assessment Personal Emergency Response System (PERS) Medical Nutrition Therapy (MNT) Post discharge In-Home Medication Reconciliation	Indicate Minimum Copayment amount for Telemonitoring Services:	Indicate Minimum Copayment amount for Personal Emergency Response System (PERS):	Indicate Minimum Copayment amount for Alternative Therapies:	
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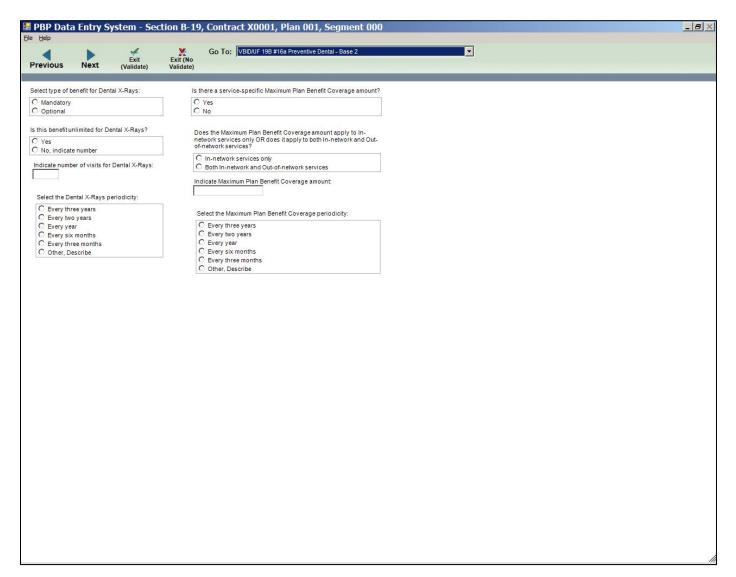




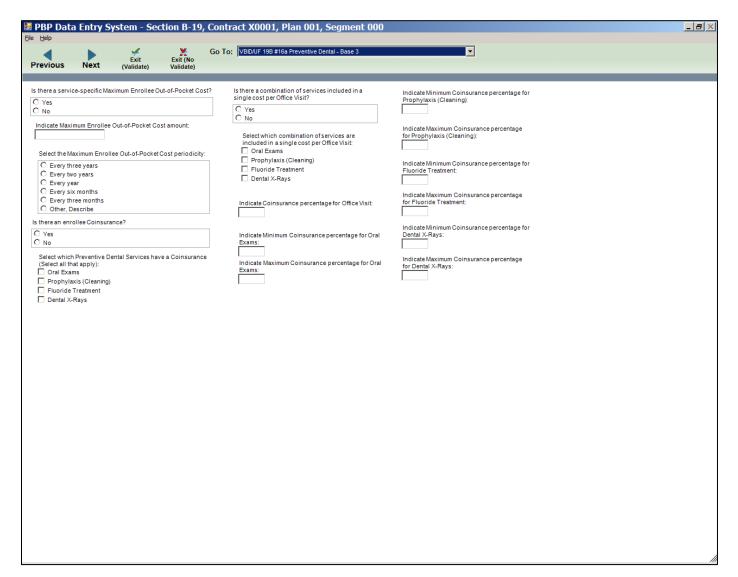
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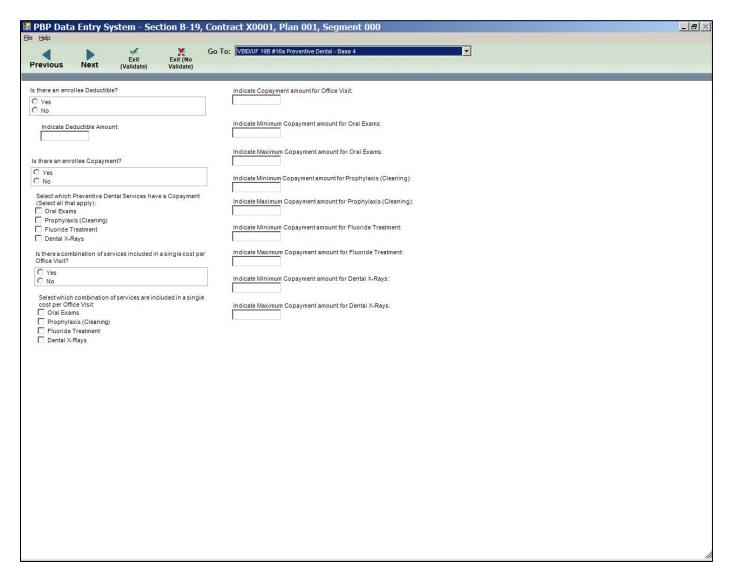
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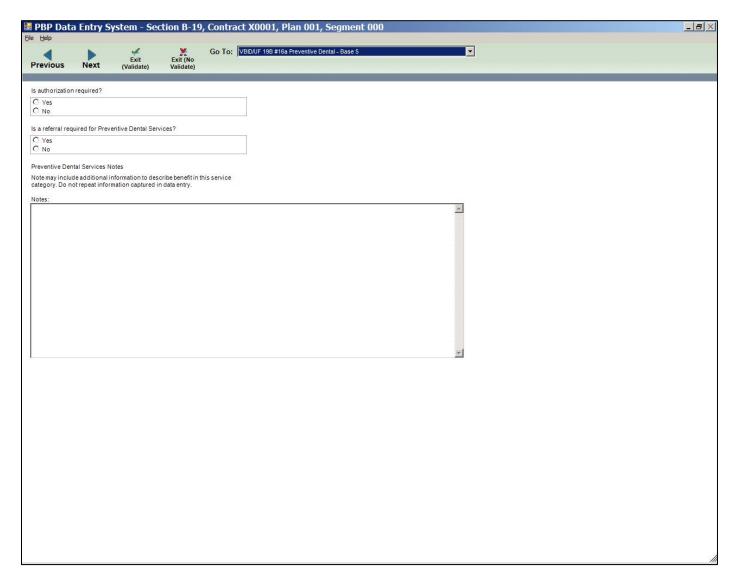
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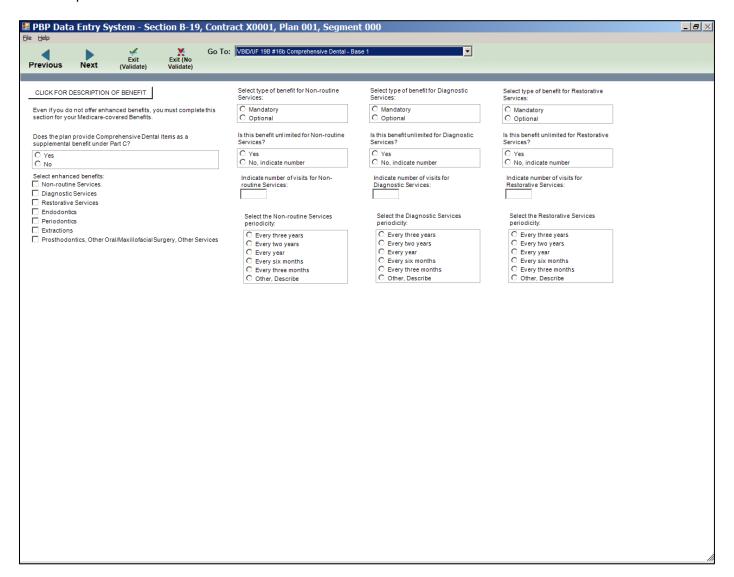


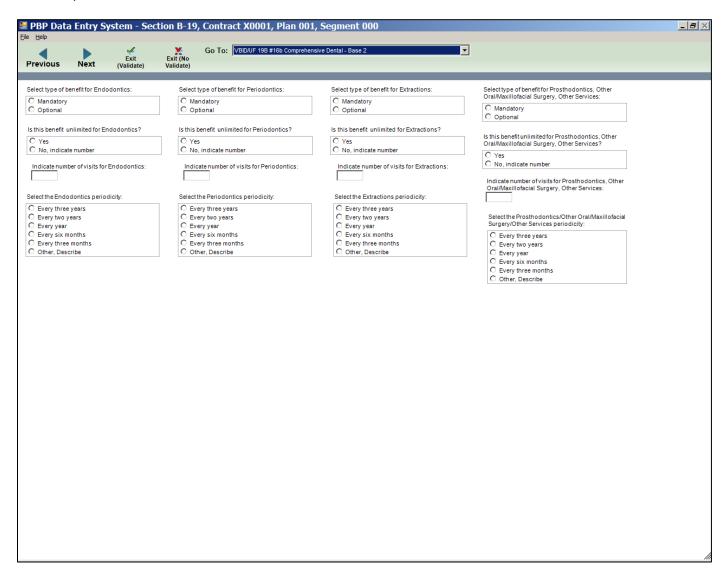
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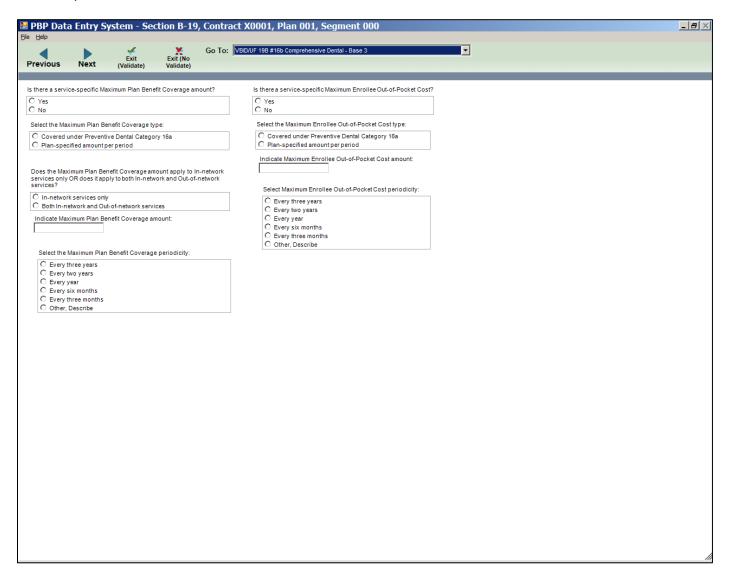


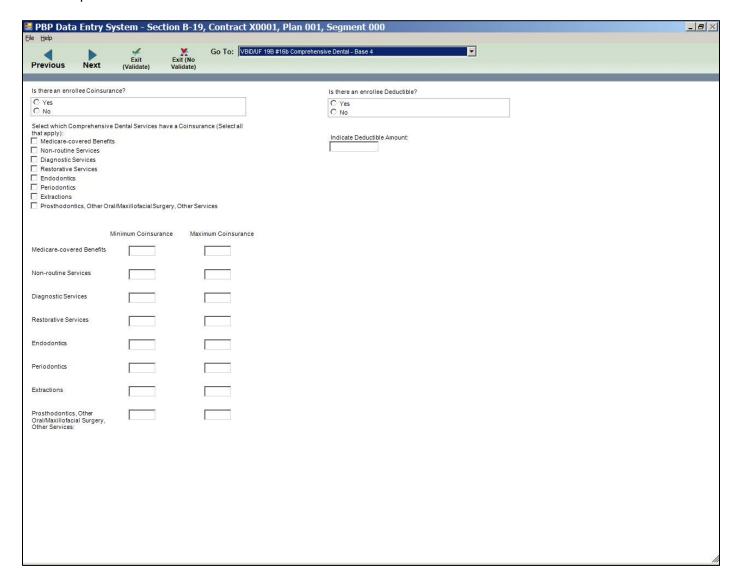
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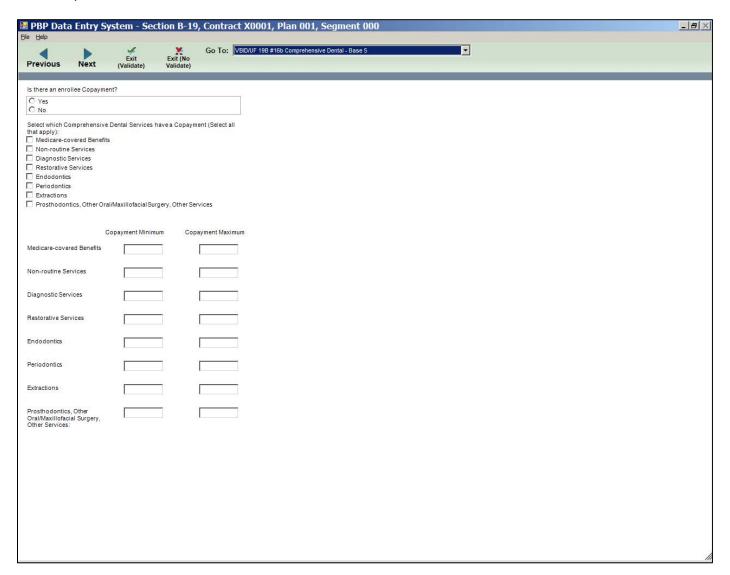


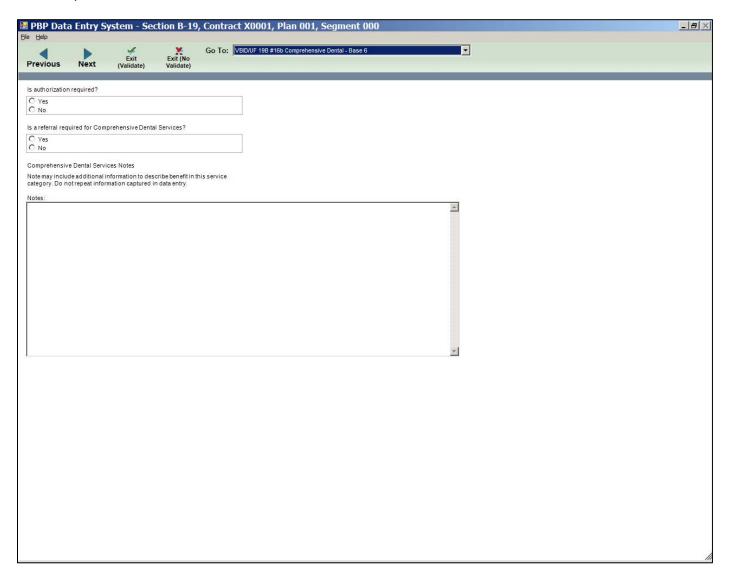




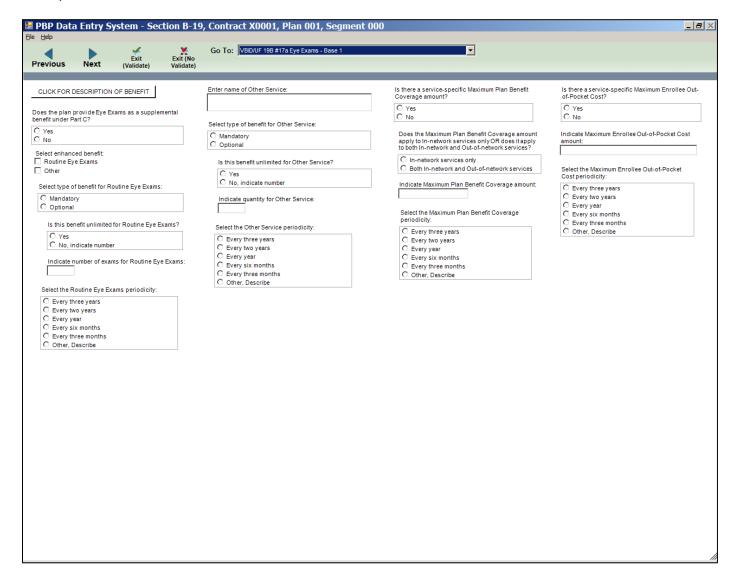




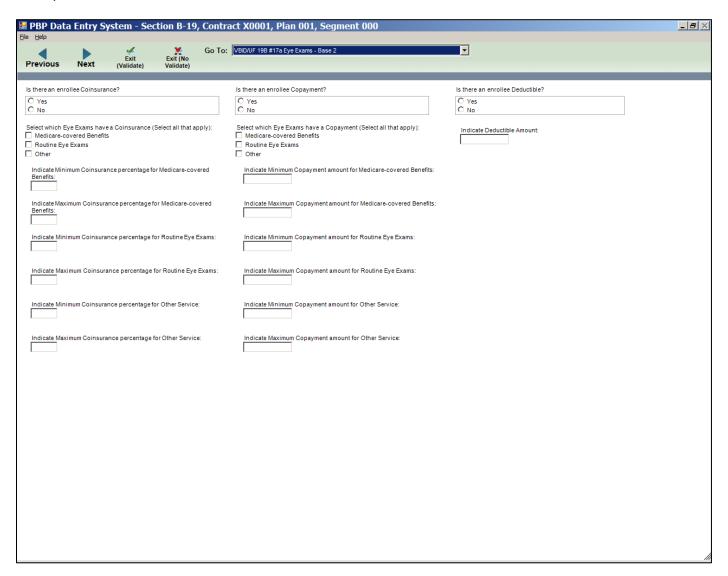




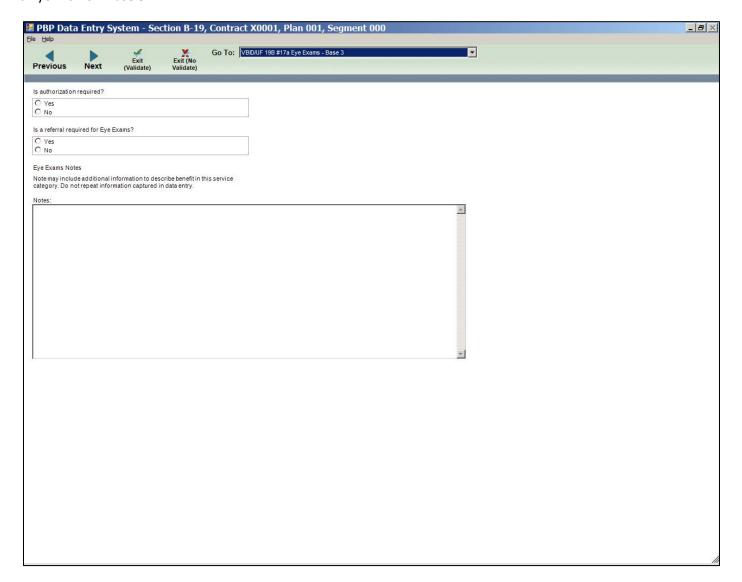
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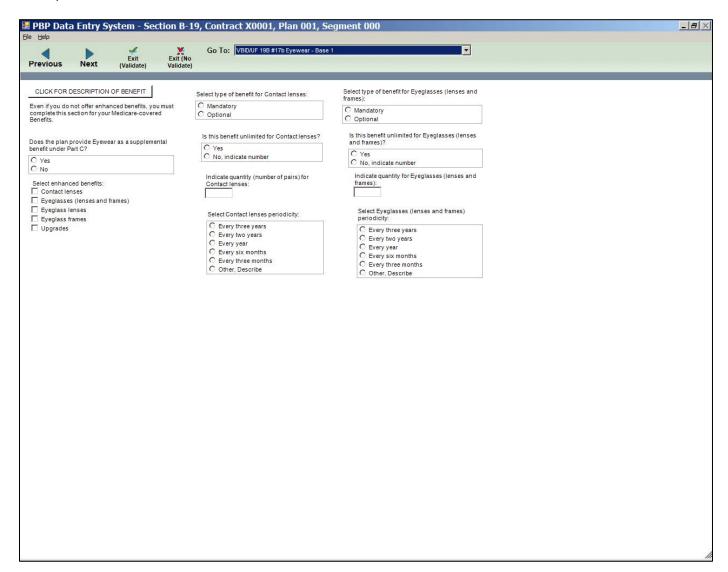


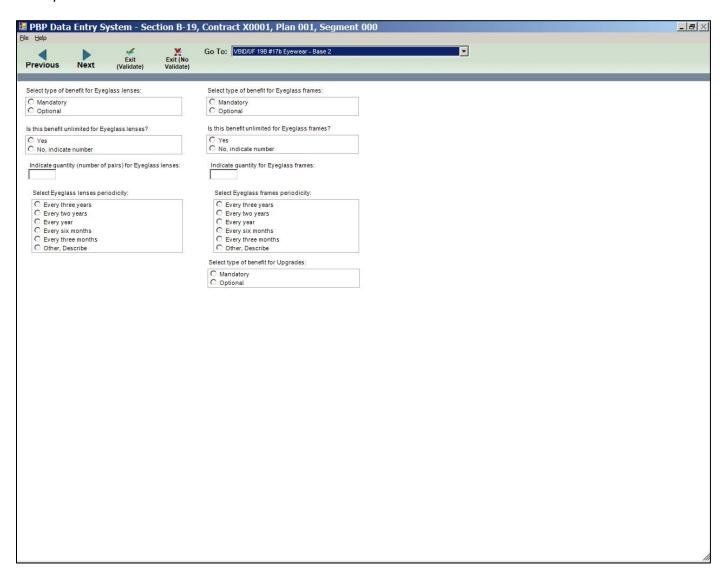
VBID/UF 19B #17a Eye Exams - Base 2

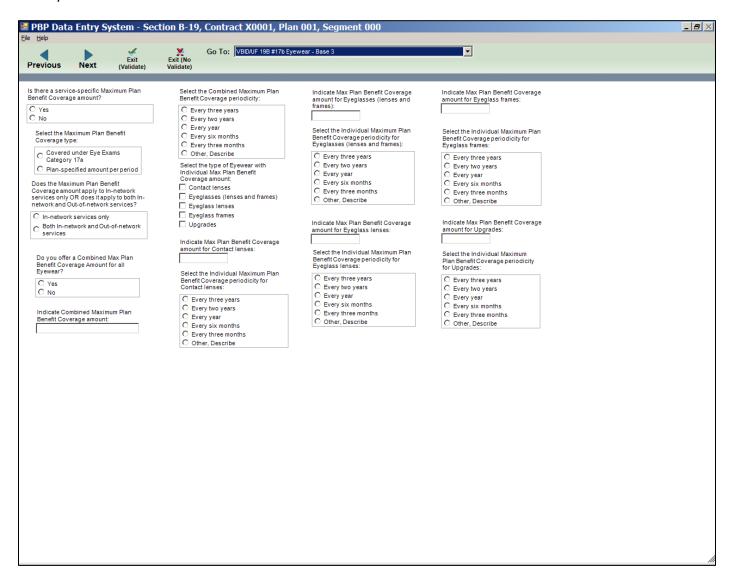


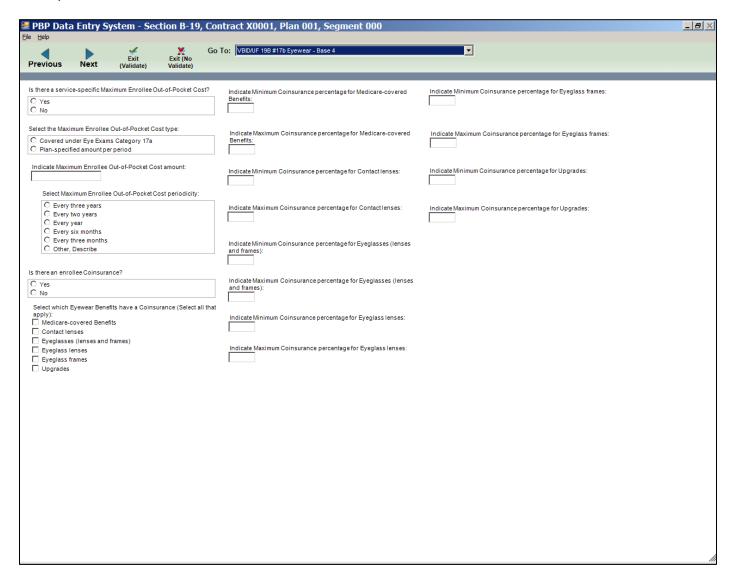
VBID 19B #17a Eye Exams - Base 3

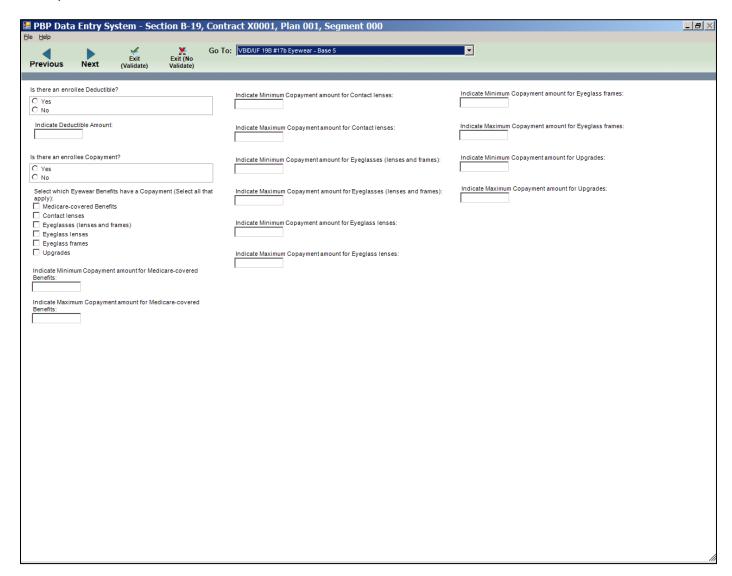


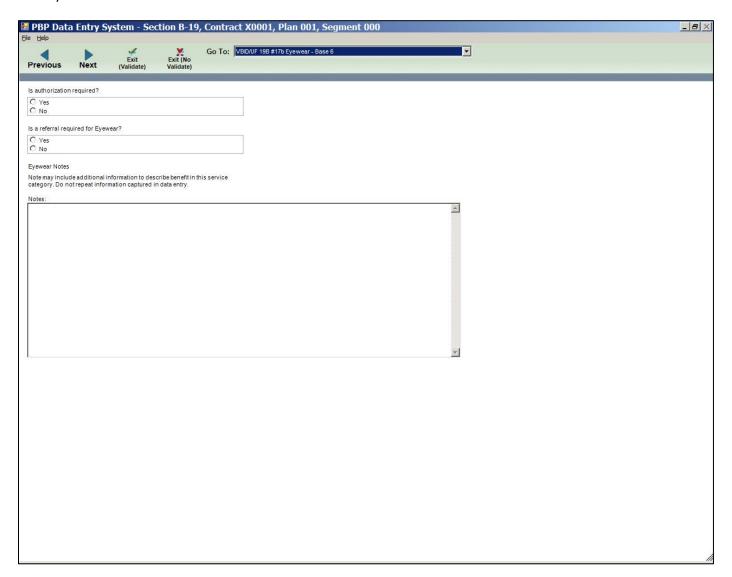




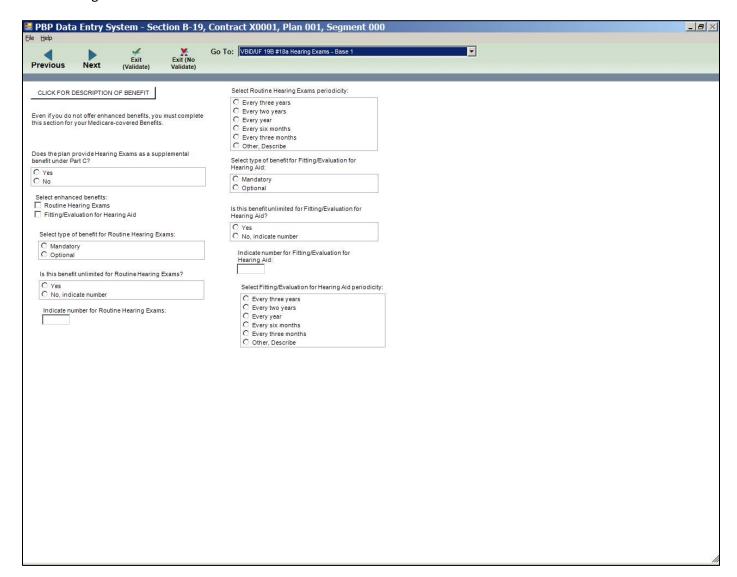




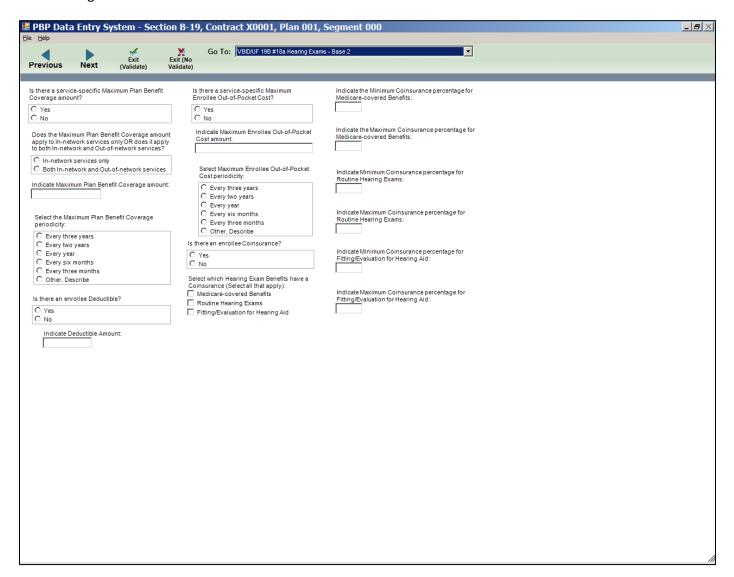




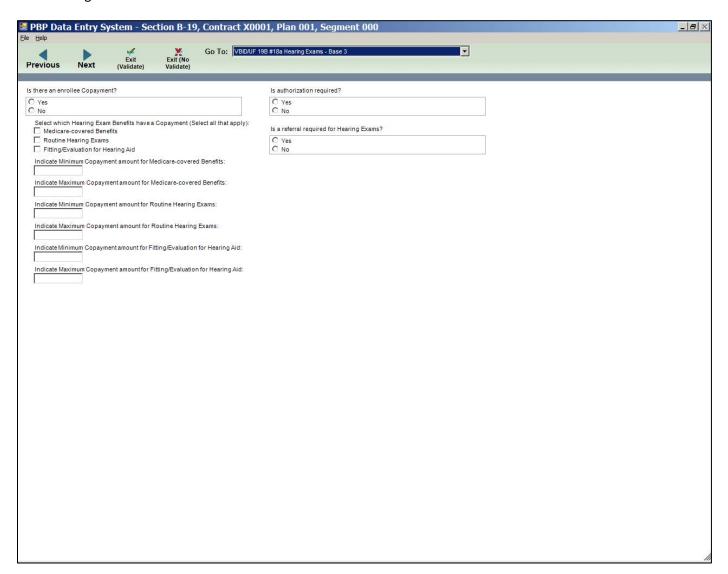
VBID/UF 19B #18a Hearing Exams – Base 1



VBID/UF 19B #18a Hearing Exams – Base 2



VBID/UF 19B #18a Hearing Exams - Base 3



VBID/UF 19B #18a Hearing Exams – Base 4

