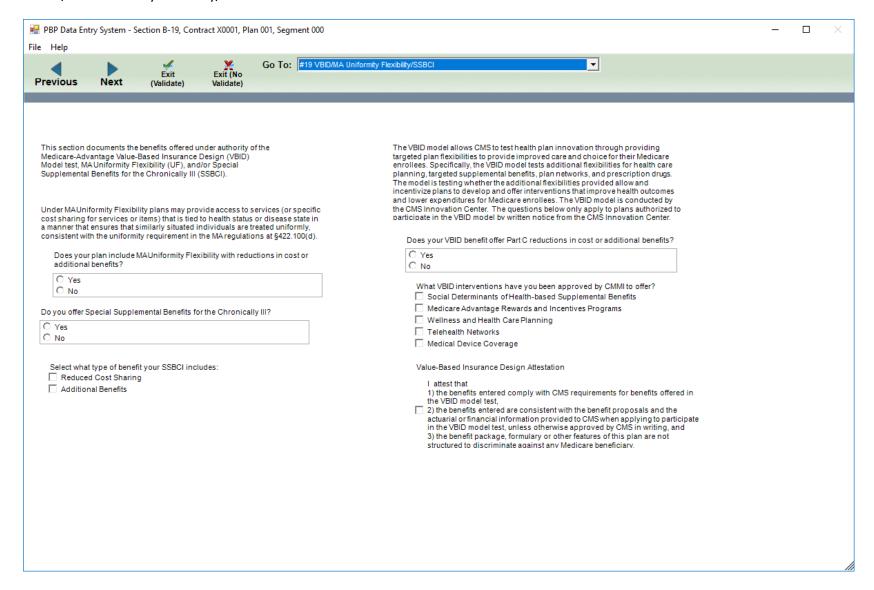
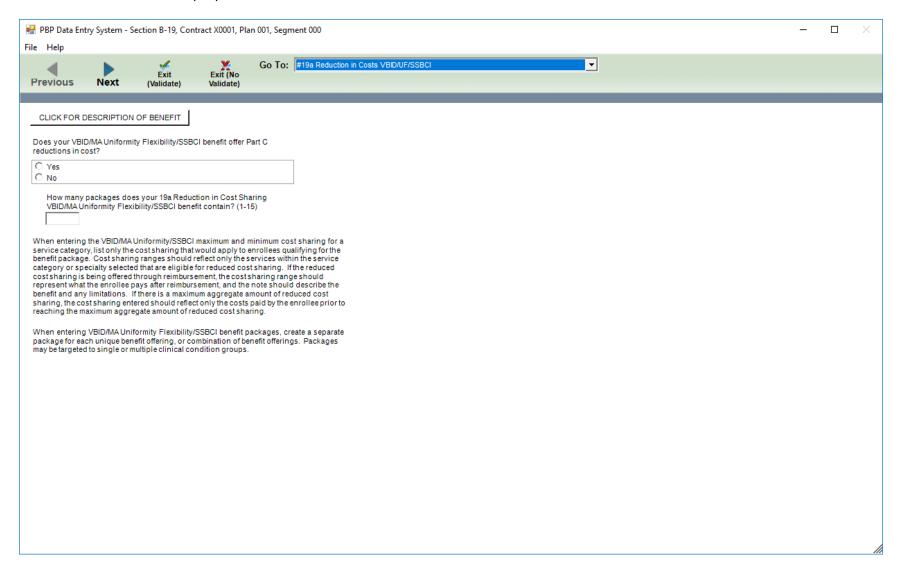
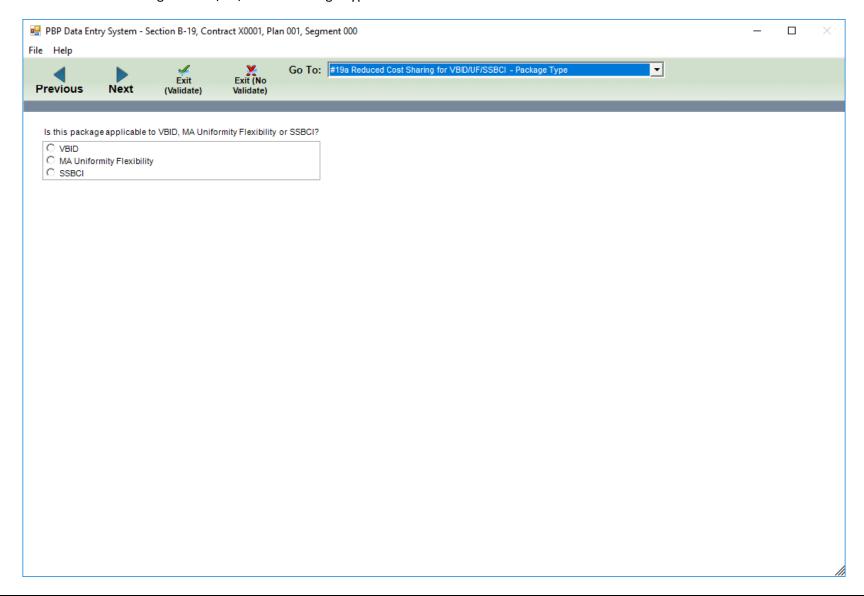
#19 VBID/MA Uniformity Flexibility/SSBCI



#19a Reduction in Costs VBID/UF/SSBCI



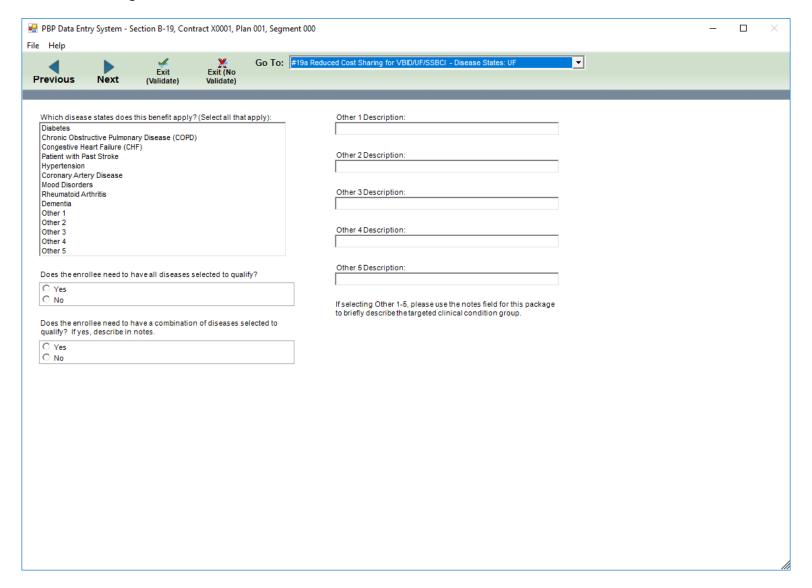
#19a Reduced Cost Sharing for VBID/UF/SSBCI – Package Type



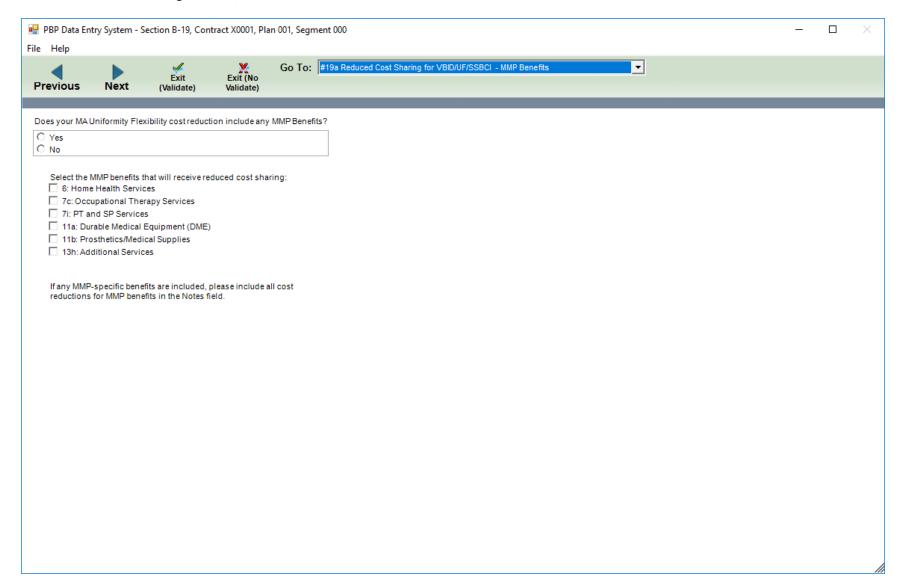
#19a Reduced Cost Sharing for VBID/UF/SSBCI – Disease States: VBID

₽BP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000	_	×
File Help		
Previous Next (Validate) Go To: #19a Reduced Cost Sharing for VBID/UF/SSBCI - Disease States: VBID Validate)		
Which disease states does this benefit apply? (Select all that apply): Diabetes		

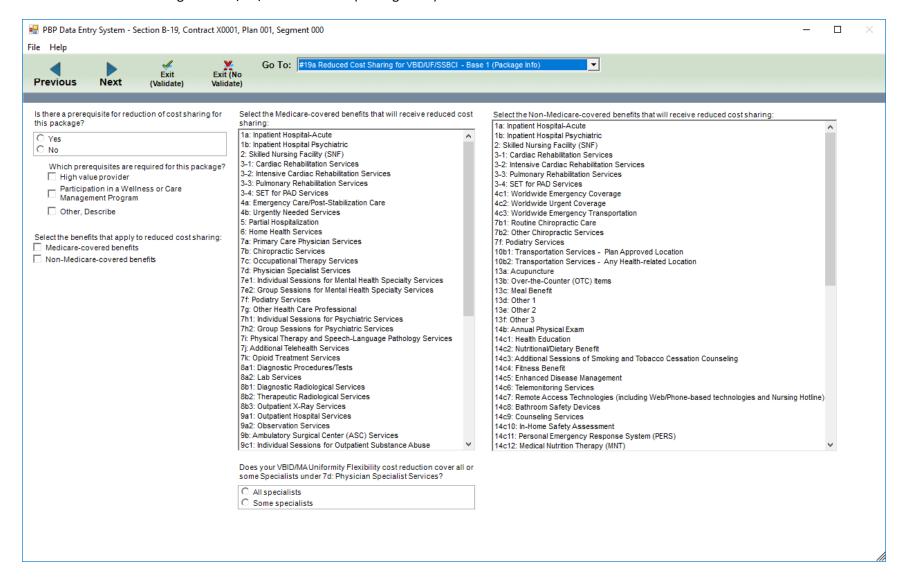
#19a Reduced Cost Sharing for VBID/UF/SSBCI - Disease States: UF



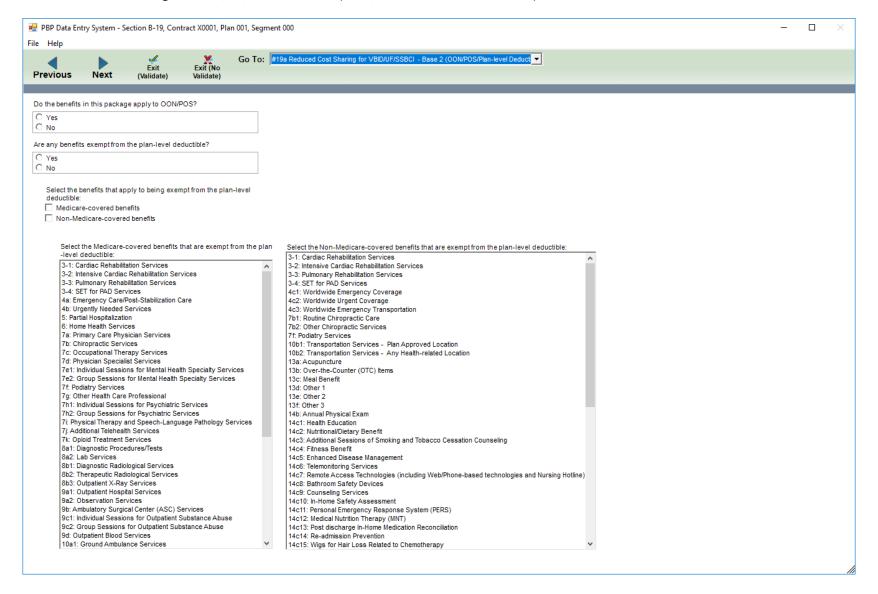
#19a Reduced Cost Sharing for VBID/UF/SSBCI – MMP Benefits



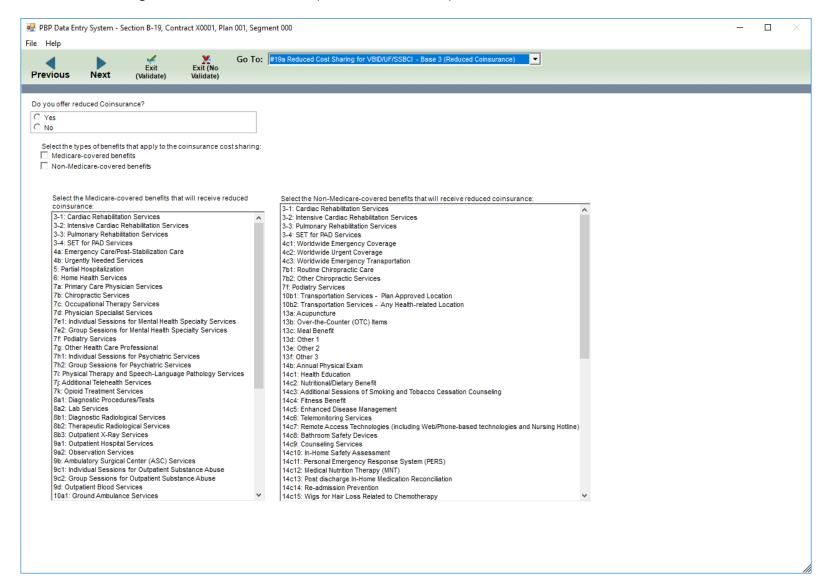
#19a Reduced Cost Sharing for VBID/UF/SSBCI - Base 1 (Package Info)



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



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



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

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File Help								
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #198	Reduced Cost Sharing for VBID/UF/SSBCI - Base	4 (Reduced Coinsurance)		
Indicate Coinsu	ırance for one or	more of the follo	owing Medicare	e-covered services	X.			
			Minimum Coinsurance	Maximum Coinsurance		Minimum Maximum Coinsurance Coinsurance		
Cardiac Rehabi	litation Services				Group Sessions for Mental Health Specialty Services			
Intensive Cardi	ac Rehabilitation	Services			Podiatry Services			
Pulmonary Reh	abilitation Service	ces			Other Health Care Professional			
SET for PAD Se	ervices				Individual Sessions for Psychiatric Services			
Emergency Car	re/Post-Stabilizat	ion Care			Group Sessions for Psychiatric Services			
Urgently Needs	ed Services				Physical Therapy and Speech-Language Pathology Services			
Partial Hospital	ization				Additional Telehealth Services			
Home Health S	ervices				Opioid Treatment Services			
Primary Care Pi	hysician Service	rs.			Diagnostic Procedures/Tests			
Chiropractic Se	ervices				Lab Services			
Occupational T	herapy Services				Diagnostic Radiological Services			
Physician Spec	cialist Services				Therapeutic Radiological Services			
Individual Sess Specialty Servi	ions for Mental I ces	Health			Outpatient X-Ray Services			

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

PBP Data Ent	try System - Se	ection B-19, Con	tract X0001, Pla	an 001, Segmer	nt 000					- 🗆	×
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Indicate Coinsu	urance for one (or more of the foll	owing Medicar	e-covered servi	ces:						
			Minimum Coinsurance	Maximum Coinsurance		Minimum Coinsurand	Maximum e Coinsurance		Minimum Coinsurance	Maximum Coinsurance	
Outpatient Hos	pital Services				Diabetic Therapeutic Shoes/Inserts			Eye Exams			
Observation Se	ervices				Dialysis Services			Eyewear			
Ambulatory Sur	gical Center (A	SC) Services			Kidney Disease Education Services			Hearing Exams			
Individual Sess Abuse	ions for Outpa	tient Substance			Glaucoma Screening						
Group Session: Abuse	s for Outpatien	t Substance			Diabetes Self-Management Training						
Outpatient Bloo	od Services				Barium Enemas						
Ground Ambula	ance Services				Digital Rectal Exams						
Air Ambulance S	Services				EKG following Welcome Visit						
Durable Medica	al Equipment (D	DME)			Other Medicare-covered Preventive Services						
Prosthetic Devi	ices				Medicare Part B Chemotherapy Drugs						
Medical Supplie	es				Other Medicare Part B Drugs						
Diabetic Supplie	es				Comprehensive Dental						
											,

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

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Indicate Coinsurance for one or more of the following Non-Medicare-covered services:	
Minimum Maximum Minimum Maximum Minimum Maximum Coinsurance Coinsurance Coinsurance Coinsurance Coinsurance Coinsurance Coinsurance Coinsurance Coinsurance	
Additional Cardiac Rehabilitation Services Meal Benefit In-Home Safety Assessment	
Additional Intensive Cardiac Rehabilitation Other 1 Personal Emergency Response System (PERS)	
Additional Pulmonary Rehabilitation Services Other 2 Medical Nutrition Therapy (MNT)	
SET for PAD Services Other 3	
Worldwide Emergency Coverage Annual Physical Exam	
Worldwide Urgent Coverage Health Education	
Worldwide Emergency Transportation Nutritional/Dietary Benefit	
Chiropractic Services - Routine Care Additional Sessions of Smoking and Tobacco Cessation Counseling	
Chiropractic Services - Other Services Fitness Benefit	
Podiatry Services - Routine Foot Care Enhanced Disease Management	
Transportation Services - Plan Approved Telemonitoring Services Location	
Transportation Services - Any Health-related Remote Access Technologies (including Location Web/Phone-based technologies and Nursing	
Acupuncture Hotline) Bathroom Safety Devices	
Over-the-Counter (OTC) Items Counseling Services	

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

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #1	9a Reduced Cost Sharing for VBID/UF/SSBCI - Base	7 (Reduced Co	insurance) ▼				
Indicate Coinsura	ance for one or	more of the follo	owing Non-Med	icare-covered s	ervices:						
			Minimum Coinsurance	Maximum Coinsurance		Minimum Coinsurance	Maximum e Coinsurance		Minimum Maximu Coinsurance Coinsu		
Post discharge Ir Reconciliation	n-Home Medic	ation			Non-routine Services			Routine Hearing Exams			
Re-admission Pr	evention				Diagnostic Services			Fitting/Evaluation for Hearing Aid			
Wigs for Hair Los	ss Related to C	hemotherapy			Restorative Services			Hearing Aids (all types)			
Weight Managen	ment Programs				Endodontics			Hearing Aids - Inner Ear			
Alternative Thera	apies				Periodontics			Hearing Aids - Outer Ear			
Therapeutic Mas	sage				Extractions			Hearing Aids - Over the Ear			
Adult Day Health	Services				Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services						
Home-Based Pall	liative Care				Routine Eye Exams						
In-Home Support	t Services				Other Eye Exam Services						
Support for Care	givers of Enroll	ees			Contact Lenses						
Oral Exams					Eyeglasses (lenses and frames)						
Prophylaxis (Cle	aning)				Eyeglass lenses						
Fluoride Treatme	ent				Eyeglass frames						
Dental X-Rays					Upgrades						

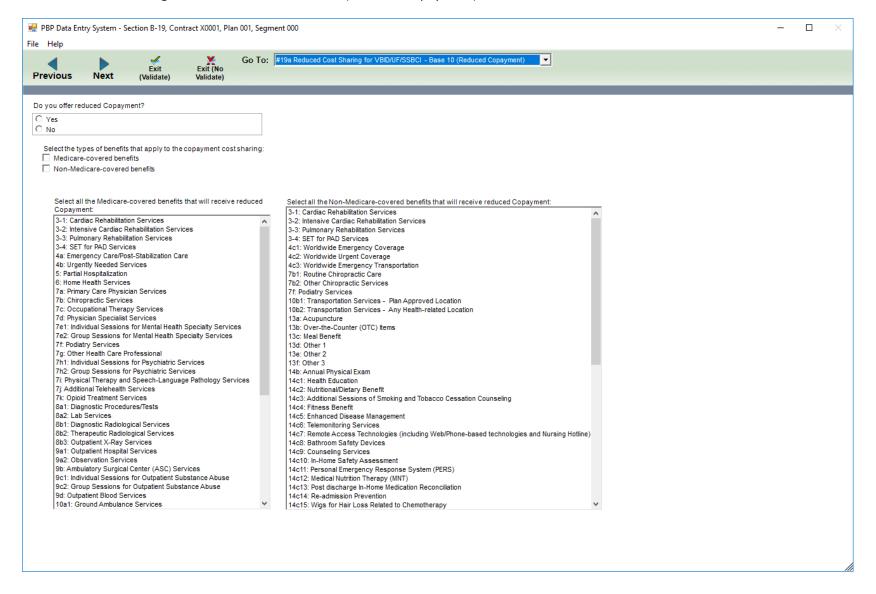
#19a Reduced Cost Sharing for VBID/UF/SSBCI – Base 8 (Reduced Deductible)

🖳 PBP Data En	itry System - Se	ection B-19, Cor	ntract X0001, Pla	n 001, Segn	nent 000				_	\times
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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#19a Reduced Cost Sharing for VBID/UF/SSBCI - t	Base 8 (Reduced Ded	luctible)			
Do you offer a	reduced deduc	tible amount?			Indicate deductible for one or more of the followi	ing services				
Select the I	benefits that wil nt Hospital-Acute nt Hospital Psych		d deductible am	ounts:	Inpatient Hospital-Acute		Other Health Care Professional			
2: Skilled N	ursing Facility (S		vices		Inpatient Hospital Psychiatric		Psychiatric Services			
5: Partial Ho	vide Emergency/ ospitalization ealth Services	/Urgent Coverage			Skilled Nursing Facility (SNF)		Physical Therapy and Speech- Language Pathology Services			
7a: Primary 7b: Chiropr	Care Physician actic Services				Cardiac and Pulmonary Rehabilitation Services		Additional Telehealth Services			
7d: Physici	ational Therapy : an Specialist Se Health Specialty	rvices			Worldwide Emergency/Urgent Coverage		Opioid Treatment Services			
7f: Podiatry 7g: Other H	/ Services lealth Care Profe				Partial Hospitalization		Diagnostic Procedures/Tests/Lab Services			
7i: Physical	atric Services I Therapy and S al Telehealth Sei	peech-Language	Pathology Service	es	Home Health Services		Outpatient Diagnostic/Therapeutic Radiological Services			
7k: Opioid 1 8a: Diagnos	Treatment Servicestic Procedures	ces /Tests/Lab Servic			Primary Care Physician Services		Outpatient Hospital Services			
9a1: Outpa	ent Diagnostic/T tient Hospital Se vation Services		logical Services		Chiropractic Services		Observation Services			
9b: Ambula 9c: Outpati	tory Surgical Ce ent Substance A	enter (ASC) Servi Abuse	ces		Occupational Therapy Services		Ambulatory Surgical Center (ASC) Services			
10a1: Grou	ent Blood Servio and Ambulance S mbulance Servi	Services			Physician Specialist Services		Outpatient Substance Abuse			
11a: Durab	portation Servic	ment (DME)			Mental Health Specialty Services		Outpatient Blood Services			
11c: Diabet 12: Dialysis					Podiatry Services		Ground Ambulance Services			
13a: Acupu 13b: Over-	incture the-Counter (OT	C) Items		~						

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

ndicate deductible for one or more	of the following ser	rvices						
	Deductible Amount		Deductible Amount		Deductible Amount		Deductible Amount	
ir Ambulance Services		Nutritional/Dietary Benefit		Weight Management Programs		Medicare Part B Rx Drugs		
ransportation Services		Additional Sessions of Smoking and Tobacco Cessation Counseling		Alternative Therapies		Preventive Dental		
Durable Medical Equipment (DME		Fitness Benefit		Therapeutic Massage		Comprehensive Dental		
Prosthetics/Medical Supplies		Enhanced Disease Management		Adult Day Health Services		Eye Exams		
iabetic Supplies and Services		Telemonitoring Services		Home-Based Palliative Care		Eyewear		
Dialysis Services		Remote Access Technologies (including Web/Phone-based		In-Home Support Services		Hearing Exams		
cupuncture		technologies and Nursing Hotline) Bathroom Safety Devices		Support for Caregivers of Enrollees		Hearing Aids		
over-the-Counter (OTC) Items		Counseling Services		Kidney Disease Education Services				
Meal Benefit		In-Home Safety Assessment		Glaucoma Screening				
Other 1		Personal Emergency Response System (PERS)		Diabetes Self-Management Training				
Other 2		Medical Nutrition Therapy (MNT)		Barium Enemas				
Other 3		Post discharge In-Home Medication Reconciliation		Digital Rectal Exams				
nnual Physical Exam		Re-admission Prevention		EKG following Welcome Visit				
lealth Education		Wigs for Hair Loss Related to Chemotherapy		Other Medicare-covered Preventive Services				

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



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

🖳 PBP Data En	ntry System - Se	ection B-19, Co	ntract X0001, Pla	an 001, Segme	nt 000			 \times
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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#19a Reduced Cost Sharing for VBID/UF/SSBCI - Base	11 (Reduced Co	payment) 🔻	
Indicate Copay	/ment for one or	r more of the follo	owing Medicare-	covered service	ces:			
			Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment	
Cardiac Rehab	ilitation Service	es			Group Sessions for Mental Health Specialty Services			
Intensive Cardi	iac Rehabilitatio	on Services			Podiatry Services			
Pulmonary Reh	nabilitation Serv	rices			Other Health Care Professional			
SET for PAD Se	ervices				Individual Sessions for Psychiatric Services			
Emergency Ca	re/Post-Stabiliz	ation Care			Group Sessions for Psychiatric Services			
Urgently Need	ed Services				Physical Therapy and Speech-Language Pathology Services			
Partial Hospita	llization				Additional Telehealth Services			
Home Health S	Services				Opioid Treatment Services			
Primary Care P	Physician Servi	ces			Diagnostic Procedures/Tests			
Chiropractic Se	ervices				Lab Services			
OccupationalT	Therapy Service	es .			Diagnostic Radiological Services			
Physician Spec	cialist Services				Therapeutic Radiological Services			
Individual Sess Specialty Servi		l Health			Outpatient X-Ray Services			

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

💀 PBP Data Ent	ry System - Sec	ction B-19, Cont	tract X0001, PI	an 001, Segme	ent 000					_	\times
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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	#19a Reduced Cost Sharing for VBID/UF/SSBCI - Base	12 (Reduced (Copayment)				
Indicate Copayr	ment for one or	more of the follow	wing Medicare	-covered servi	ces:						
			Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment	
Outpatient Hosp	oital Services				Diabetic Therapeutic Shoes/Inserts			Eye Exams			
Observation Ser	rvices				Dialysis Services			Eyewear			
Ambulatory Surg	gical Center (AS	SC) Services			Kidney Disease Education Services			Hearing Exams			
Individual Sessi Abuse					Glaucoma Screening						
Group Sessions Abuse		Substance			Diabetes Self-Management Training						
Outpatient Bloo					Barium Enemas						
Ground Ambula					Digital Rectal Exams						
Air Ambulance S		145)			EKG following Welcome Visit						
Durable Medical		IVIE)			Other Medicare-covered Preventive Services Medicare Part B Chemotherapy Drugs						
Medical Supplie					Other Medicare Part B Drugs						
Diabetic Supplie					Comprehensive Dental						
	- -										

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

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Previous Next (Validate)	Exit (No Validate)	Go To: #1	9a Reduced Cost Sharing for VBID/UF/SSBCI - Base	13 (Reduced C	opayment)				
Indicate Copayment for one or more of the follo	wing Non-Medi	care-covered se	rvices:						
	Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment	
Additional Cardiac Rehabilitation Services			Meal Benefit			In-Home Safety Assessment			
Additional Intensive Cardiac Rehabilitation Services			Other 1			Personal Emergency Response System (PERS)			
Additional Pulmonary Rehabilitation Services			Other 2			Medical Nutrition Therapy (MNT)			
SET for PAD Services			Other 3						
Worldwide Emergency Coverage			Annual Physical Exam						
Worldwide Urgent Coverage			Health Education						
Worldwide Emergency Transportation			Nutritional/Dietary Benefit						
Chiropractic Services - Routine Care			Additional Sessions of Smoking and Tobacco Cessation Counseling						
Chiropractic Services - Other Services			Fitness Benefit						
Podiatry Services - Routine Foot Care			Enhanced Disease Management						
Transportation Services - Plan Approved Location			Telemonitoring Services						
Transportation Services - Any Health-related Location			Remote Access Technologies (including Web/Phone-based technologies and Nursing						
Acupuncture			Hotline) Bathroom Safety Devices						
Over-the-Counter (OTC) Items			Counseling Services						
									,

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

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Previous	Next	Exit (Validate)	Exit (No Validate)	Go To: #1	9a Reduced Cost Sharing for VBID/UF/SSBCI - Ba	ase 14 (Reduced Co	opayment)				
Indicate Copay	ment for one o	or more of the follo	wing Non-Medi	care-covered se	rvices:						
			Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment	
Post discharge Reconciliation	In-Home Med	dication			Non-routine Services			Routine Hearing Exams			
Re-admission F	Prevention				Diagnostic Services			Fitting/Evaluation for Hearing Aid			
Wigs for Hair Lo	oss Related to	Chemotherapy			Restorative Services			Hearing Aids (all types)			
Weight Manage	ement Progran	ms			Endodontics			Hearing Aids - Inner Ear			
Alternative The	rapies				Periodontics			Hearing Aids - Outer Ear			
Therapeutic Ma	assage				Extractions			Hearing Aids - Over the Ear			
Adult Day Healt	th Services				Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services						
Home-Based Pa	alliative Care				Routine Eye Exams						
In-Home Suppo	ort Services				Other Eye Exam Services						
Support for Car	regivers of Enr	ollees			Contact Lenses						
Oral Exams					Eyeglasses (lenses and frames)						
Prophylaxis (Cl	leaning)				Eyeglass lenses						
Fluoride Treatm	nent				Eyeglass frames						
Dental X-Rays					Upgrades						

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

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Exit	Go To: #19a Re Exit (No /alidate)	duced Cost Sharing for VE	BD/UF/SSBCI - Base 15 (Reduced S	Specialist Coinsu 🔻	
Select all Specialists with a reduced coinsurance: Geriatrics	Indicate Coinsurance for or	ne ormore of the following	Specialists:		
Allergy and Immunology		Minimum Maximun	1	Minimum Maximum	
Cardiology		Coinsurance Coinsura		Coinsurance Coinsurance	
Dermatology Endocrinology					
ENT/Otolaryngology	Geriatrics		Oncology - Medical, Surgical		
Gastroenterology			Oncology - Radiation/		
General Surgery	Allergy and Immunology		Radiation Oncology		
Gynecology, OB/GYN Infectious Diseases	Odistant		On both almost and		
Nephrology	Cardiology		Ophthalmology		
Neurology	Desmetales		Orthopedic Surgery		
Neurosurgery Oncology - Medical, Surgical	Dermatology		Orthopedic Surgery		
Oncology - Radiation/Radiation Oncology	Endocrinology		Physiatry, Rehabilitative		
Ophthalmology	Endocrinology		Medicine		
Orthopedic Surgery Physiatry, Rehabilitative Medicine	ENT/Otolaryngology		Plastic Surgery		
Plastic Surgery	Livi7Otolalyligology		Plastic Surgery		
Pulmonology	Gastroenterology		Pulmonology		
Rheumatology Urology	Castrochicrology		Tamoriology		
Vascular Surgery	General Surgery		Rheumatology		
Cardiothoracic Surgery	Ochicial Surgery		Titreamatorogy		
Other*	Gynecology, OB/GYN		Urology		
* Please list the provider's actual	Oynocology, Oblotic		Crology		
specialty in the Notes	Infectious Diseases		Vascular Surgery		
	11110011003 21300303		vasodiai cargory		
	Nephrology		Cardiothoracic Surgery		
	Neurology		Other		
	Neurosurgery		1		

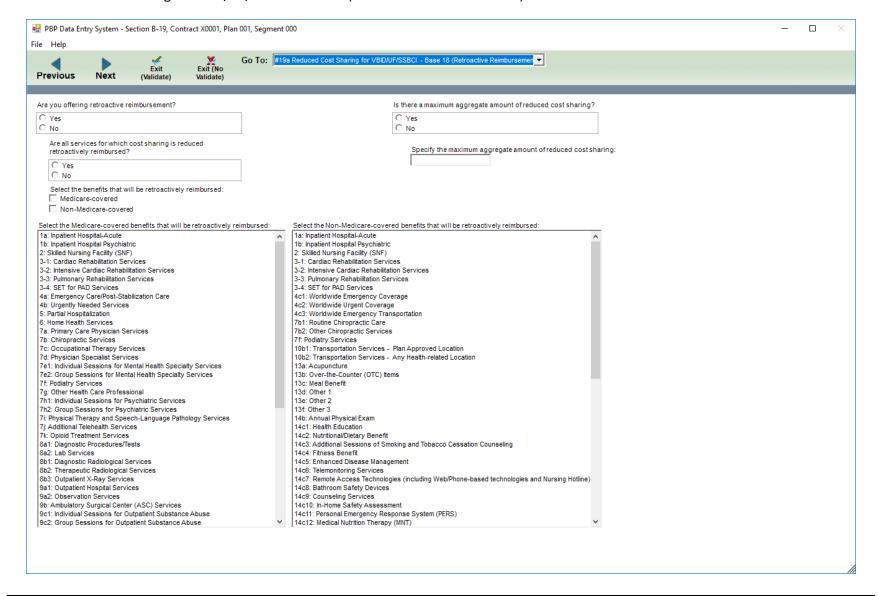
#19a Reduced Cost Sharing for VBID/UF/SSBCI – Base 16 (Reduced Specialist Deductible)

🖳 PBP Data Entry Syst	tem - Section E	-19, Contract X00	001, Plan	001, Segment 0	000									_	×
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4		4 2	(No	Go To: #198	Reduced	Cost Sharing for \	/BID/UF/SSBCI - Base 10	6 (Reduced	Specialist D	educi 🔻					
Previous Ne		xit Exit date) Valid	(No late)												
Select all Specialists w	vith a reduced o	eductible:	Indicate	e Deductible for o	ne or mor	e of the following	Specialists:								
Geriatrics Allergy and Immunology	,				Dad	uctible			Deductible						
Cardiology	,				Amo				Amount						
Dermatology Endocrinology			Geriatri	00			Oncology - Medical, S	Surgical F							
ENT/Otolaryngology			Genain	CS			Officology - Medical, s	Surgical							
Gastroenterology General Surgery			Allergy	and Immunology	, _		Oncology - Radiation Radiation Oncology	′ г							
Gynecology, OB/GYN Infectious Diseases															
Nephrology			Cardiol	ogy			Ophthalmology								
Neurology Neurosurgery			Dermato	ology			Orthopedic Surgery	Г							
Oncology - Medical, Su								L							
Oncology - Radiation/R Ophthalmology	adiation Oncolog	У	Endocr	inology			Physiatry, Rehabilitat Medicine	ive [
Orthopedic Surgery Physiatry, Rehabilitative	Madiatas		ENTIO					_							
Plastic Surgery	Medicine		EN1/Ot	olaryngology			Plastic Surgery	L							
Pulmonology Rheumatology			Gastroe	enterology			Pulmonology	Г							
Urology								-							
Vascular Surgery Cardiothoracic Surgery	,		Genera	l Surgery			Rheumatology								
Other*			Gyneco	ology, OB/GYN			Urology	Г							
* Please list the provid	ler's actual		_,				2.2.23,	L							
specialty in the Notes			Infectio	us Diseases			Vascular Surgery								
			Nephro	low			Cardiothoracic Surge	F							
			мершо	logy			Cardiotrioracic Surge	ary [
			Neurolo	gy			Other	Γ							
			Neuros	urgery											

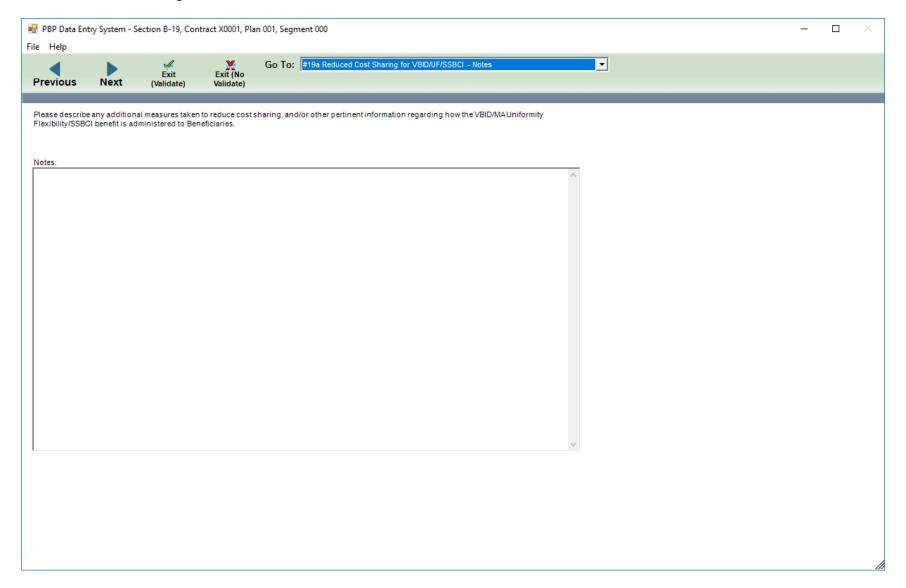
#19a Reduced Cost Sharing for VBID/UF/SSBCI – Base 17 (Reduced Specialist Copayment)

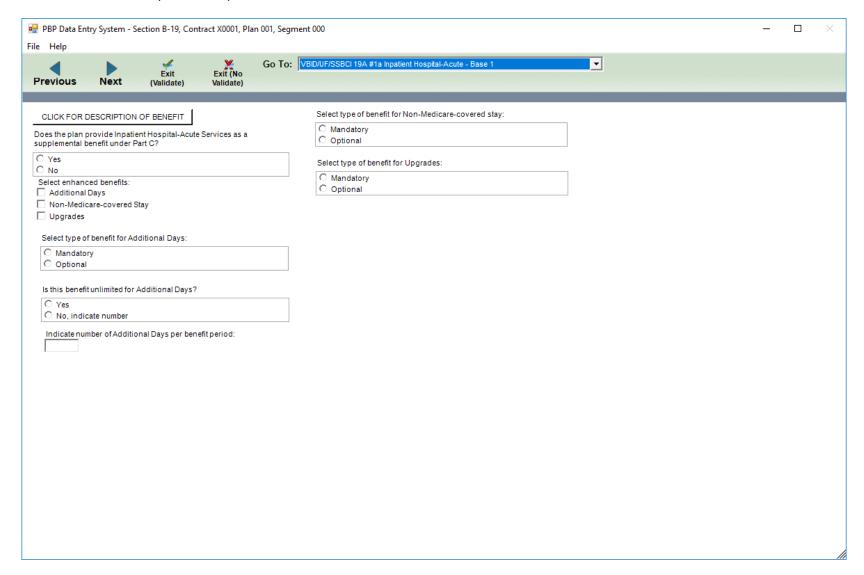
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File Help								
Exit Exi	Go To: #19a Red	duced Cost Sharing for VBID/	UF/SSBCI - Base 17 (Reduced S	pecialist Copay	<u> </u>			
	date)							
Select all Specialists with a reduced copayment: Geriatrics	Indicate Copayment for one		ecialists:					
Allergy and Immunology Cardiology Dermatology		Minimum Maximum Copayment Copayment		Minimum Copayment	Maximum Copayment			
Endocrinology ENT/Otolaryngology	Geriatrics		Oncology - Medical, Surgical					
Gastroenterology General Surgery Gynecology, OB/GYN	Allergy and Immunology		Oncology - Radiation/ Radiation Oncology					
Infectious Diseases Nephrology Neurology	Cardiology		Ophthalmology					
Neurosurgery Oncology - Medical, Surgical	Dermatology		Orthopedic Surgery					
Oncology - Radiation/Radiation Oncology Ophthalmology Orthopedic Surgery	Endocrinology		Physiatry, Rehabilitative Medicine					
Physiatry, Rehabilitative Medicine Plastic Surgery	ENT/Otolaryngology		Plastic Surgery					
Pulmonology Rheumatology Urology	Gastroenterology		Pulmonology					
Vascular Surgery Cardiothoracic Surgery Other*	General Surgery		Rheumatology					
* Please list the provider's actual	Gynecology, OB/GYN		Urology					
specialty in the Notes	Infectious Diseases		Vascular Surgery					
	Nephrology		Cardiothoracic Surgery					
	Neurology		Other					
	Neurosurgery							

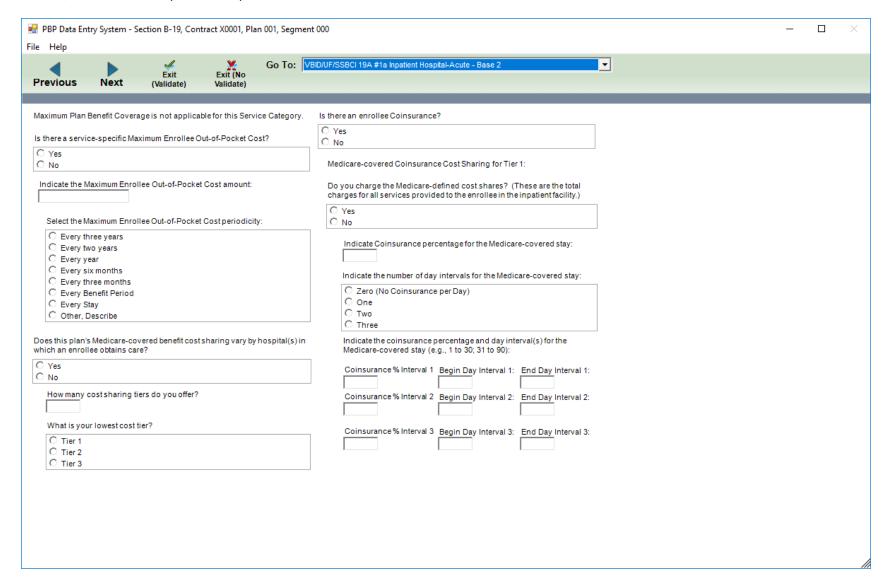
#19a Reduced Cost Sharing for VBID/UF/SSBCI - Base 18 (Retroactive Reimbursement)

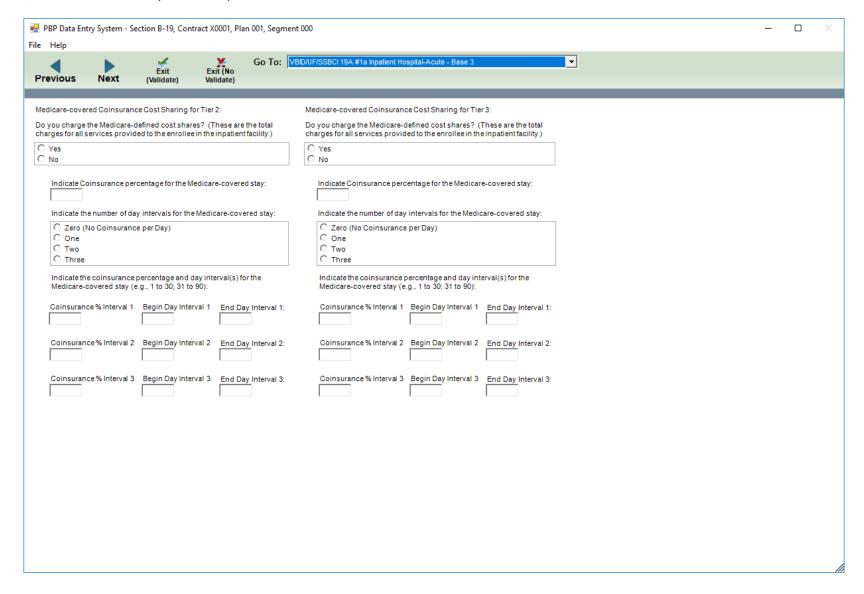


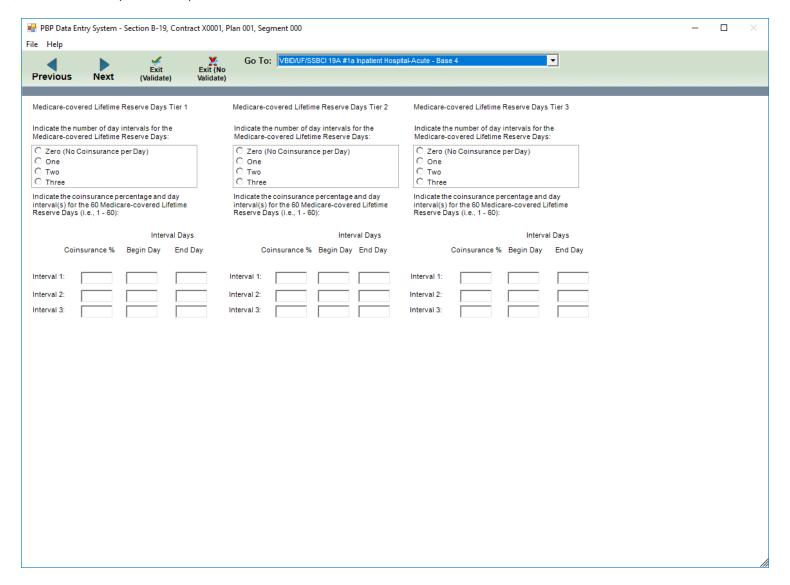
#19a Reduced Cost Sharing for VBID/UF/SSBCI – Notes

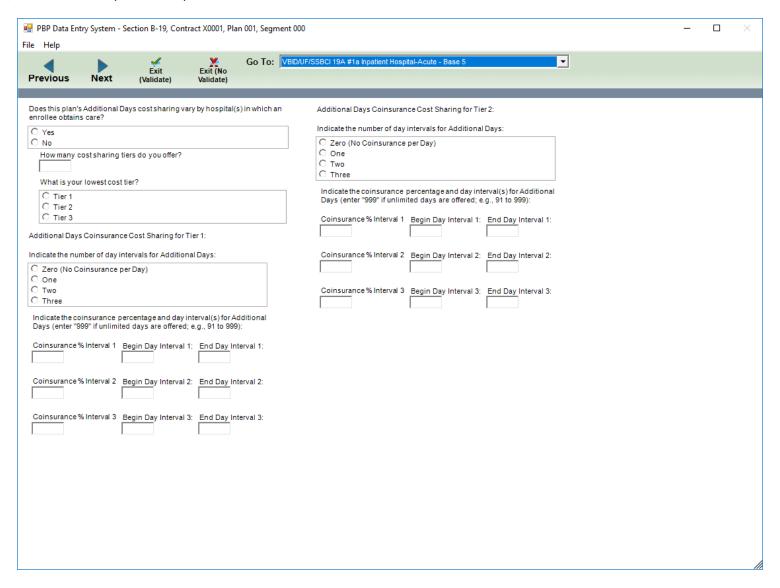


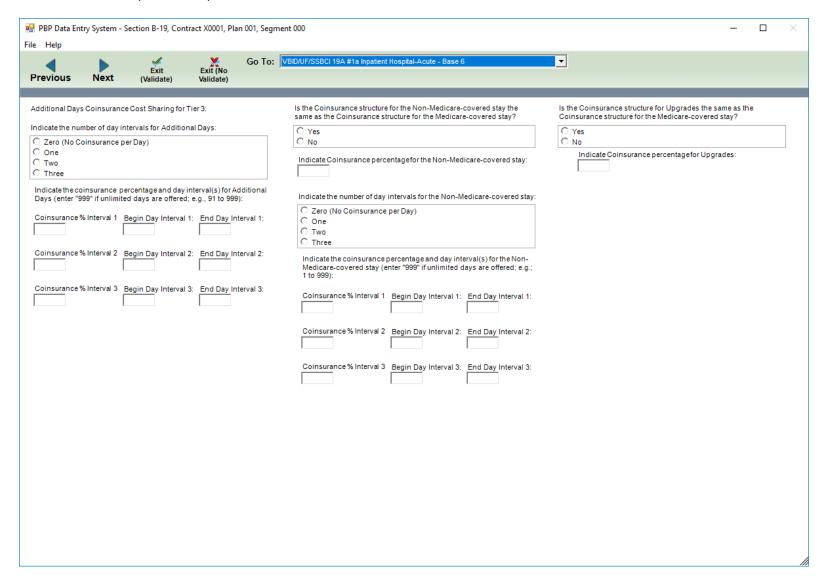


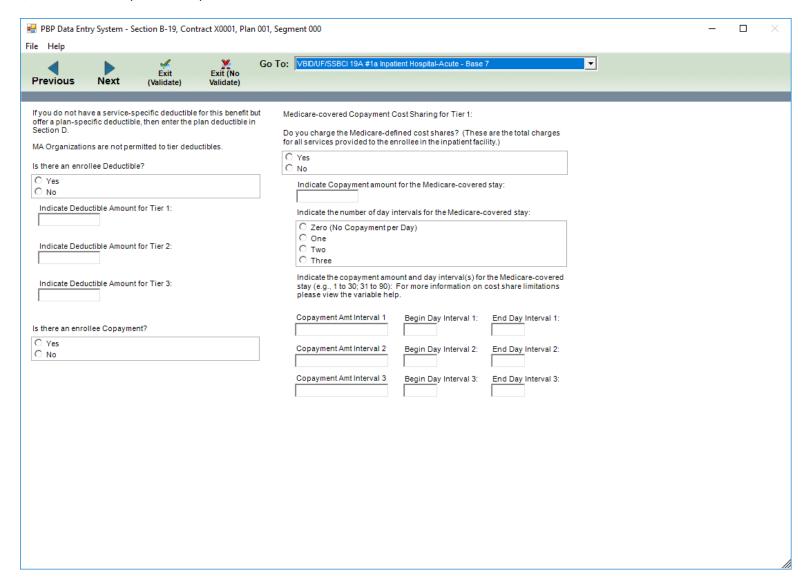


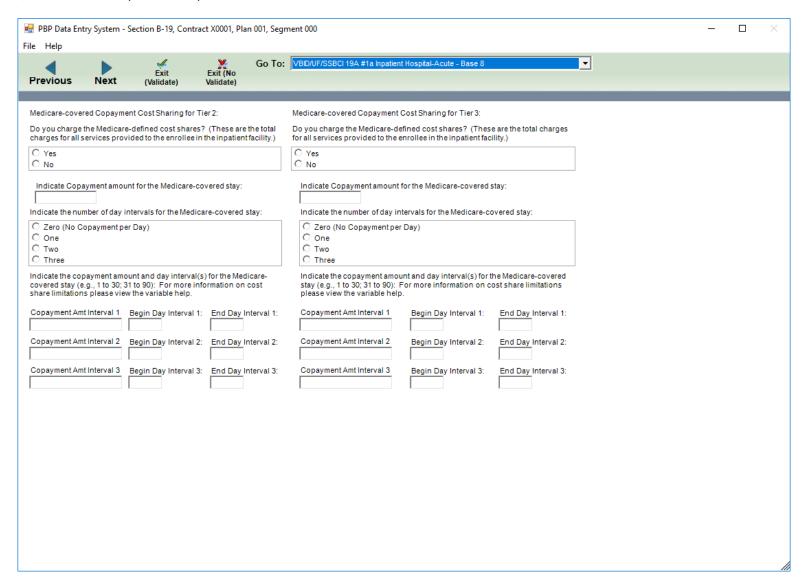




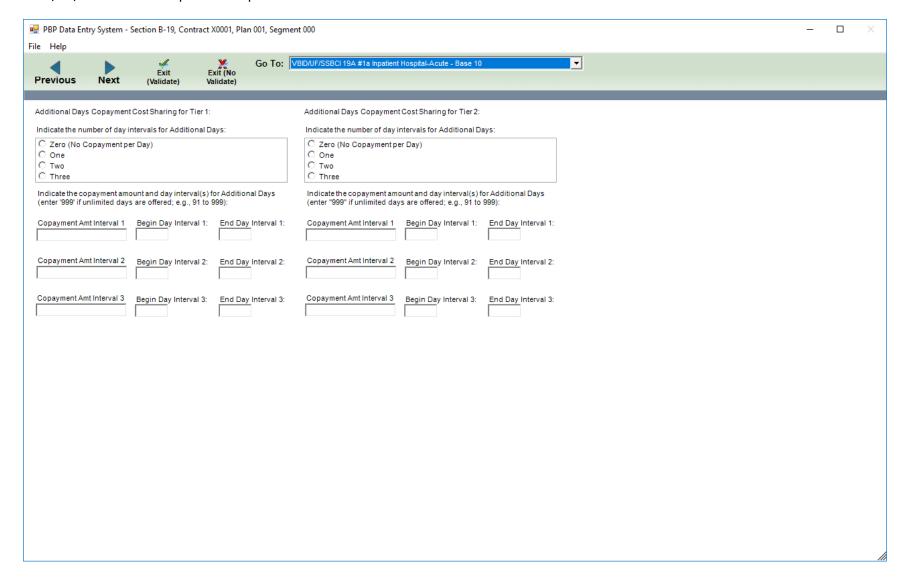






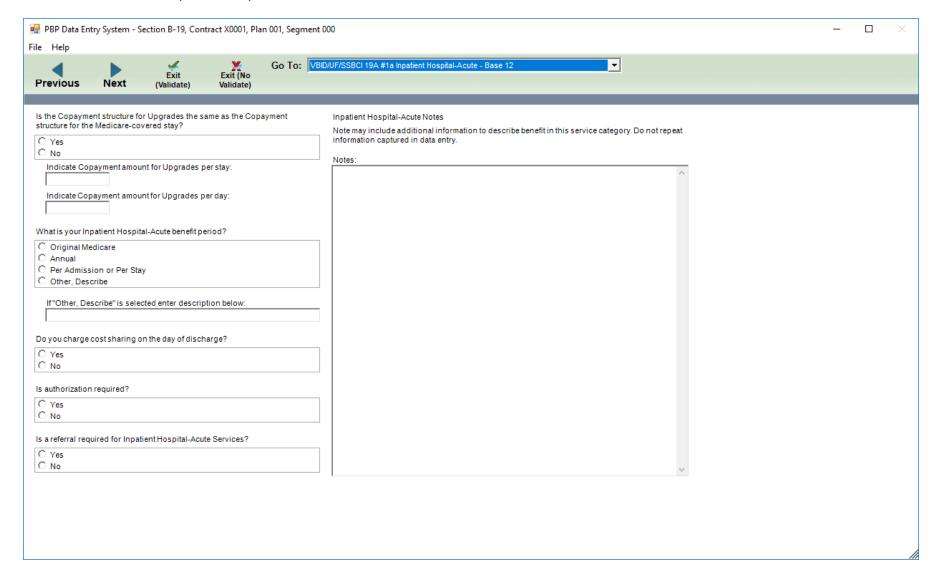


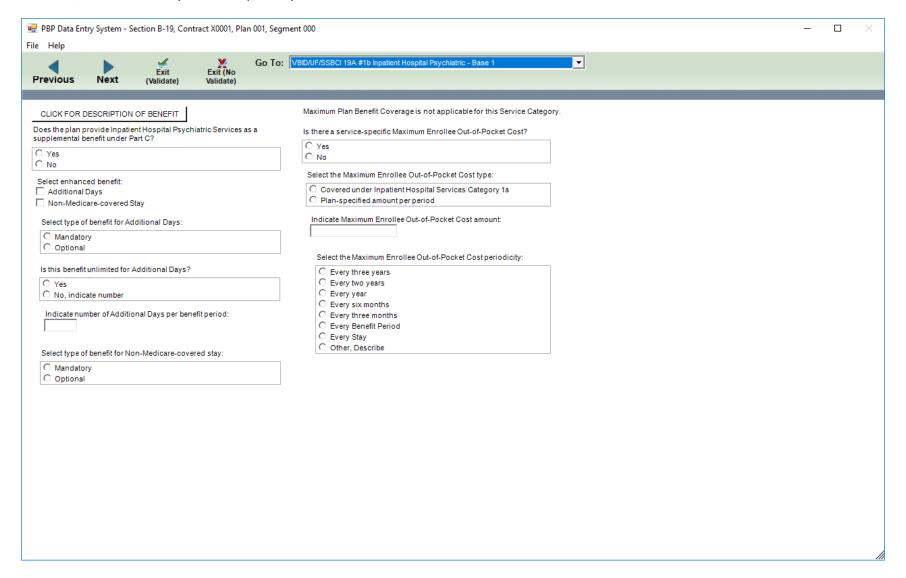
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Medicare-covered Lifetime Reserve Days Tier 1 Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: C Zero (No Copayment per Day) One Two Three Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Interval Days Copay Amount Begin Day End Day Interval 1:	lo	Medicare-covered Lifetime Reserve Days Tier 3 Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: C Zero (No Copayment per Day) C One C Two O Three Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Interval Days Copay Amount Begin Day End Day Interval 1:	
Interval 3:	Interval 3:	Interval 3:	

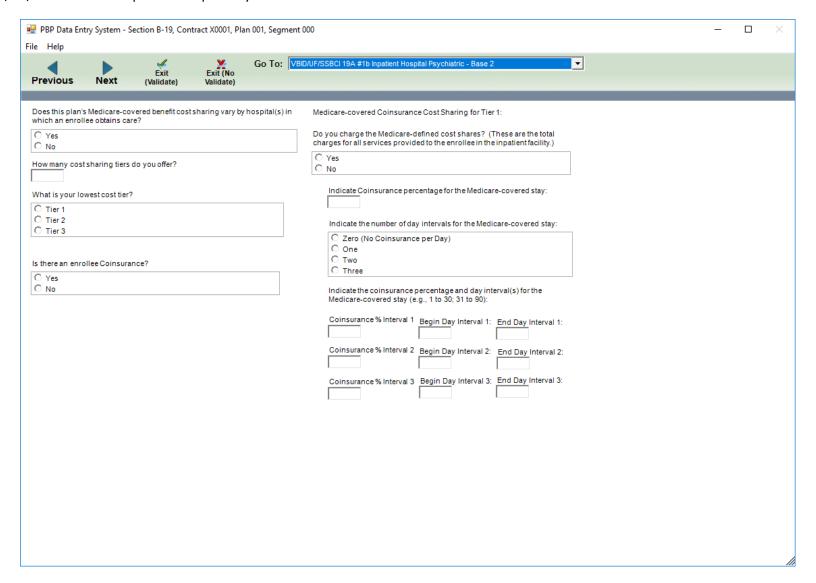


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Additional Days Copayment Indicate the number of day C Zero (No Copayment of C One C Two C Three Indicate the copayment are (enter "999" if unlimited do Copayment Amt Interval 1 Copayment Amt Interval 2 Copayment Amt Interval 3	nount and day interval(s) ays are offered; e.g., 91 to Begin Day Interval 1:	for Additional Days o 999): End Day Interval 1	C Two C Three Indicate the copayment amount and day interval (s) for the Non-Medicare- covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999): Copayment Amt Interval 1. Begin Day Interval 1: End Day Interval 1:		

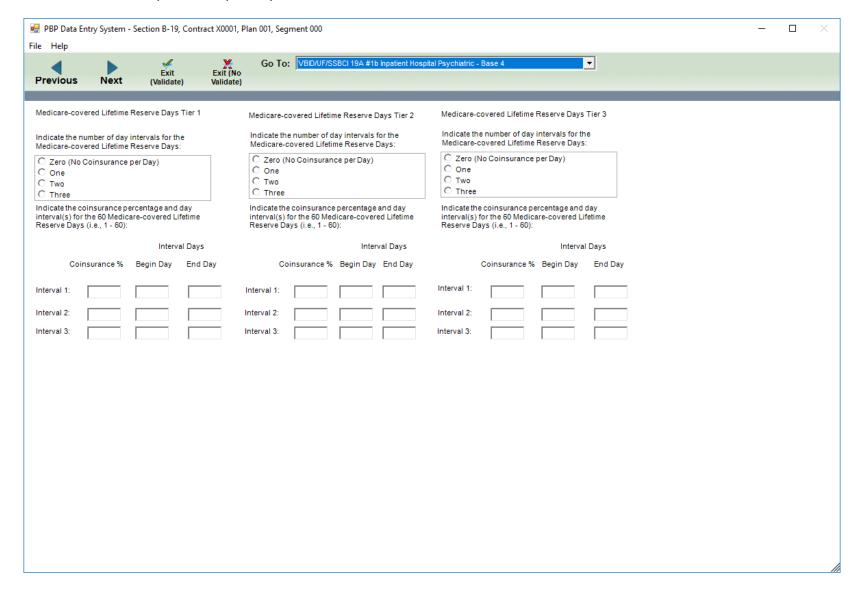
VBID/UF/SSBCI 19A #1a Inpatient Hospital-Acute - Base 12





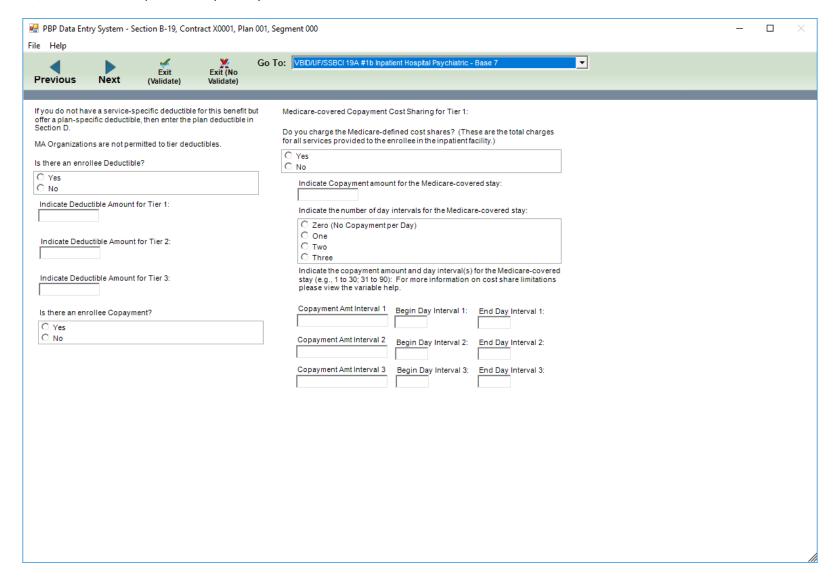


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Medicare-covered Coinsurance Cost Sharing for Tier 2:	Medicare-covered Coinsurance Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the total	Do you charge the Medicare-defined cost shares? (These are the total	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



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

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Additional Days Coinsurance Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "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:	Is the Coinsurance structure for the Non-Medicare-covered stay? C Yes No Indicate Coinsurance percentage for the Non-Medicare-covered stay: Indicate the number of day intervals for the Non-Medicare-covered stay: C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day interval (s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999): Coinsurance % Interval 1 Begin Day Interval 1: 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:	

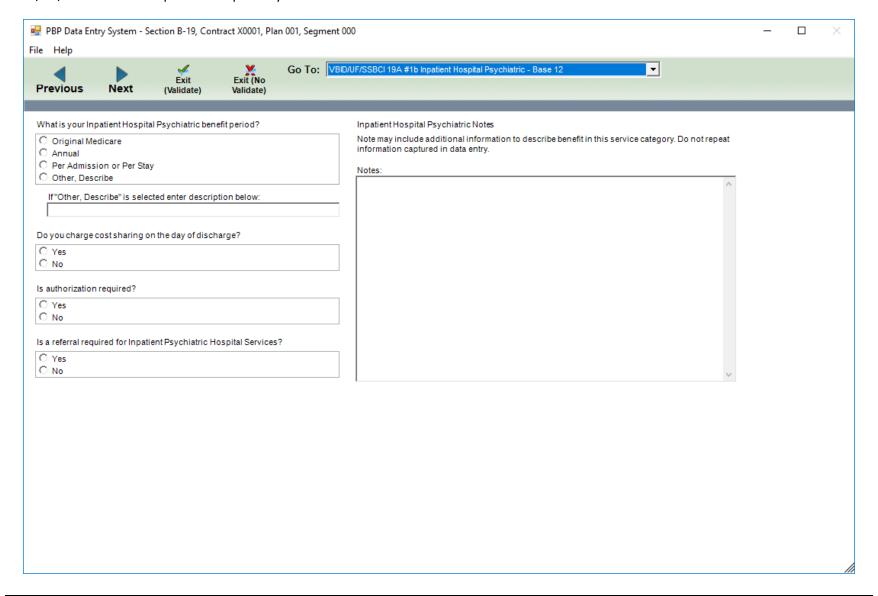


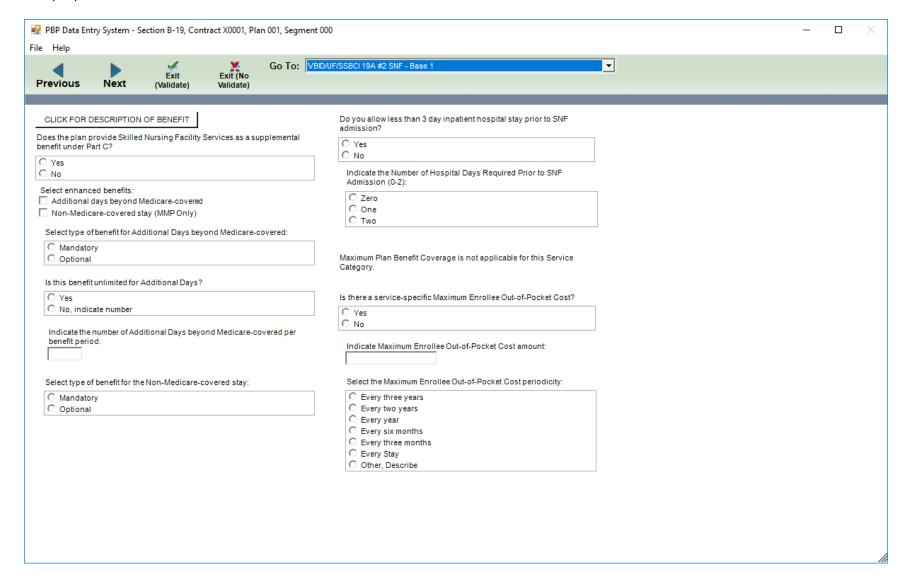
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W. F	W. F		
Medicare-covered Copayment Cost Sharing for Tier 2:	Medicare-covered Copayment Cost Sharing for Tier 3:		
Do you charge the Medicare-defined cost shares? (These are the tota charges for all services provided to the enrollee in the inpatient facility.			
C Yes	C Yes		
○ No	○ No		
Indicate Copayment amount for the Medicare-covered stay:	Indicate Copayment amount for the Medicare-covered stay:		
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:		
C Zero (No Copayment per Day) C One	C Zero (No Copayment per Day) C One		
C Two	O Two		
C Three	C Three		
Indicate the copayment amount and day interval(s) for the Medicare- covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.	Indicate the copayment amount and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90): For more information on cost share limitations please view the variable help.		
Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval	Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:		
Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:		
Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval	Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:		
			/

■ PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segment 000					
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Medicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3			
Indicate the number of day intervals for the Medi covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare- covered Lifetime Reserve Days:			
C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copayment per Day) C One C Two C Three			
Indicate the copayment amount and day interval for the 60 Medicare-covered Lifetime Reserve Da (i.e., 1 - 60):		Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):			
Interval Days	Interval Days	Interval Days			
Copay Amount Begin Day End	Day Copay Amount Begin Day End Day	Copay Amount Begin Day End Day			
Interval 1:	Interval 1:	Interval 1:			
Interval 2:	Interval 2:	Interval 2:			
Interval 3:	Interval 3:	Interval 3:			

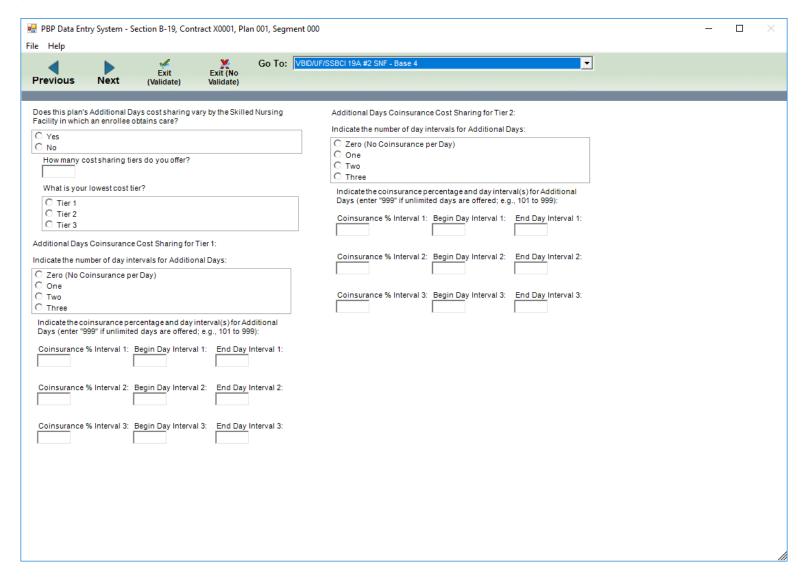
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Additional Days Copayment Indicate the number of day C Zero (No Copayment of One C Two C Three Indicate the copayment and (enter "999" if unlimited day Copayment Amt Interval 1 Copayment Amt Interval 2 Copayment Amt Interval 3	nount and day interval(s) ays are offered; e.g., 91 t Begin Day Interval 1:	Days:) for Additional Days o 999): : End Day Interval 1: End Day Interval 2:	Copayment Amt Interval 2	intervals for Additional D er Day) ount and day interval(s)	for Additional Days 1999): End Day Interval 1: End Day Interval 2:			

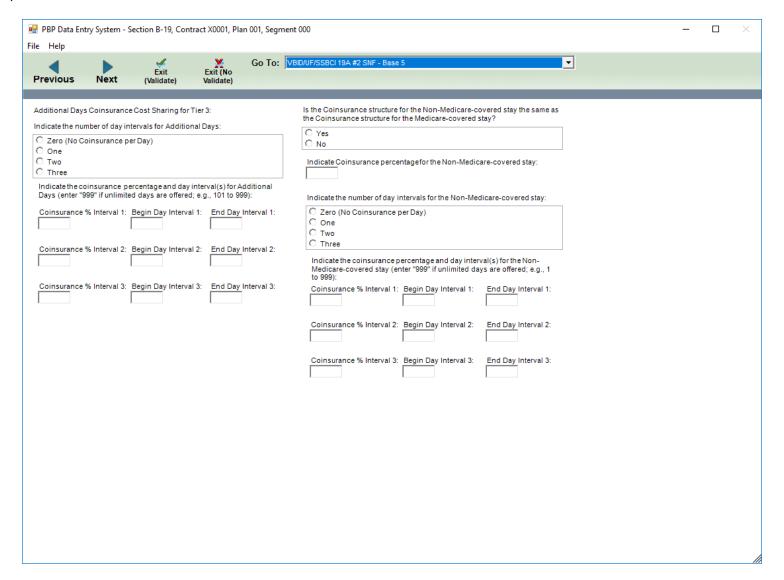
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Additional Days Copayment Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days: C Zero (No Copayment per Day) C One C Two C Three Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited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

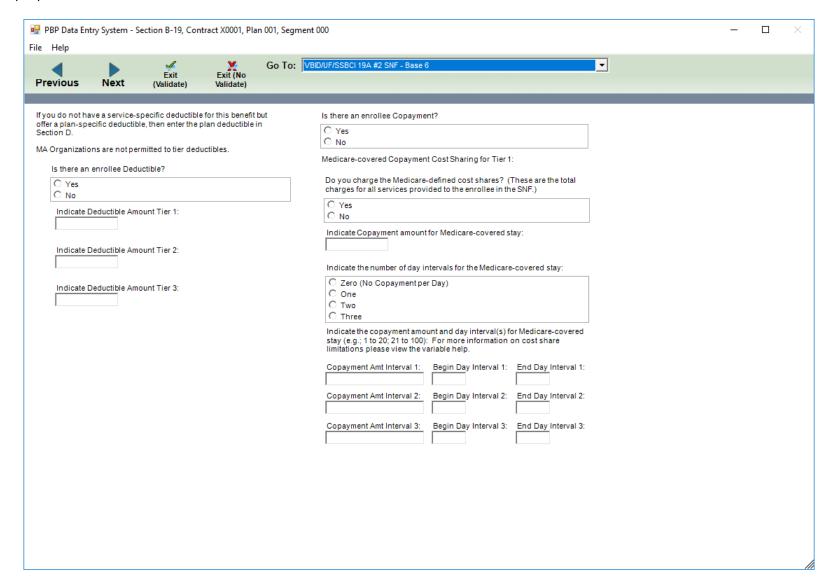




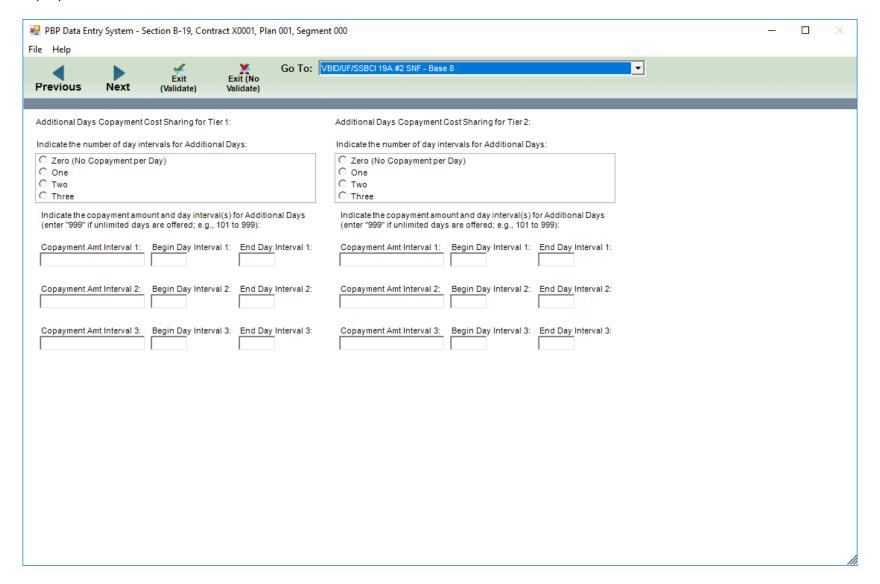
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File Help			
	D/UF/SSBCI 19A #2 SNF - Base 3		
Exit Exit (No	Medicare-covered Coinsurance Cost Sharing for Tier 3: Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.) C Yes No Indicate Coinsurance percentage 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 2: End Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:		

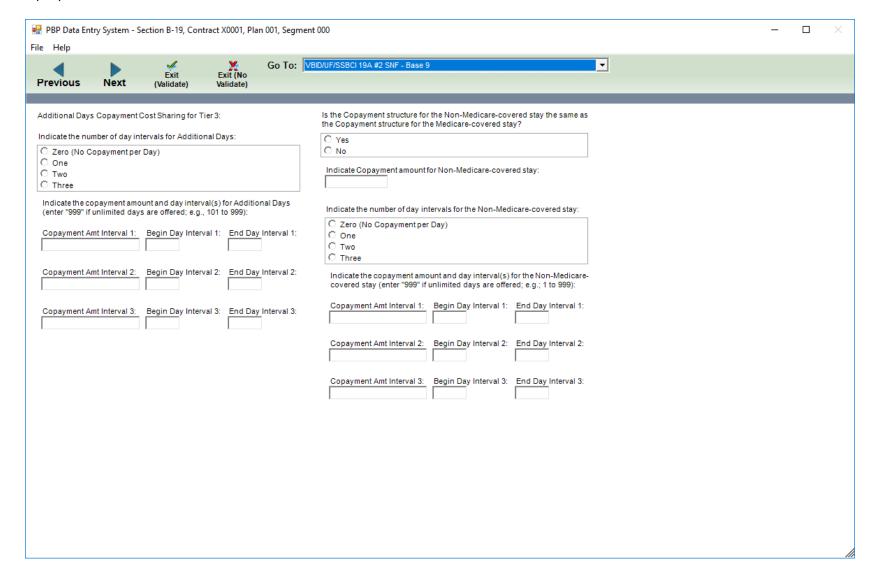


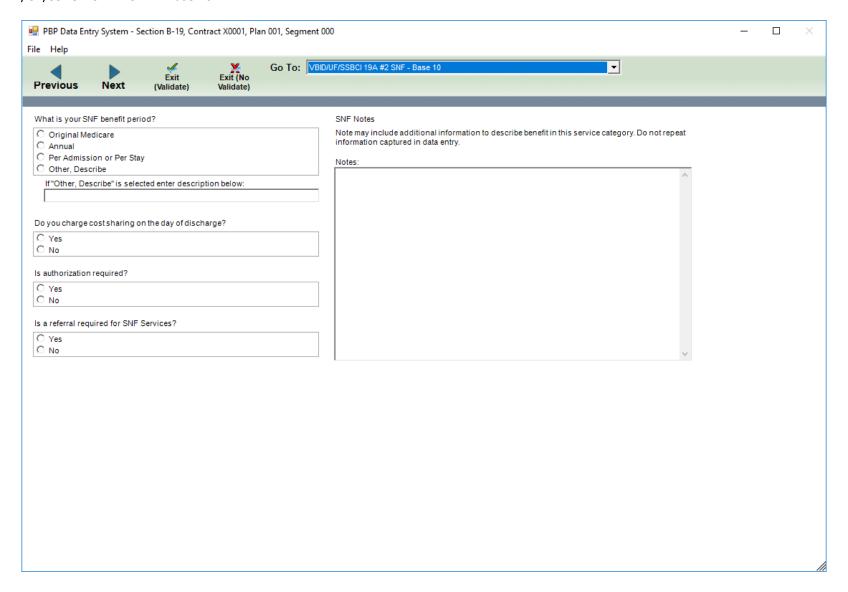




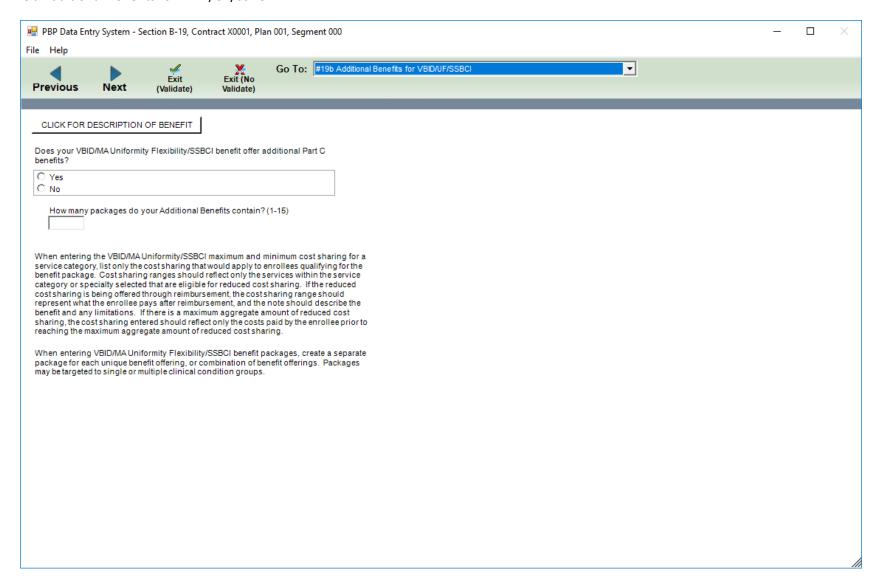
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Medicare-covered Copayment Cost Sharing for Tier 2:	Medicare-covered Copayment Cost Sharing for Tier 3:	
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	
C Yes C No	C Yes C No	
Indicate Copayment amount for Medicare-covered stay:	Indicate Copayment amount for Medicare-covered stay:	
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:	
C Zero (No Copayment per Day) C One	C Zero (No Copayment per Day) One	
C Two	○ Two	
C Three	C Three	
Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): For more information on cost share limitations please view the variable help.	Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): For more information on cost share limitations please view the variable help.	
Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1:	
Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:	



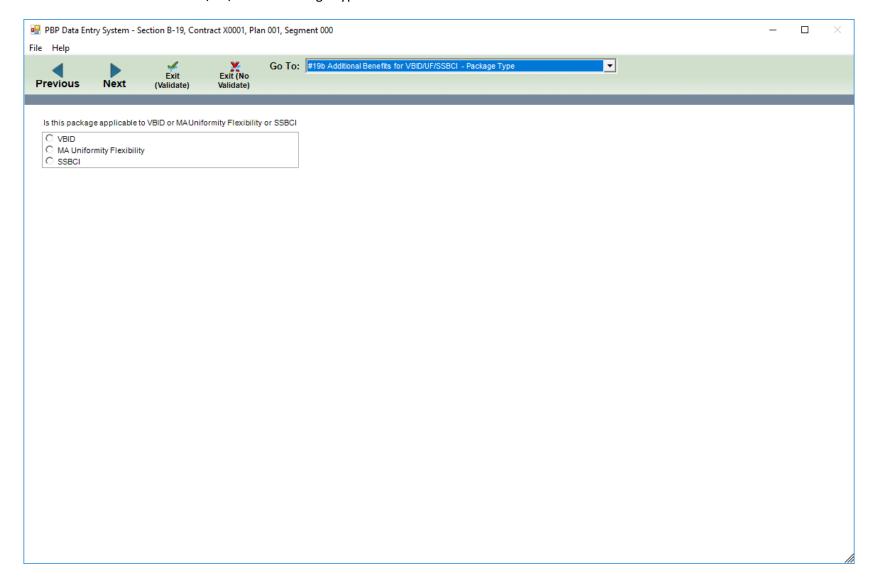




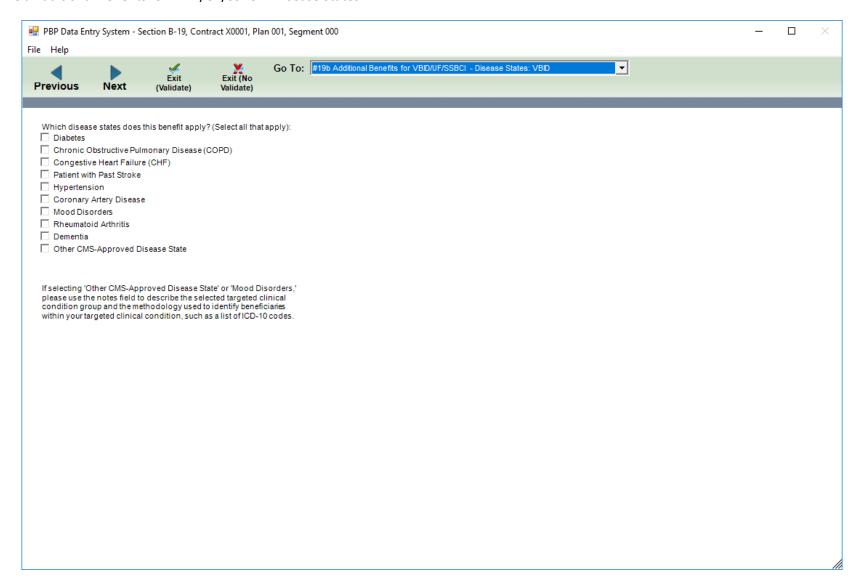
#19b Additional Benefits for VBID/UF/SSBCI



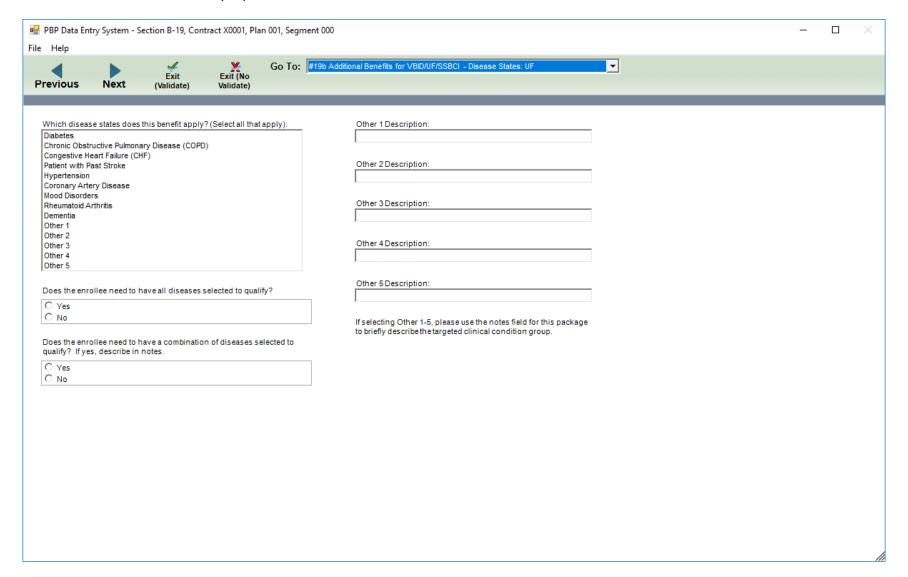
#19b Additional Benefits for VBID/UF/SSBCI – Package Type



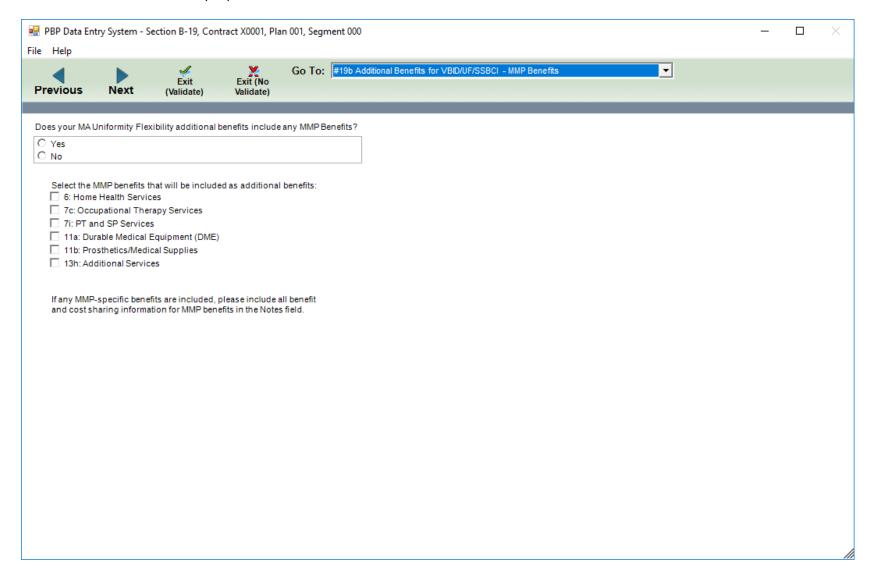
#19b Additional Benefits for VBID/UF/SSBCI - Disease States: VBID



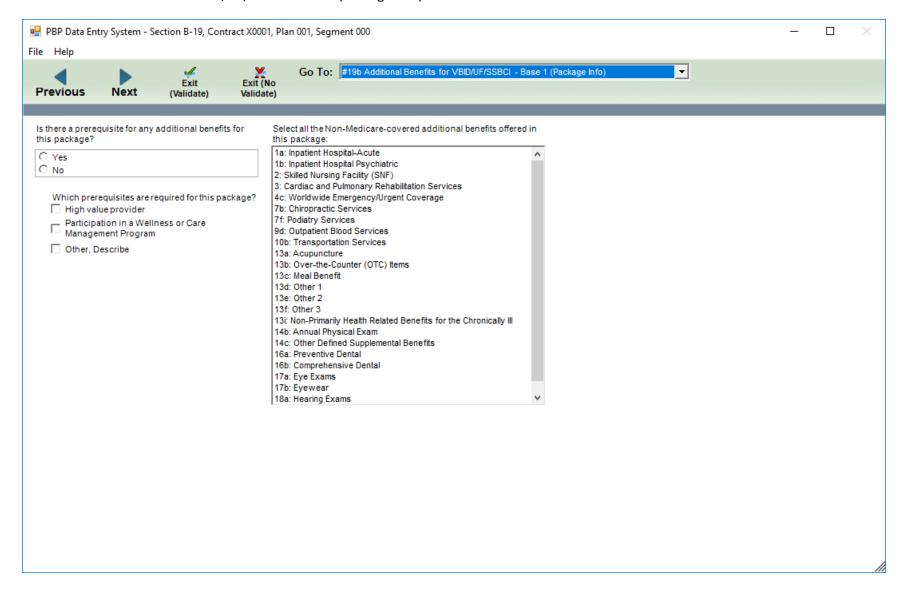
#19b Additional Benefits for VBID/UF/SSBCI - Disease States: UF



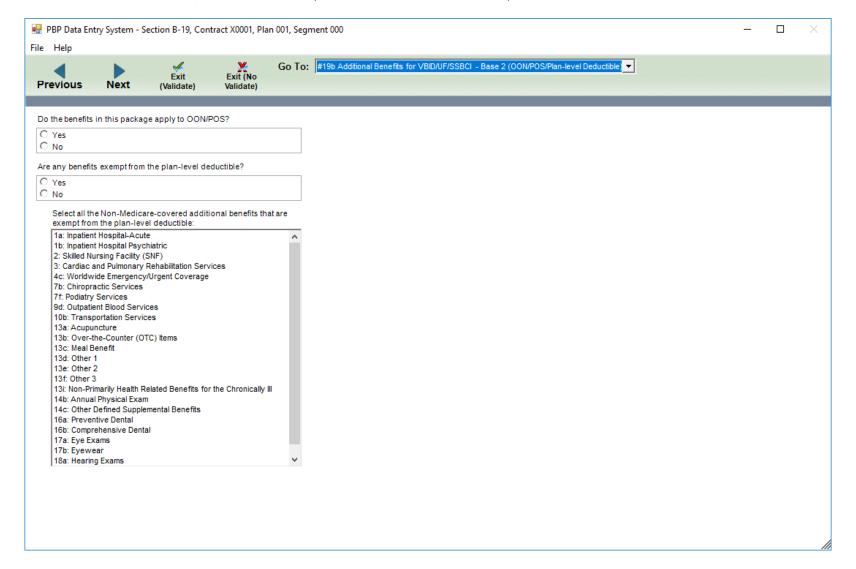
#19b Additional Benefits for VBID/UF/SSBCI - MMP Benefits



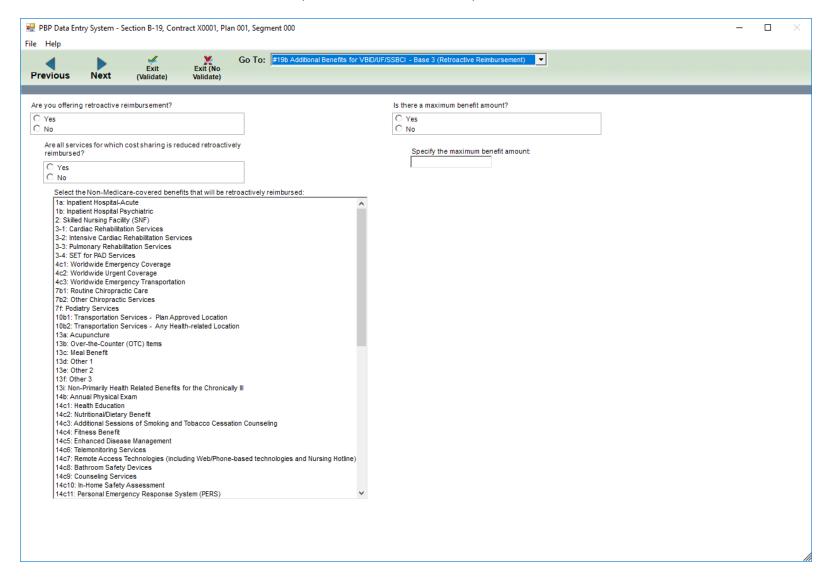
#19b Additional Benefits for VBID/UF/SSBCI - Base 1 (Package Info)



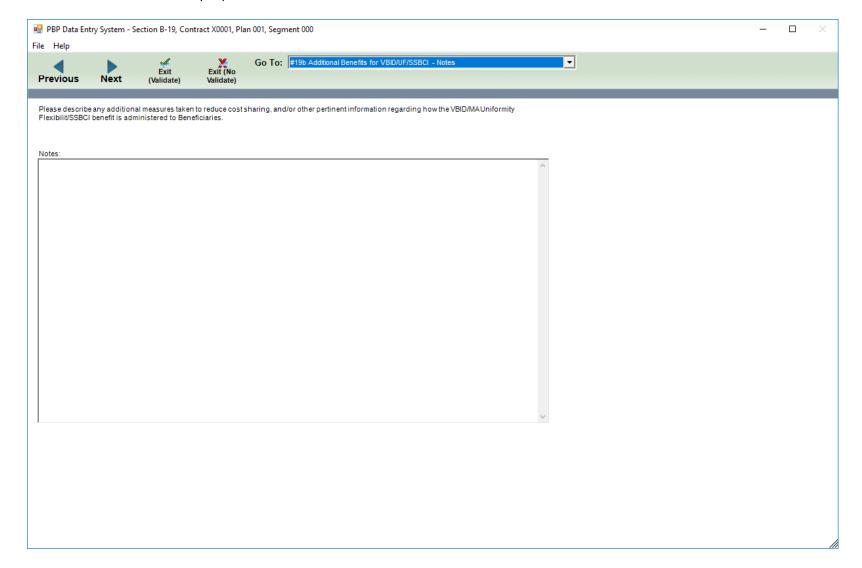
#19b Additional Benefits for VBID/UF/SSBCI - Base 2 (OON/POS/Plan-level Deductible)



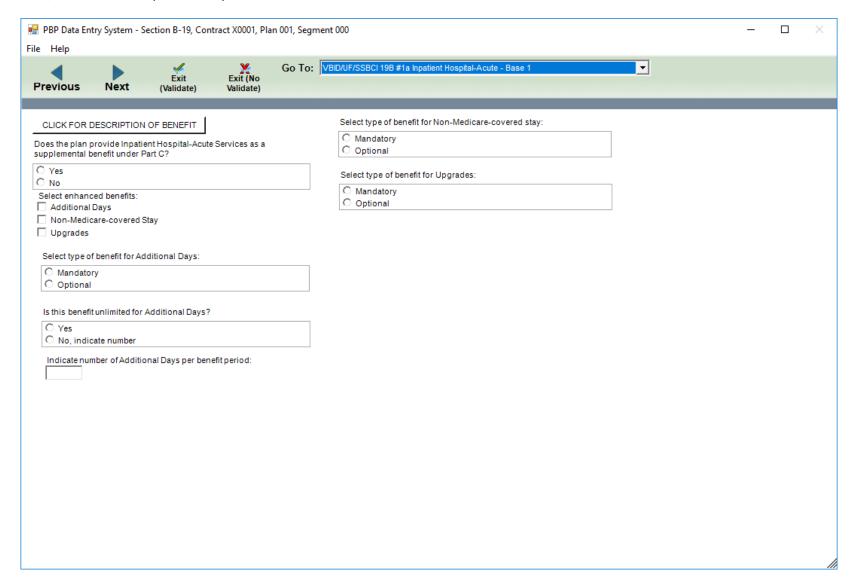
#19b Additional Benefits for VBID/UF/SSBCI - Base 3 (Retroactive Reimbursement)



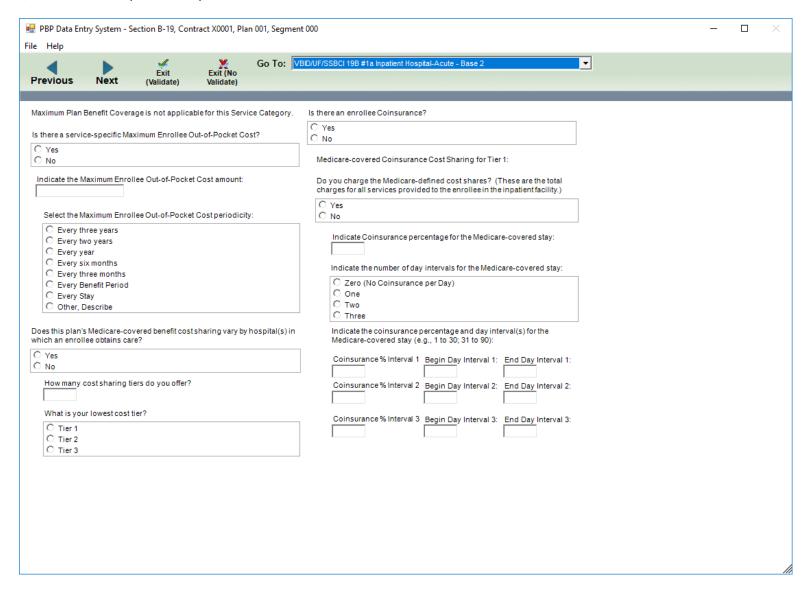
#19b Additional Benefits for VBID/UF/SSBCI - Notes



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



VBID/UF/SSBCI 19B #1a Inpatient Hospital-Acute - Base 2



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

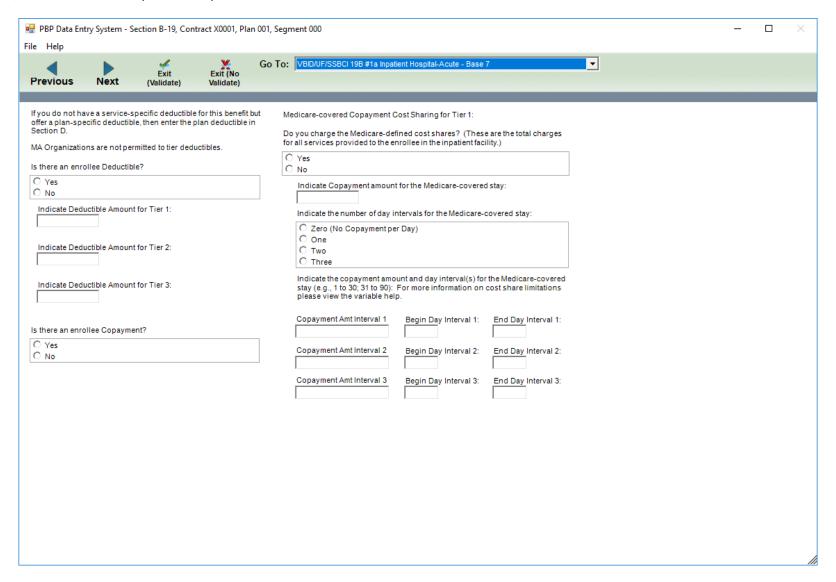
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Medicare cove	red Coincuran	ce Cost Sharing for Tier	. 2.	Medicare-covered Coinsurance Cost Sharing for Tier 3:		
		defined cost shares? (1		Do you charge the Medicare-defined cost shares? (These are the total		
charges for all		led to the enrollee in the		charges for all services provided to the enrollee in the inpatient facility.)		
○ Yes ○ No				○ Yes ○ No		
Indicate C	oinsurance per	centage for the Medica	re-covered stay:	Indicate Coinsurance percentage for the Medicare-covered stay:		
Indicate th	e number of da	y intervals for the Medi	care-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:		
C Zero (I C One	No Coinsuranc	e per Day)		C Zero (No Coinsurance per Day) C One		
C Two				C Two		
C Three				C Three		
		percentage and day int e.g., 1 to 30; 31 to 90):	erval(s) for the	Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):		
Coinsuran	ce % Interval 1	Begin Day Interval 1	End Day Interval 1:	Coinsurance % Interval 1 Begin Day Interval 1 End Day Interval 1:		
Coinsuran	ce % Interval 2	Begin Day Interval 2	End Day Interval 2:	Coinsurance % Interval 2 Begin Day Interval 2 End Day Interval 2:		
Coinsuran	ce % Interval 3	Begin Day Interval 3	End Day Interval 3:	Coinsurance % Interval 3 Begin Day Interval 3 End Day Interval 3:		
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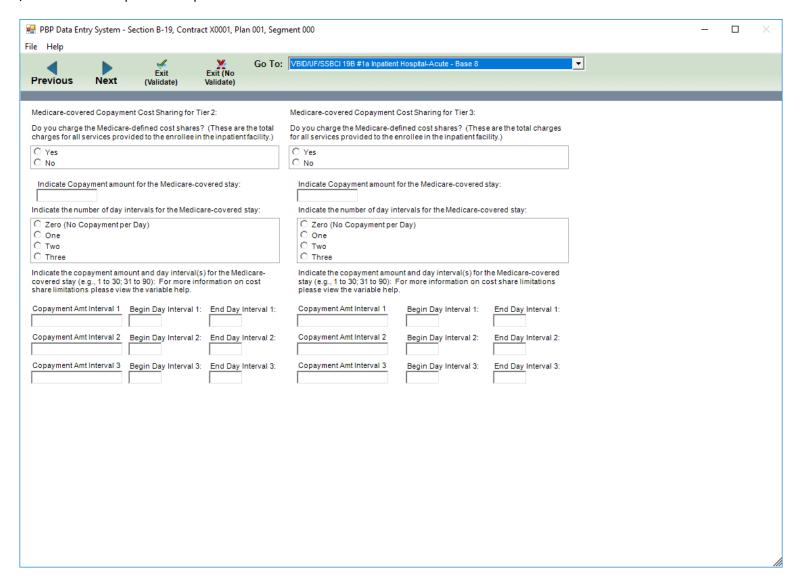
VBID/UF/SSBCI 19B #1a Inpatient Hospital-Acute – Base 4

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Medicare-covered Lifetime Reserve Days Tier 1	Medicare-covered Lifetime Reserve Days Tier 2	Medicare-covered Lifetime Reserve Days Tier 3	
Wedical 6-covered Elicanic Nessive Days 11cl 1	Wedicare-covered Engline (Costive Days 116) 2	Wedleard-Covered Elleanie Neserve Days Tiel 3	
Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:	
C Zero (No Coinsurance per Day)	C Zero (No Coinsurance per Day)	C Zero (No Coinsurance per Day)	
C One C Two	One O Two	C One C Two	
C Three	C Three	O Three	
Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	
Interval Days	Interval Days	Interval Days	
Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day	Coinsurance % Begin Day End Day	
Interval 1:	Interval 1:	Interval 1:	
Interval 2:	Interval 2:	Interval 2:	
Interval 3:	Interval 3:	Interval 3:	
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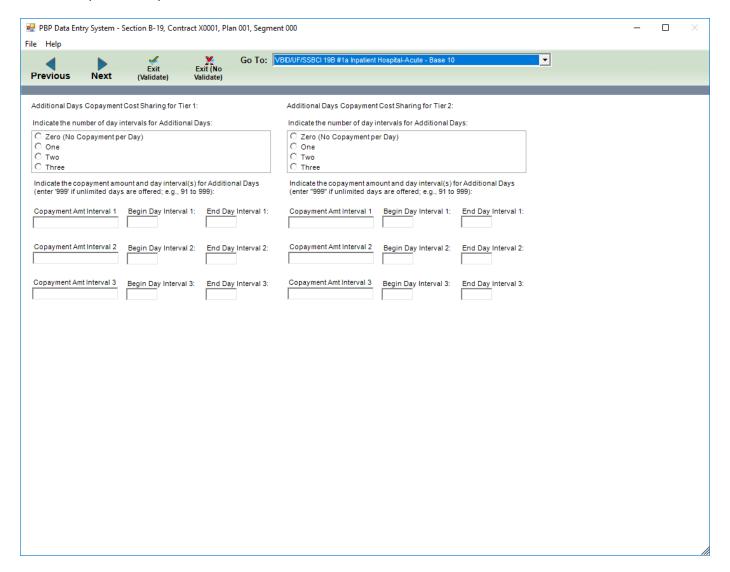
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Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care? C Yes No How many cost sharing tiers do you offer? What is your lowest cost tier? C Tier 1 C Tier 2 C Tier 3 Additional Days Coinsurance Cost Sharing for Tier 1: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One C Two C Three Indicate the 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 3:	Additional Days Coinsurance Cost Sharing for Tier 2: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999): Coinsurance % Interval 1 Begin Day Interval 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:	

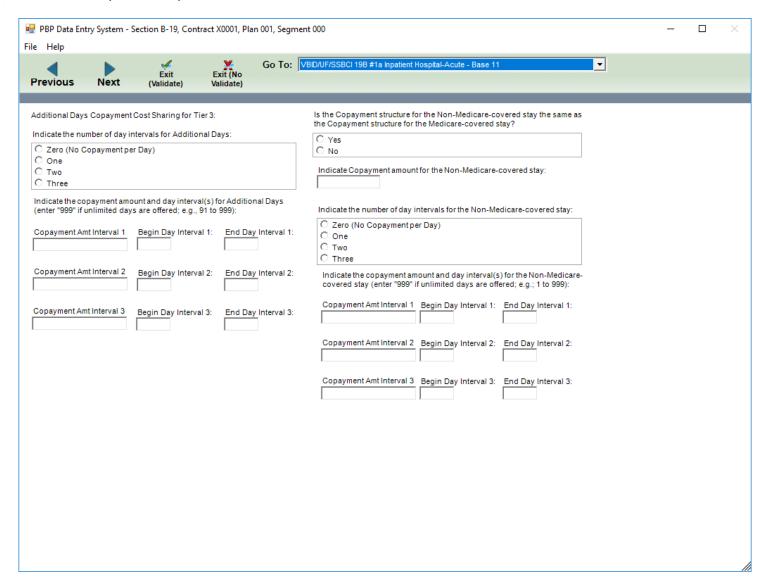
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Additional Days Coinsurance Indicate the number of day in Caro (No Coinsurance of One Two Three Indicate the coinsurance of Days (enter "999" if unlimit Coinsurance % Interval 1 Coinsurance % Interval 2 Coinsurance % Interval 3	ntervals for Additions per Day) percentage and day intered days are offered; Begin Day Interval 1 Begin Day Interval 2	al Days: aterval(s) for A(e.g., 91 to 999 : End Day Inf): terval 1: terval 2:	Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay? C Yes No Indicate Coinsurance percentage for the Non-Medicare-covered stay: Indicate the number of day intervals for the Non-Medicare-covered stay: C Zero (No Coinsurance per Day) O One C Two Three Indicate the coinsurance percentage and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g.; 1 to 999): Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 1: Coinsurance % Interval 2 Begin Day Interval 2: End Day Interval 2: Coinsurance % Interval 3 Begin Day Interval 3: End Day Interval 3:	Is the Coinsurance structure for Upgrades the same as the Coinsurance structure for the Medicare-covered stay? O Yes No Indicate Coinsurance percentage for Upgrades:	

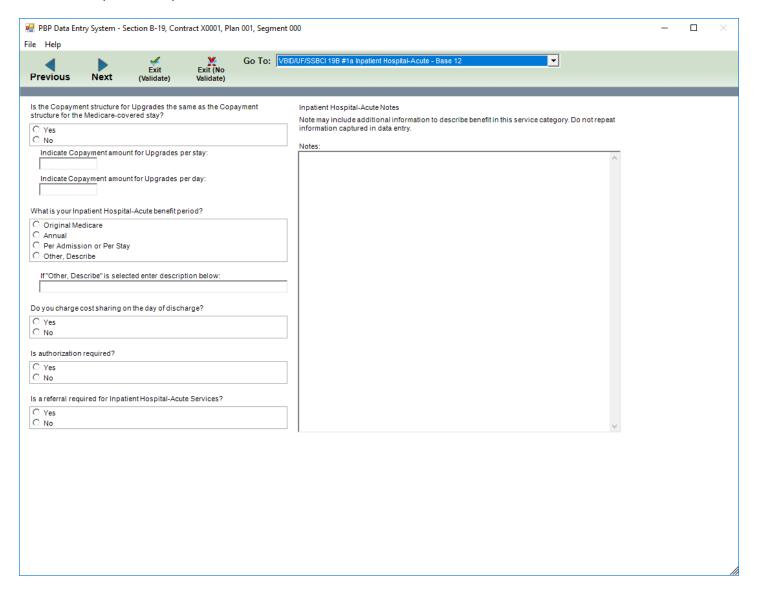


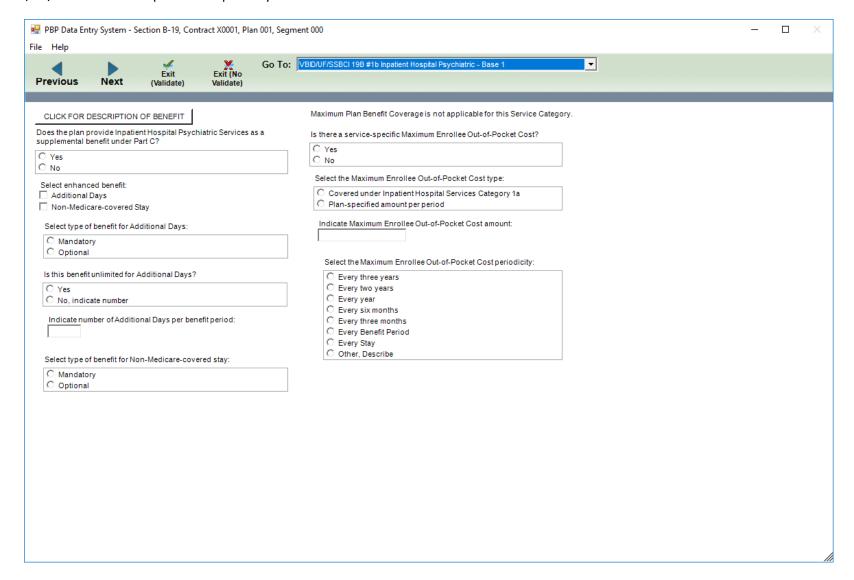


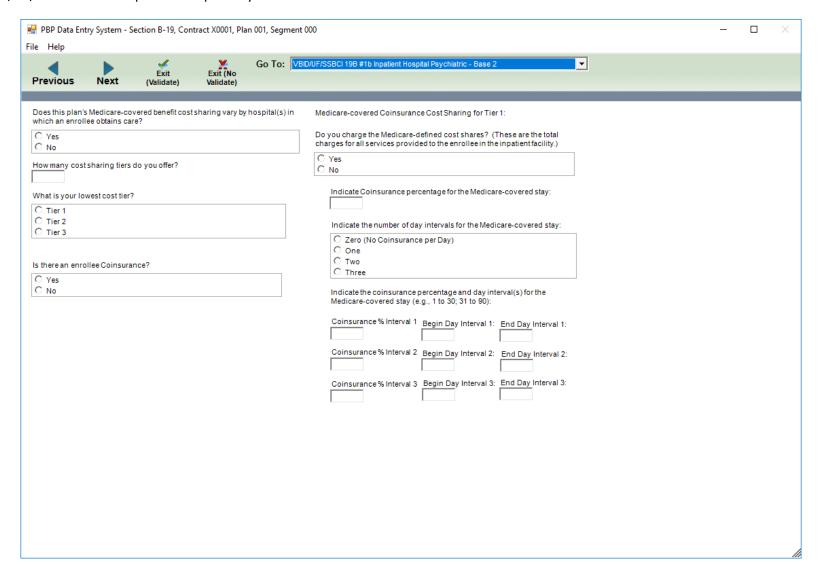
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Medicare-covered Lifetime Reserve Days Tier 1 Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: C Zero (No Copayment per Day) One Two Three Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Interval Days Copay Amount Begin Day End Day Interval 2: Interval 3:	0	Medicare-covered Lifetime Reserve Days Tier 3 Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: C Zero (No Copayment per Day) C One C Two C Three Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60): Interval Days Copay Amount Begin Day End Day Interval 2: Interval 3:	
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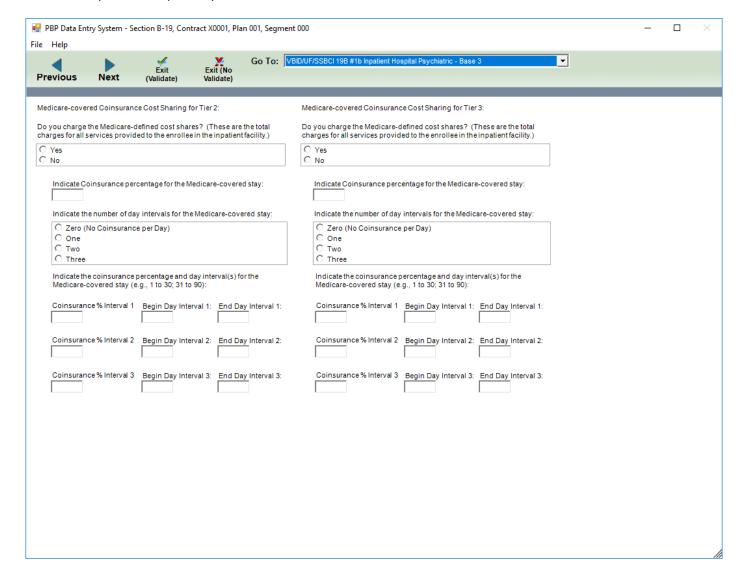












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Medicare-covered	Lifetime Rese	erve Days Tier 1		Medicare-covered Lifetime Reserve Days Tier 2 Medicare-covered Lifetime Reserve Days Tier 3		
Indicate the numbe Medicare-covered				Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days: Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:		
C Zero (No Coin:	surance per E	ay)		C Zero (No Coinsurance per Day)		
C One C Two				○ One ○ ○ Two		
C Three				C Three		
Indicate the coinsu interval(s) for the 6 Reserve Days (i.e.,	60 Medicare-c		_	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		
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Interval 1:				nterval 1: Interval 1:		
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Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care? O vest No How many cost sharing tiers do you offer? What is your lowest cost tier? O Tier 1 O Tier 2 Tier 3 Additional Days Coinsurance Cost Sharing for Tier 1: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance percentage and day interval 1 and Day Interval 1: C Tier 3 Additional Days Coinsurance per Day) C One C Two C Tier 3 Additional Days Coinsurance Cost Sharing for Tier 1: Indicate the number of day intervals for Additional Days: C Zero (No Coinsurance percentage and day interval 1: End Day Interval 1: End Day Interval 2: End Day Interval 2: End Day Interval 2: End Day Interval 3: End Da	PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segmen	nt 000	– 🗆 ×
Indicate the number of day interval for Additional Days: C Yes What is your lowest cost tier? C Tier 1 C Tier 2 C Tier 3 Additional Days Coinsurance Cost Sharing for Tier 1: Indicate the number of day interval for Additional Days: C Zero (No Coinsurance Per Day) C Coinsurance % Interval 1 Begin Day Interval 1: End Day Interval 2: C Zero (No Coinsurance per Day) C One C Two C Three Indicate the coinsurance per Day interval 2: C Zero (No Coinsurance Per Day) C One C Two C Three Indicate the coinsurance per Day interval 3: C Zero (No Coinsurance Per Day) C One C Two C Three Indicate the coinsurance per Day interval 3: End Day Interval 2: End Day Interval 3: End Day Interval 4: End Day I	Exit Exit (No	/BID/UF/SSBCI 19B #1b Inpatient Hospital Psychiatric - Base 5 ▼	
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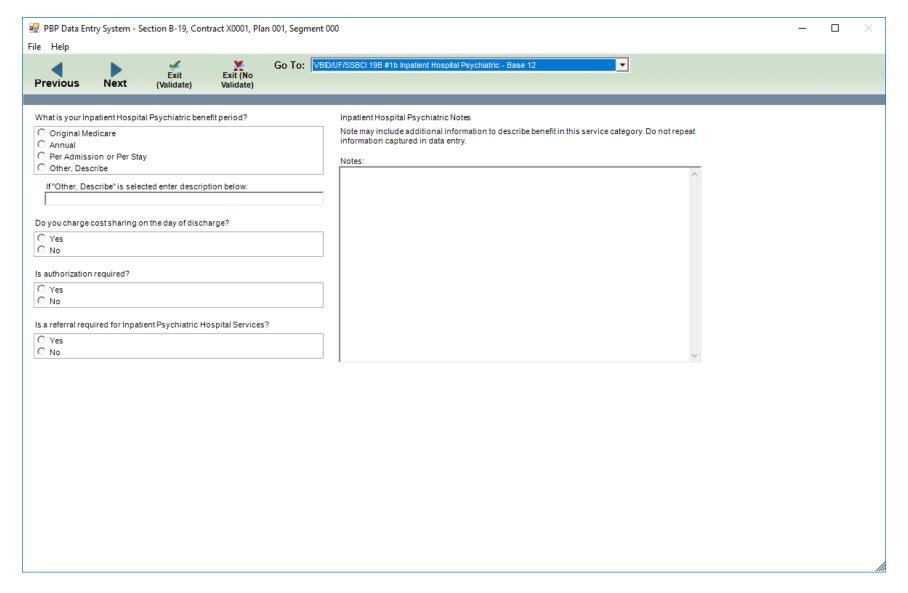
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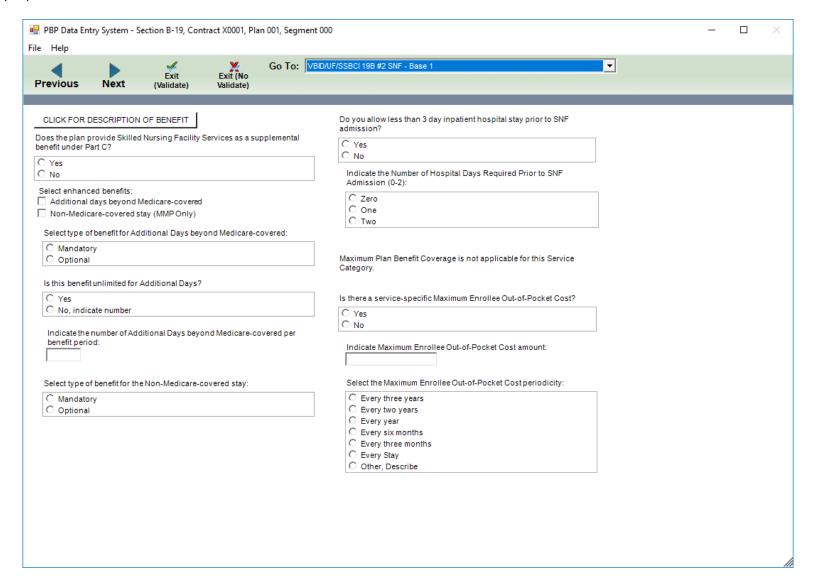
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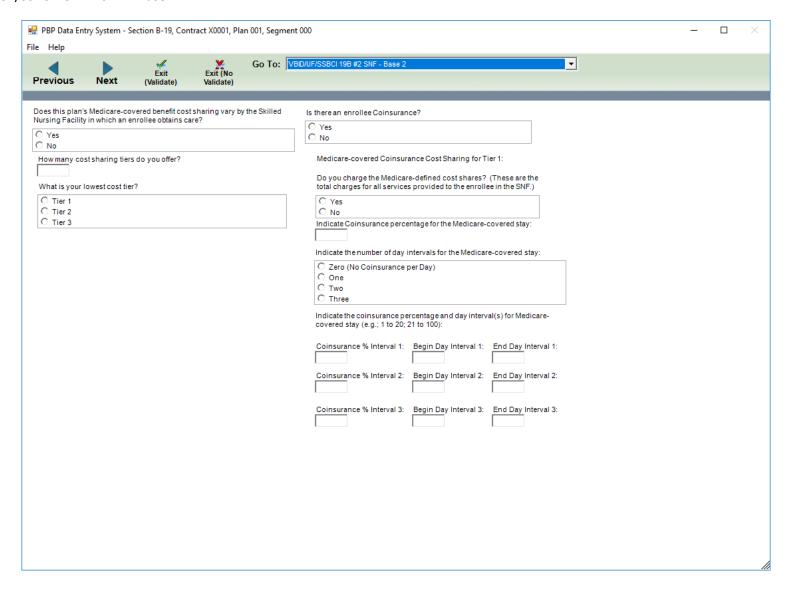
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Medicare-covered Lifetime Reserve Days Tier 1 Indicate the number of day intervals for the Medicare-	Medicare-covered Lifetime Reserve Days Tier 2 Indicate the number of day intervals for the Medicare-	Medicare-covered Lifetime Reserve Days Tier 3 Indicate the number of day intervals for the Medicare-	
Covered Lifetime Reserve Days: C Zero (No Copayment per Day) C One C Two C Three	Covered Lifetime Reserve Days: C Zero (No Copayment per Day) C One C Two C Three	Covered Lifetime Reserve Days: C Zero (No Copayment per Day) C One C Two C Three	
Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):	
Interval Days	Interval Days	Interval Days	
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Additional Days Copayment Cost Sharing for Tier 3: Indicate the number of day intervals for Additional Days: C Zero (No Copayment per Day) C One C Two C Three Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999): Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	Is the Copayment structure for the Non-Medicare-covered stay the same as the Copayment structure for the Medicare-covered stay? C Yes No Indicate Copayment amount for the Non-Medicare-covered stay: Indicate the number of day intervals for the Non-Medicare-covered stay: C Zero (No Copayment per Day) One C Two Three Indicate the copayment amount and day interval(s) for the Non-Medicare-covered stay (enter "999" if unlimited days are offered; e.g., 1 to 999): Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 2: Copayment Amt Interval 2 Begin Day Interval 3: End Day Interval 3:		

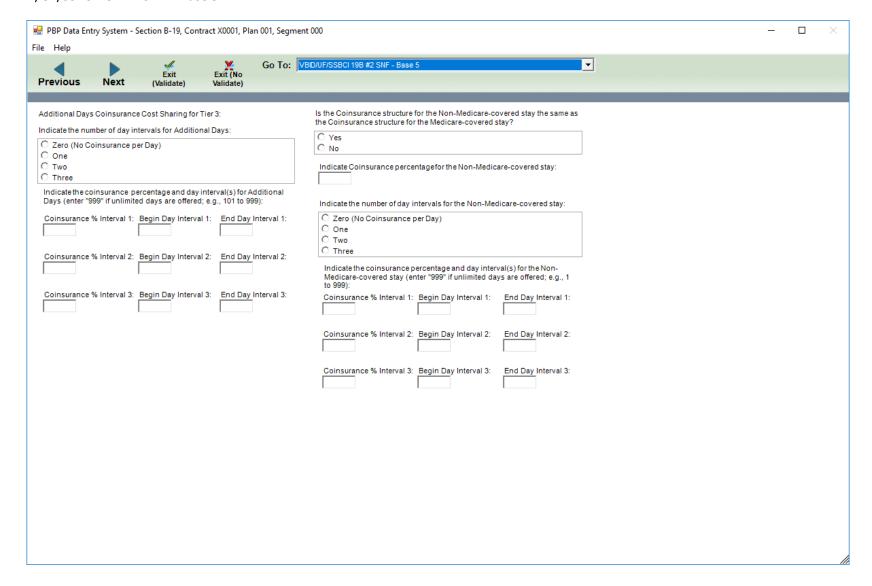


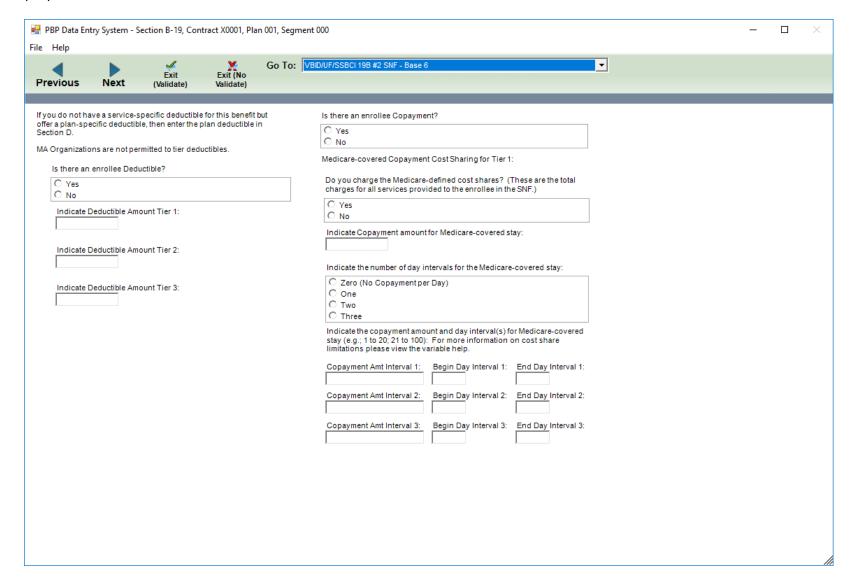




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Medicare-cove	red Coinsura	nce Cost Sharing fo	rTier2:		Medicare-covered Coinsurance Cost Sharing for Tier 3:		
		-defined cost share provided to the enr			Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)		
C Yes					○ Yes		
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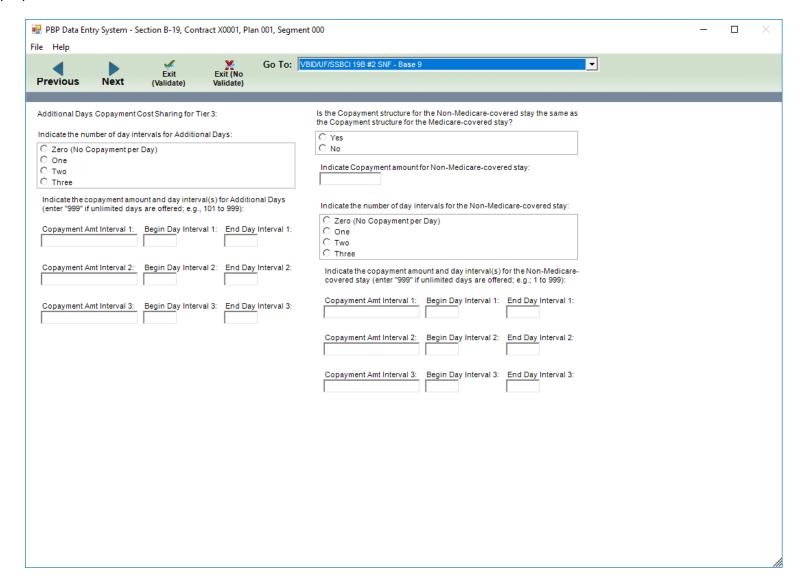
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(validate) validate)		
Does this plan's Additional Days cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	Additional Days Coinsurance Cost Sharing for Tier 2: Indicate the number of day intervals for Additional Days:	
C Yes C No How many costsharing tiers do you offer?	C Zero (No Coinsurance per Day) C One	
	C Two C Three	
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., 101 to 999):	
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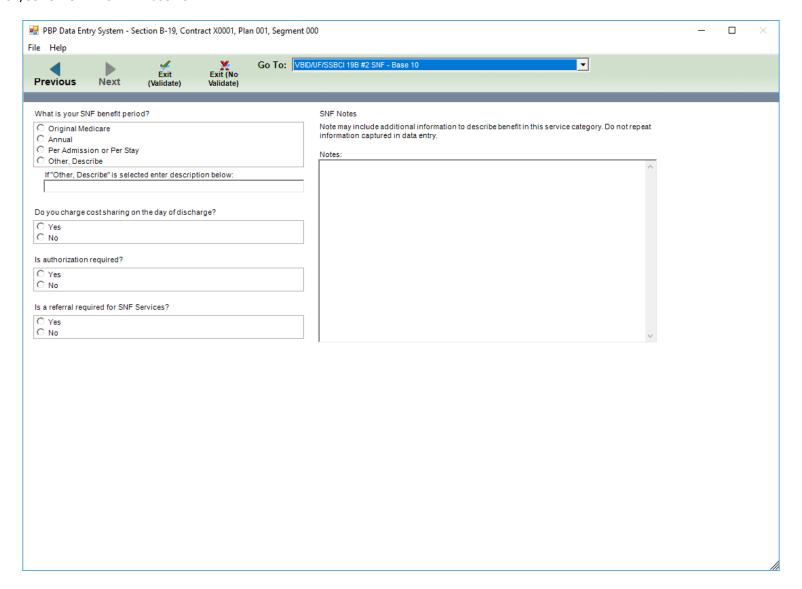




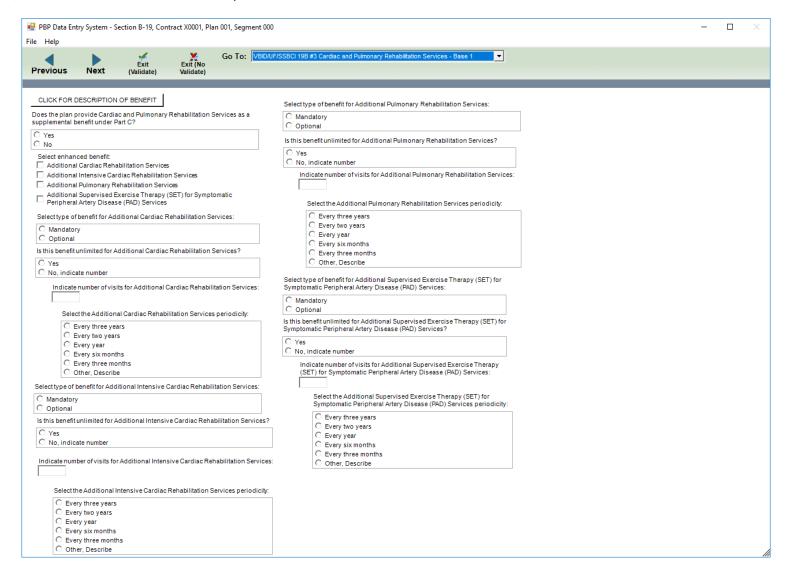
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Medicare-covered Copayment Cost Sharing for Tier 2:	Medicare-covered Copayment Cost Sharing for Tier 3:		
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)		
C Yes C No	C Yes C No		
Indicate Copayment amount for Medicare-covered stay:	Indicate Copayment amount for Medicare-covered stay:		
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:		
C Zero (No Copayment per Day) C One C Two C Three	C Zero (No Copayment per Day) C One C Two C Three		
Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): For more information on cost share limitations please view the variable help.	Indicate the copayment amount and day interval(s) for Medicare-covered stay (e.g.; 1 to 20; 21 to 100): For more information on cost share limitations please view the variable help.		
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VBID/UF/SSBCI 19B #3 Cardiac and Pulmonary Rehabilitation Services - Base 1



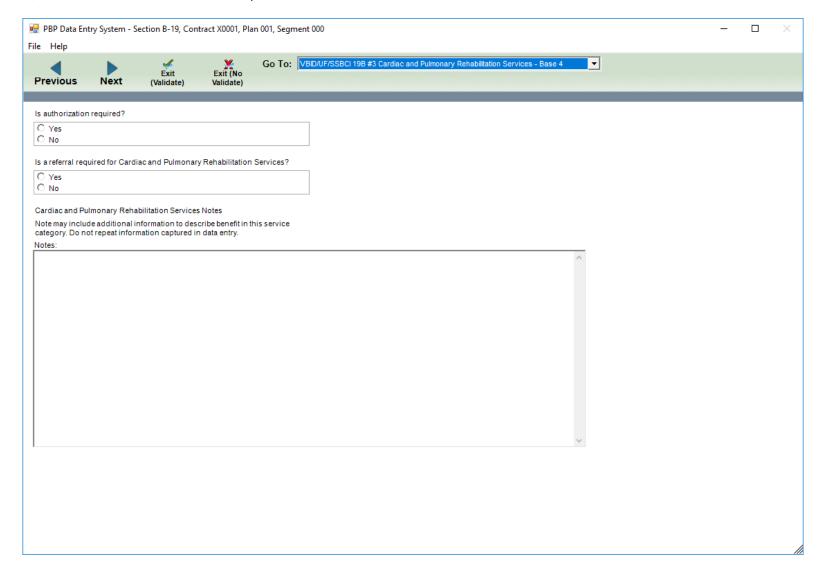
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File Help					
·	VBID/UF/SSBCI 19B #3 Cardiac and Pulmonary Rehabilitation Se	ervices - Base 2	2		
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes No Indicate Maximum Enrollee Out-of-Pocket Cost amount: Select Maximum Enrollee Out-of-Pocket Cost periodicity: Every three years Every two years Every six months Every three months Other, Describe You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay. Is there an enrollee Coinsurance? Yes No	ry. Select which Cardiac and Pulmonary Rehabilitation Servic Coinsurance (Select all that apply): Medicare-covered Cardiac Rehabilitation Services Medicare-covered Intensive Cardiac Rehabilitation Services Medicare-covered Pulmonary Rehabilitation Services Medicare-covered Supervised Exercise Therapy (SET Symptomatic Peripheral Artery Disease (PAD) Services Additional Cardiac Rehabilitation Services Additional Cardiac Rehabilitation Services Additional Pulmonary Rehabilitation Services Additional Supervised Exercise Therapy (SET) for Symperipheral Artery Disease (PAD) Services Indicate Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services: Indicate Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services: Indicate Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services: Indicate Coinsurance percentage for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: Indicate Coinsurance percentage for Additional Cardiac Rehabilitation Services: Indicate Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services: Indicate Coinsurance percentage for Additional Pulmonary Rehabilitation Services: Indicate Coinsurance percentage for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: Indicate Coinsurance percentage for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	rvices) for s nptomatic Minimum	Maximum Coinsurance		

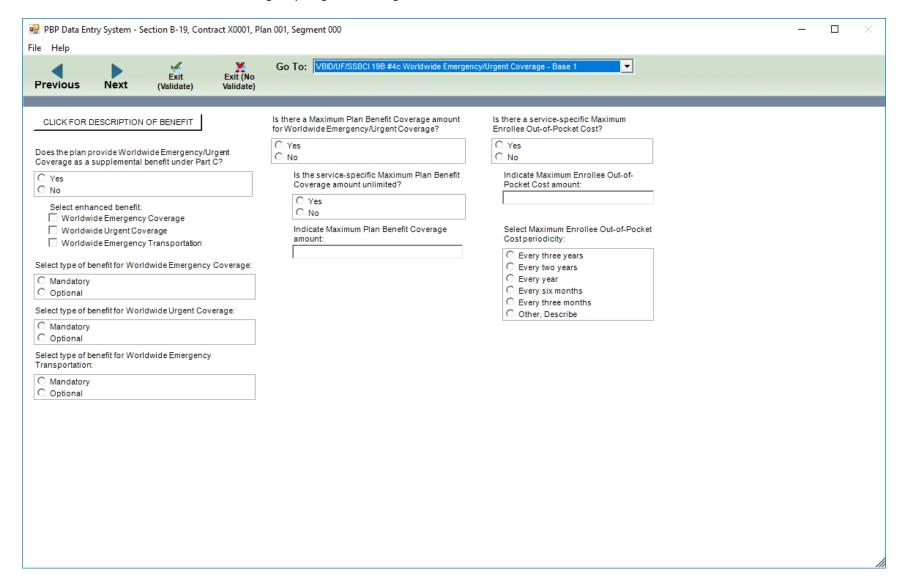
VBID/UF/SSBCI 19B #3 Cardiac and Pulmonary Rehabilitation Services – Base 3

🖳 PBP Data Entry System - Section B-19, Contract X0001, Plan 001	l, Segment 000			- [) ×
File Help					
	To: VBID/UF/SSBCI 19B #3 Cardiac and Pulmonary Rehab	ilitation Services - Base 3	▼		
Exit Exit (No Previous Next (Validate) Validate)					
Is there an enrollee Deductible?		Minimum Copayment	Maximum Copayment		
C Yes	ladia ta Caramanta and ta Madiana				
	Indicate Copayment amount for Medicare-covered Cardiac Rehabilitation Services:				
Indicate Deductible Amount:	Indicate Copayment amount for Medicare-covered Intensive Cardiac Rehabilitation Services:				
Is there an enrollee Copayment?	Indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services:				
C Yes C No	Indicate Copayment amount for Medicare-covered				
Select which Cardiac and Pulmonary Rehabilitation Services have	Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:				
a Copayment (Select all that apply): Medicare-covered Cardiac Rehabilitation Services	Indicate Copayment amount for Additional Cardiac Rehabilitation Services:				
	Indicate Copayment amount for Additional Intensive Cardiac Rehabilitation Services:				
☐ Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:				
☐ Additional Cardiac Rehabilitation Services ☐ Additional Intensive Cardiac Rehabilitation Services ☐ Additional Pulmonary Rehabilitation Services	Indicate Copayment amount for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:				
Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services					

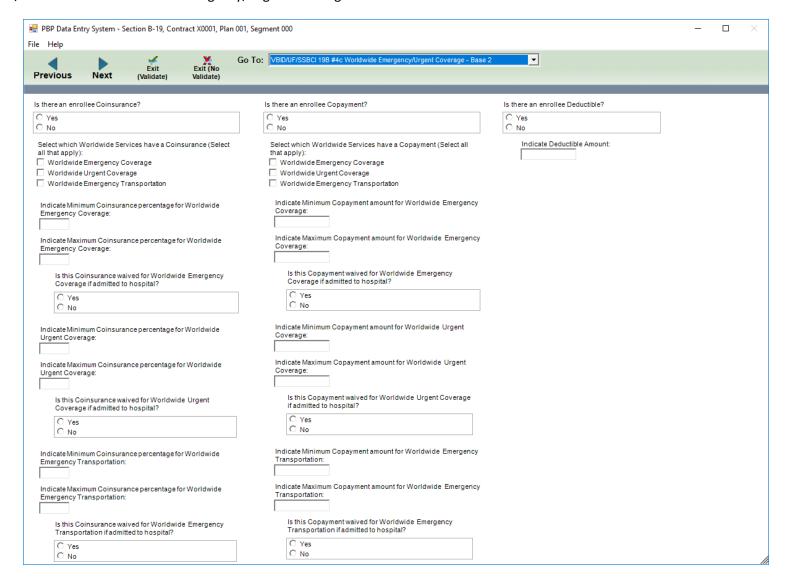
VBID/UF/SSBCI 19B #3 Cardiac and Pulmonary Rehabilitation Services - Base 4



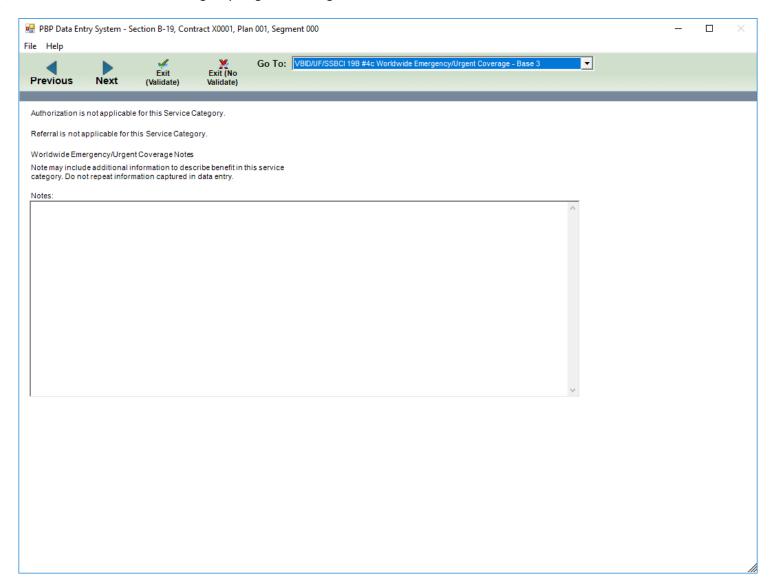
VBID/UF/SSBCI 19B #4c Worldwide Emergency/Urgent Coverage - Base 1



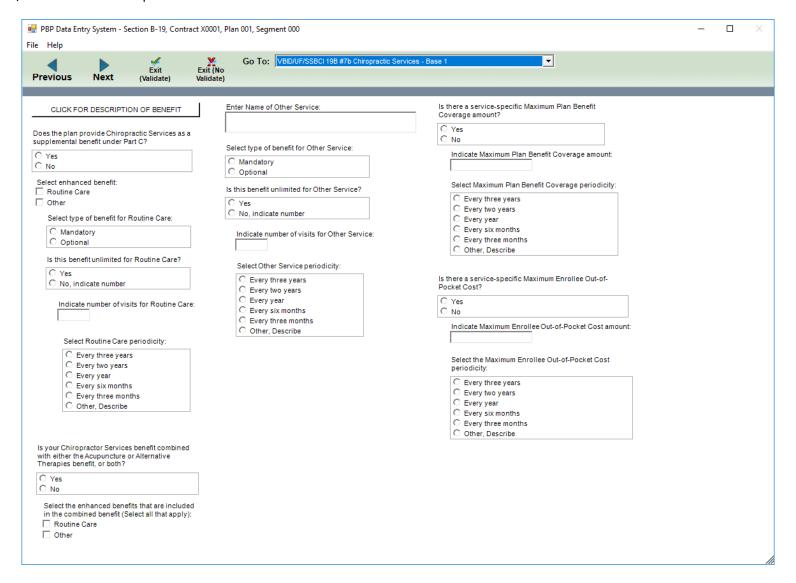
VBID/UF/SSBCI 19B #4c Worldwide Emergency/Urgent Coverage - Base 2



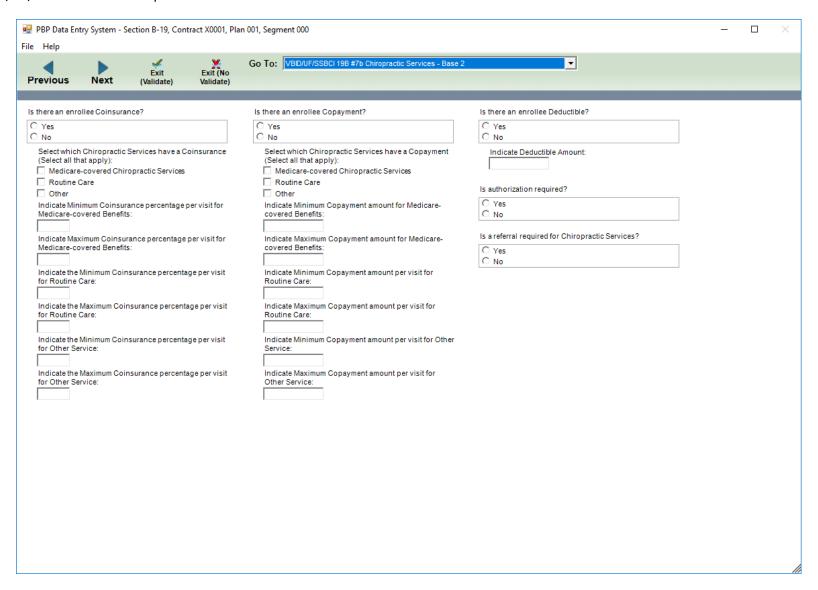
VBID/UF/SSBCI 19B #4c Worldwide Emergency/Urgent Coverage - Base 3



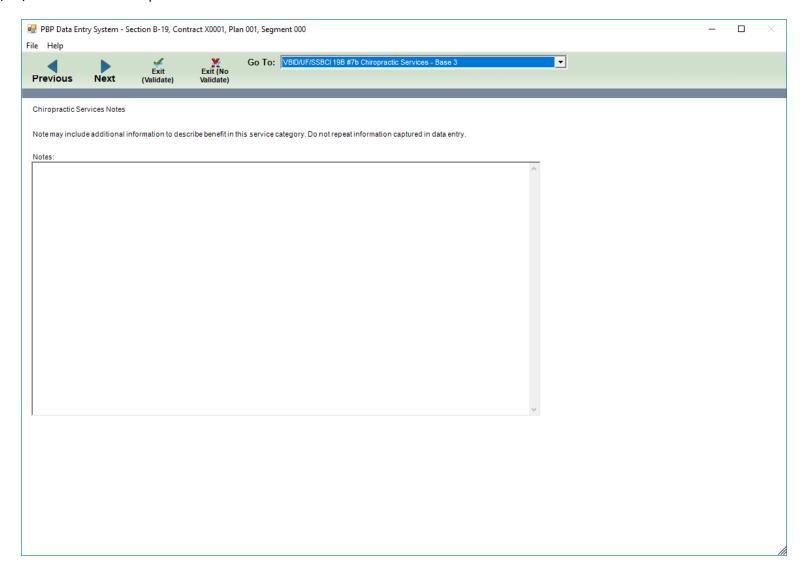
VBID/UF/SSBCI 19B #7b Chiropractic Services - Base 1



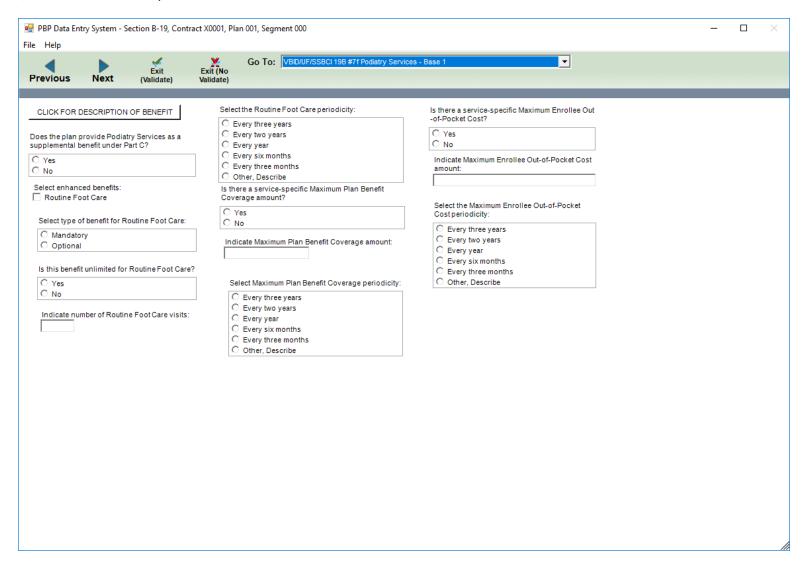
VBID/UF/SSBCI 19B #7b Chiropractic Services - Base 2



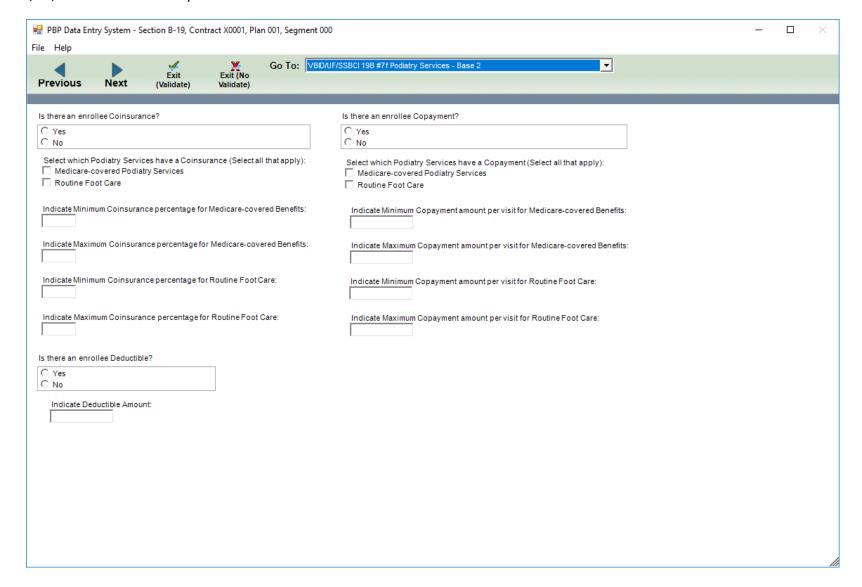
VBID/UF/SSBCI 19B #7b Chiropractic Services - Base 3



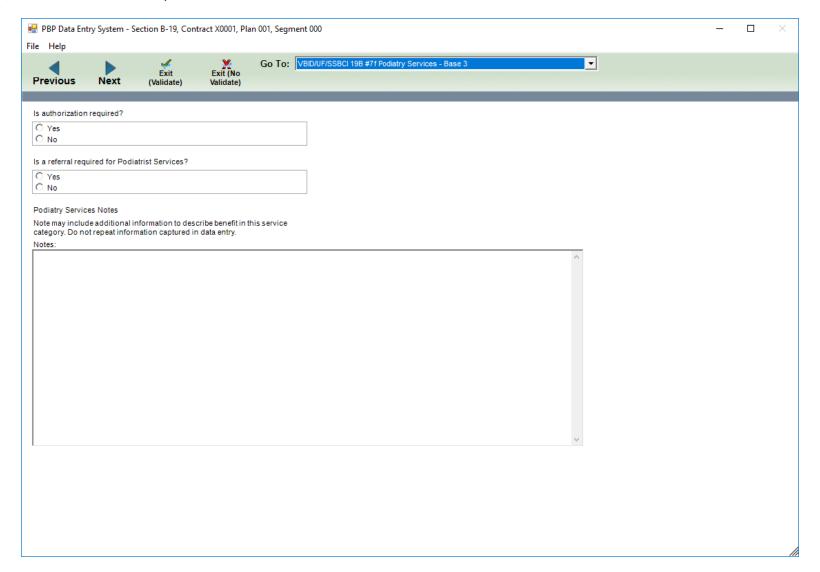
VBID/UF/SSBCI 19B #7f Podiatry Services – Base 1



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



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

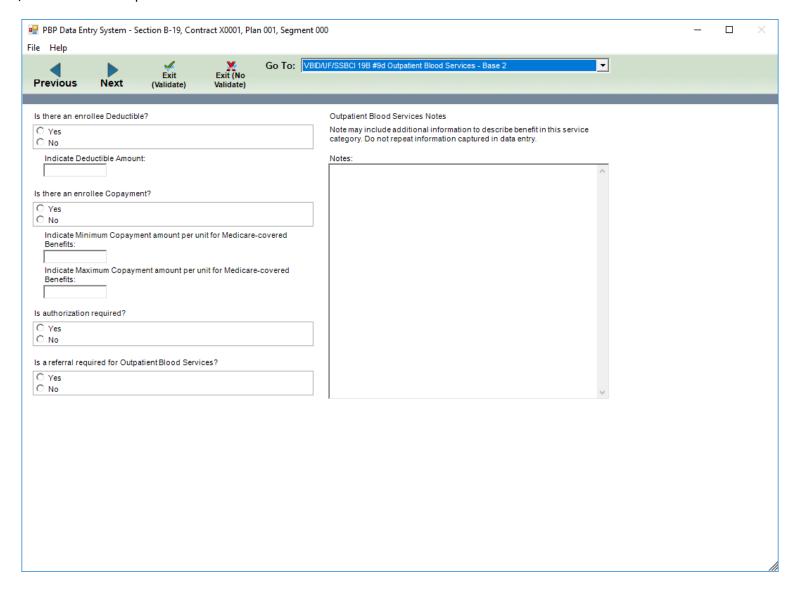


CY 2020 PBP Data Entry System Screens

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

🖳 PBP Data Entry System - Section B-19, Contract X0001, Plan 001, Segm	_	\times	
File Help			
Previous Next (Validate) Go To:	VBID/UF/SSBCI 19B #9d Outpatient Blood Services - Base 1		
CLICK FOR DESCRIPTION OF BENEFIT If blood is given as a part of an inpatient hospital stay, the cost sharing for the blood should be included in the inpatient hospital cost sharing. Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C? C Yes No Select enhanced benefit: Three (3) Pint Deductible Waived Select type of benefit for Three (3) Pint Deductible Waived: C Mandatory O Optional Maximum Plan Benefit Coverage is not applicable for this Service Category. 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 Every two years Every year Every six months C Every three months Other, Describe Is there an enrollee Coinsurance? Yes No Indicate Minimum Coinsurance percentage per unit for Medicare-covered Benefits: Indicate Maximum Coinsurance percentage per unit for Medicare-covered Benefits:		
			/

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

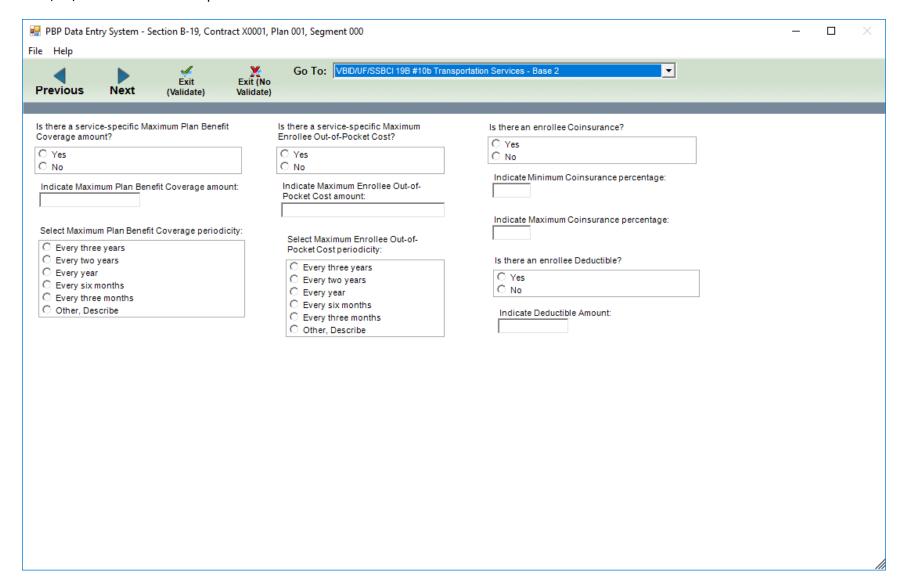


VBID/UF/SSBCI 19B #10b Transportation Services – Base 1

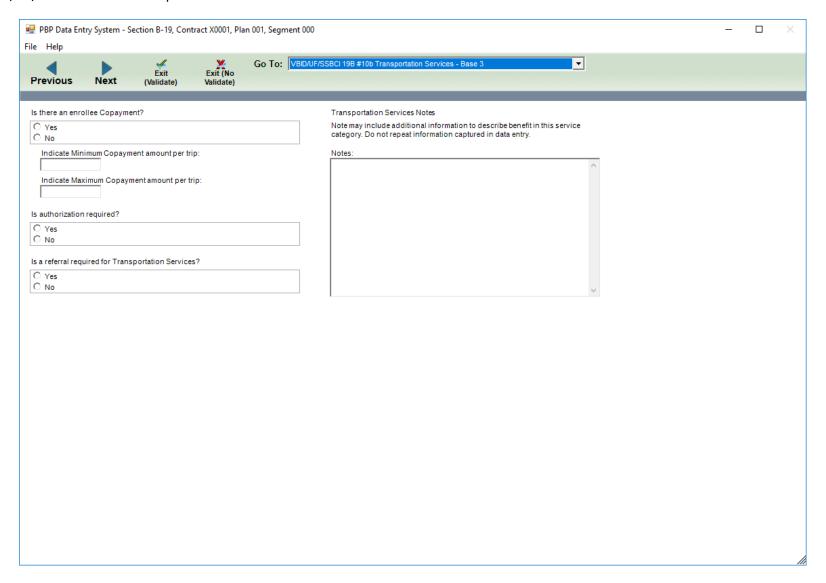
Go To: VBID/UF/SSBCI 19B #10b Transportation Services - Base 1				
CLICK FOR DESCRIPTION OF BENEFIT Toes the plan provide Transportation Services as a supplemental benefit under Part C? Yes No Select enhanced benefit: C Plan-approved Location C Any Health-related Location Select type of benefit for Plan-approved Location: C Mandatory C Optional Is this benefit unlimited for number of trips for Plan-approved Location? C Yes C No	Select Type of Transportation for Plan-approved Location: C One-way Round Trip Days Other, Describe Indicate number of days for Plan-approved Location: Taxi Rideshare Services Bus/Subway Van Medical Transport Other, Describe	Indicate number of trips for Any Health-related Location: Select Any Health-related Location Trips periodicity: Every three years Every two years Every year Every six months Every three months Other, Describe Select Type of Transportation for Any Health-related Location: One-way Round Trip Days Other, Describe		
Indicate number of trips for Plan-approved Location: Select Plan-approved Location Trips periodicity: Every three years Every two years Every year Every year Every six months Cevery three months Other, Describe	Select type of benefit for Any Health-related Location: C Mandatory Optional Is this benefit unlimited for number of trips for Any Health-related Location? C Yes No	Indicate number of days for Any Health- related Location: Select Mode of Transportation for Any Health- related Location: Taxi Rideshare Services Bus/Subway Van Medical Transport Other, Describe		

CY 2020 PBP Data Entry System Screens

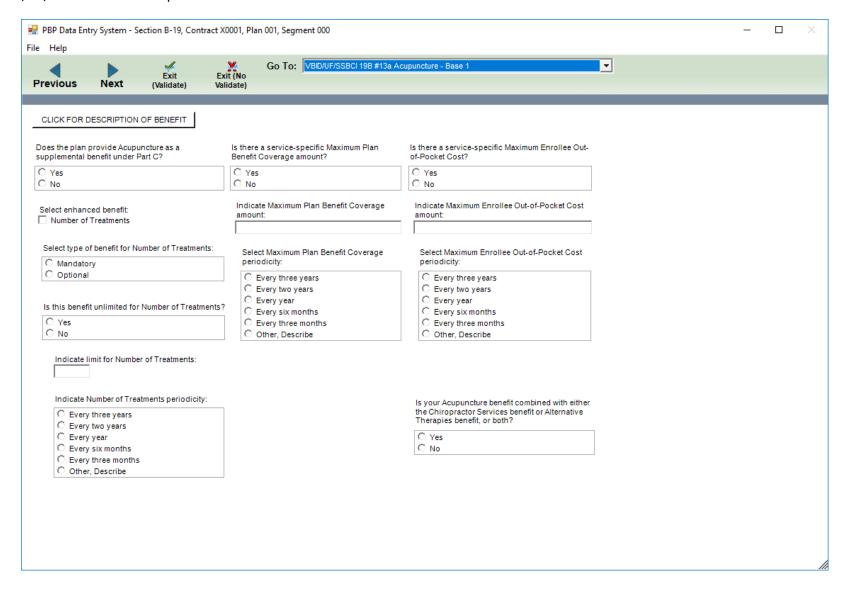
VBID/UF/SSBCI 19B #10b Transportation Services – Base 2



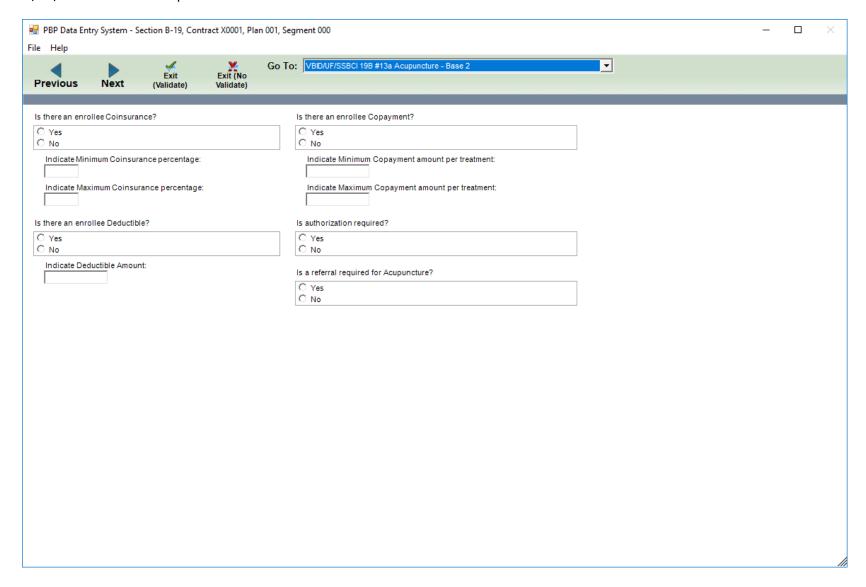
VBID/UF/SSBCI 19B #10b Transportation Services - Base 3



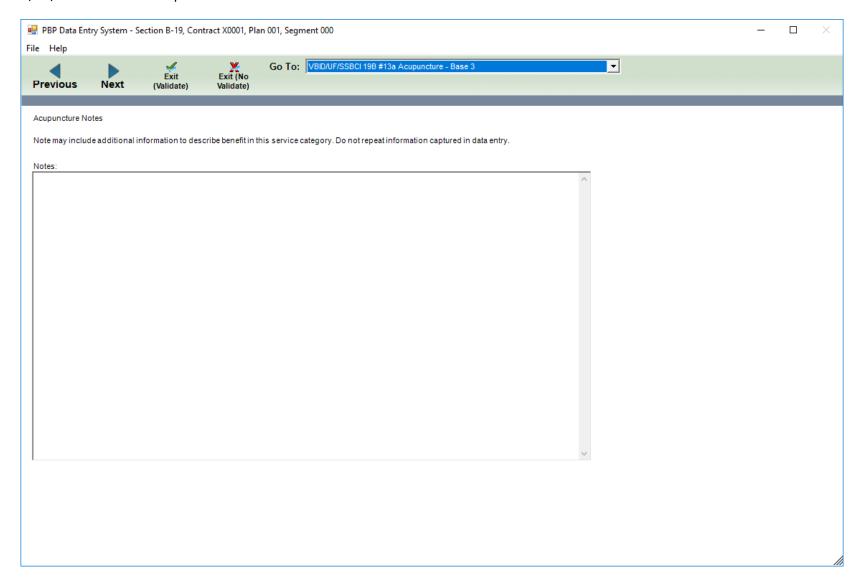
VBID/UF/SSBCI 19B #13a Acupuncture - Base 1



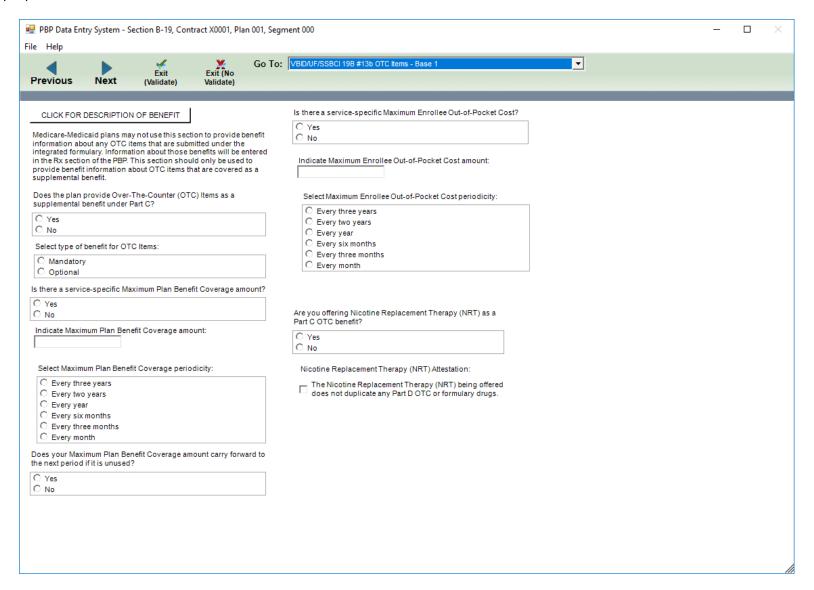
VBID/UF/SSBCI 19B #13a Acupuncture - Base 2



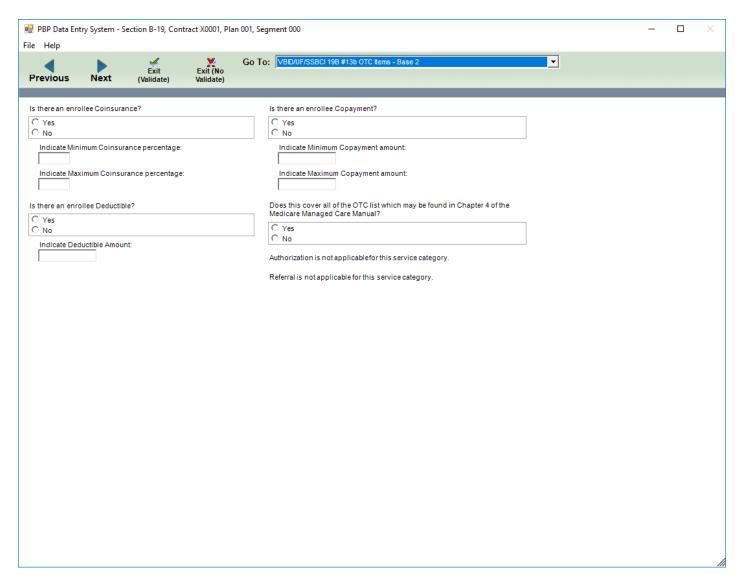
VBID/UF/SSBCI 19B #13a Acupuncture - Base 3



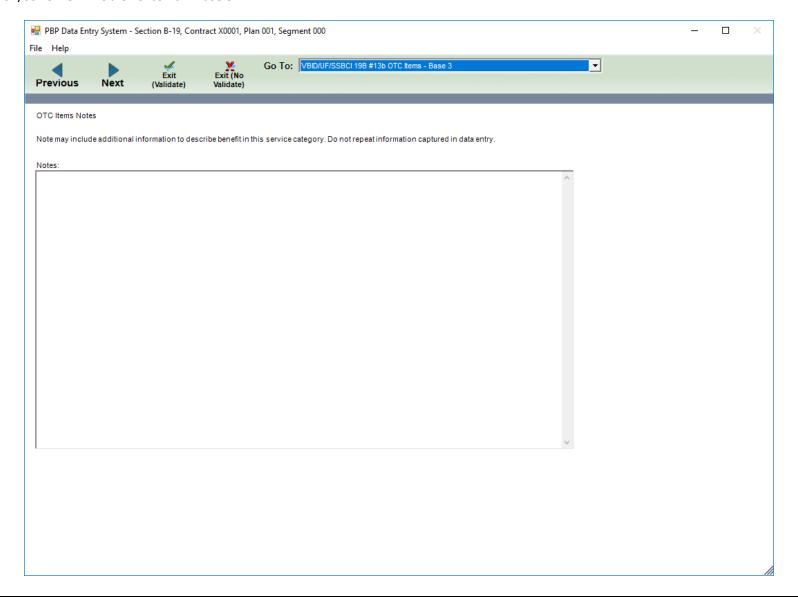
VBID/UF/SSBCI 19B #13b OTC Items - Base 1



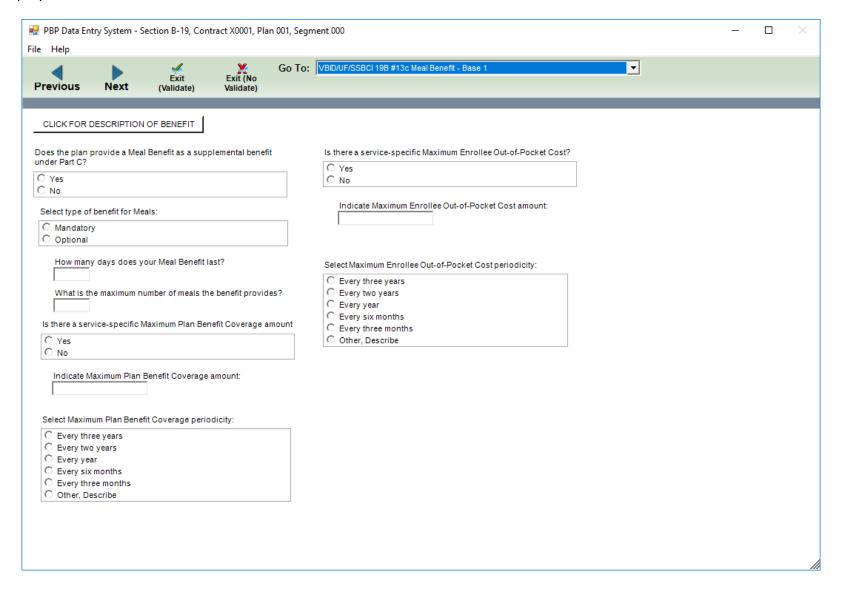
VBID/UF/SSBCI 19B #13b OTC Items – Base 2



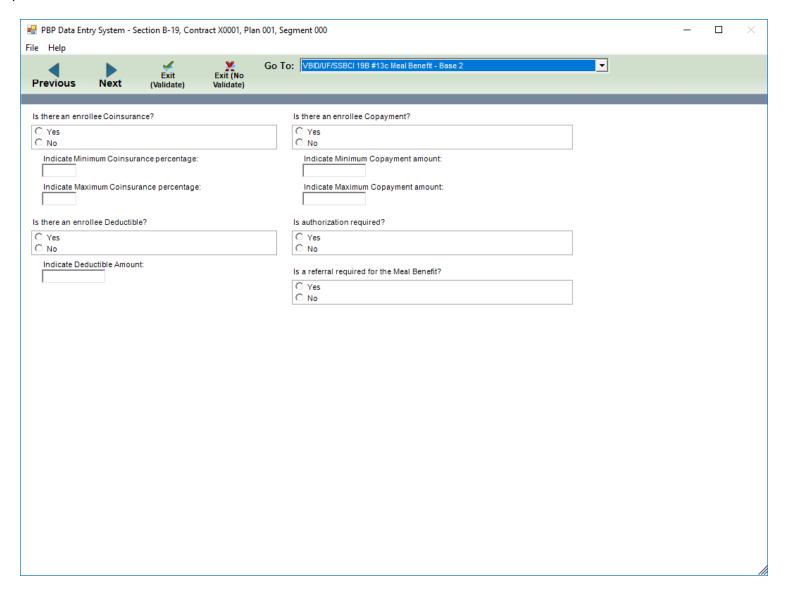
VBID/UF/SSBCI 19B #13b OTC Items - Base 3



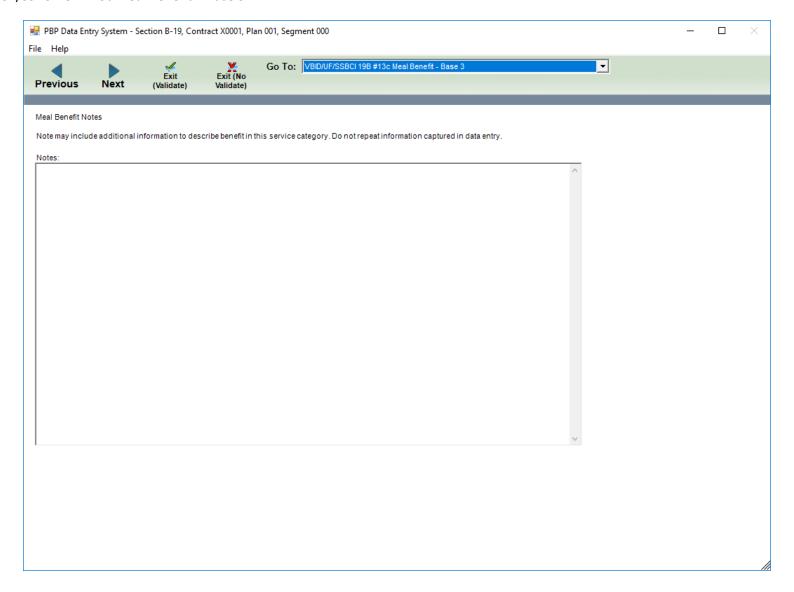
VBID/UF/SSBCI 19B #13c Meal Benefit - Base 1



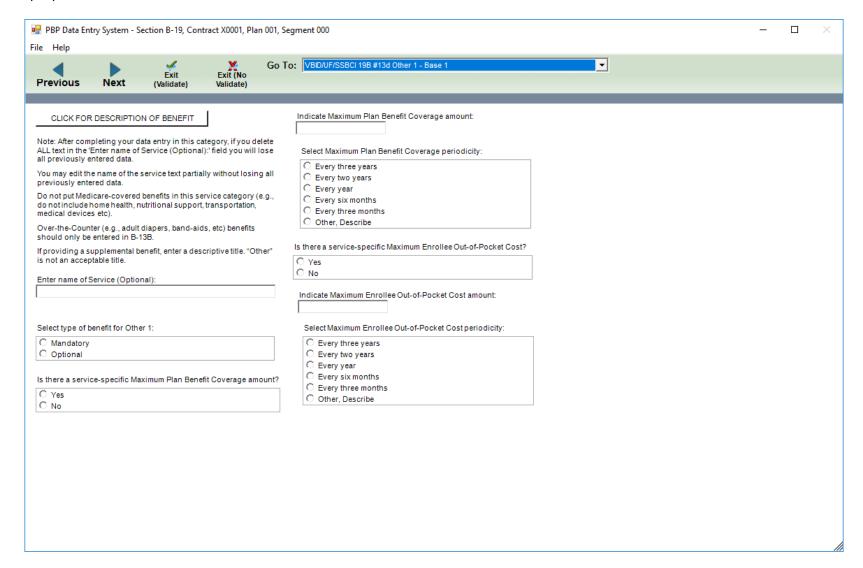
VBID/UF/SSBCI 19B #13c Meal Benefit - Base 2



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

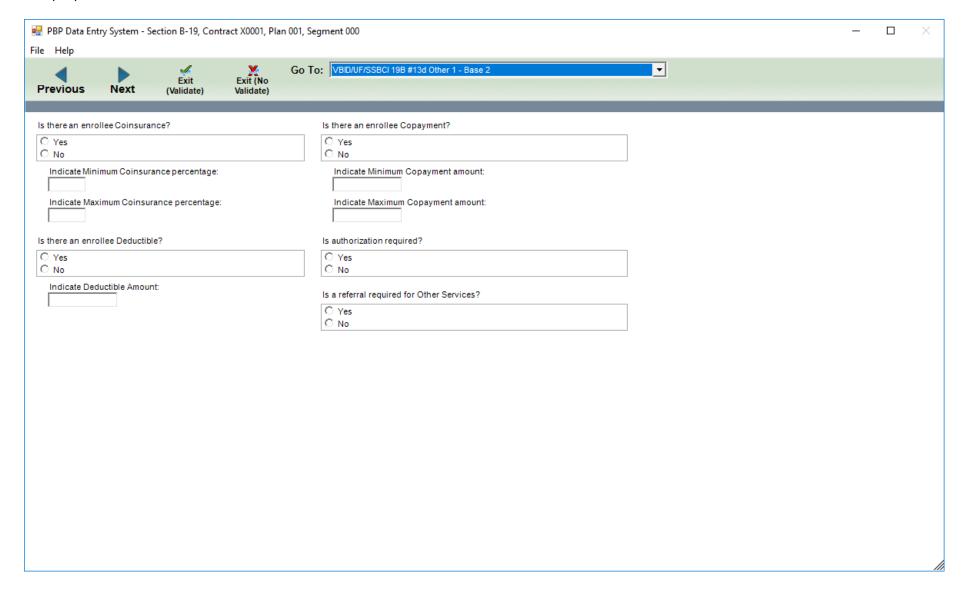


VBID/UF/SSBCI 19B #13d Other 1 - Base 1



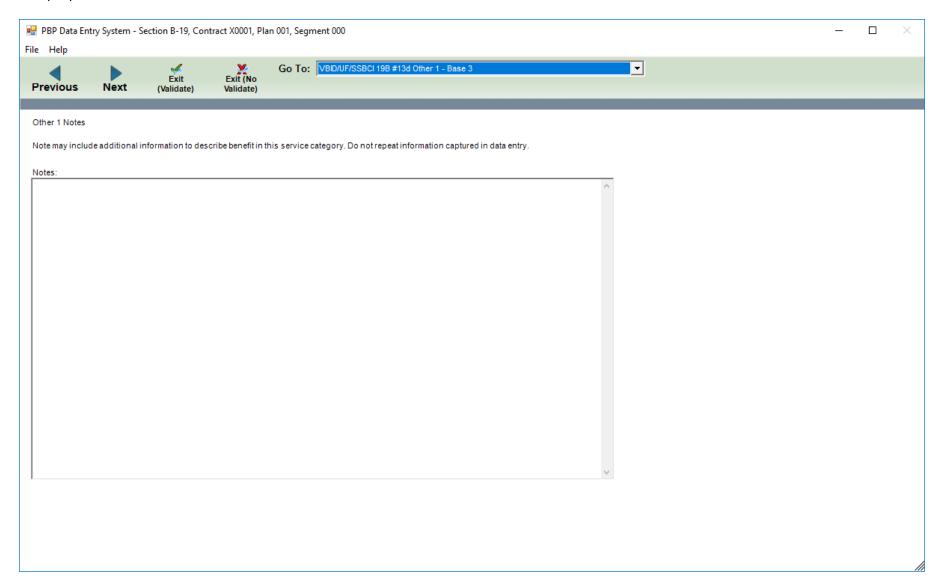
CY 2020 PBP Data Entry System Screens

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

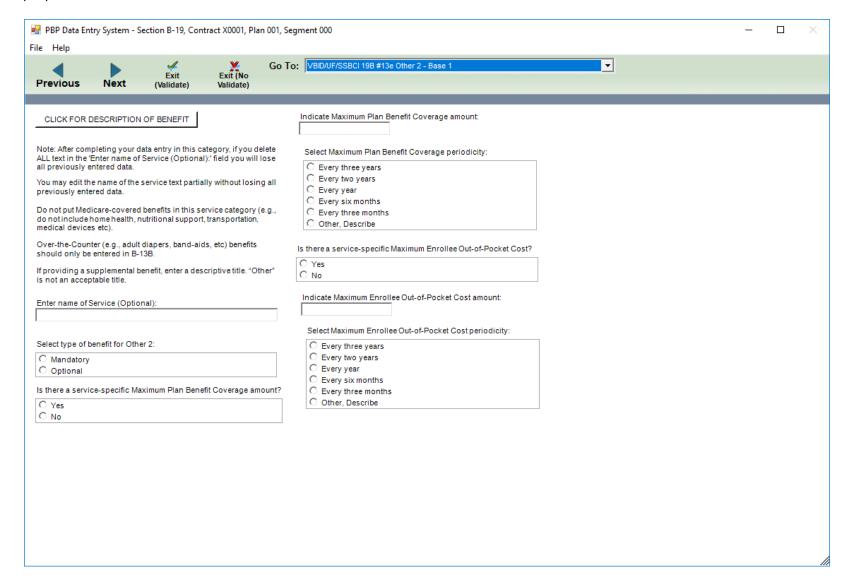


CY 2020 PBP Data Entry System Screens

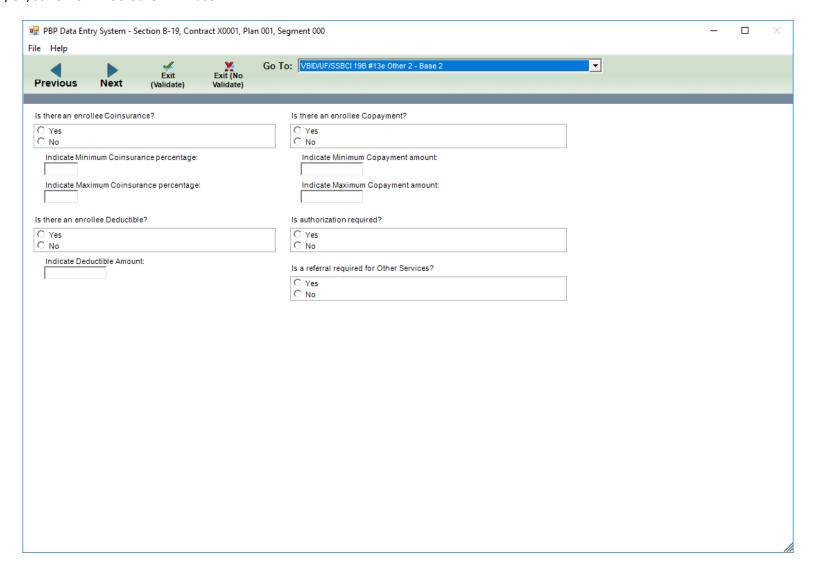
VBID/UF/SSBCI 19B #13d Other 1 – Base 3



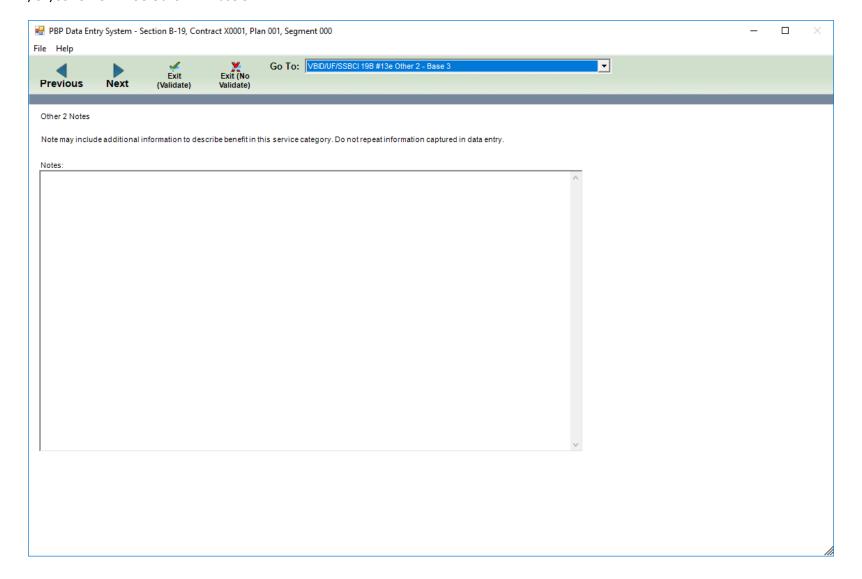
VBID/UF/SSBCI 19B #13e Other 2 - Base 1



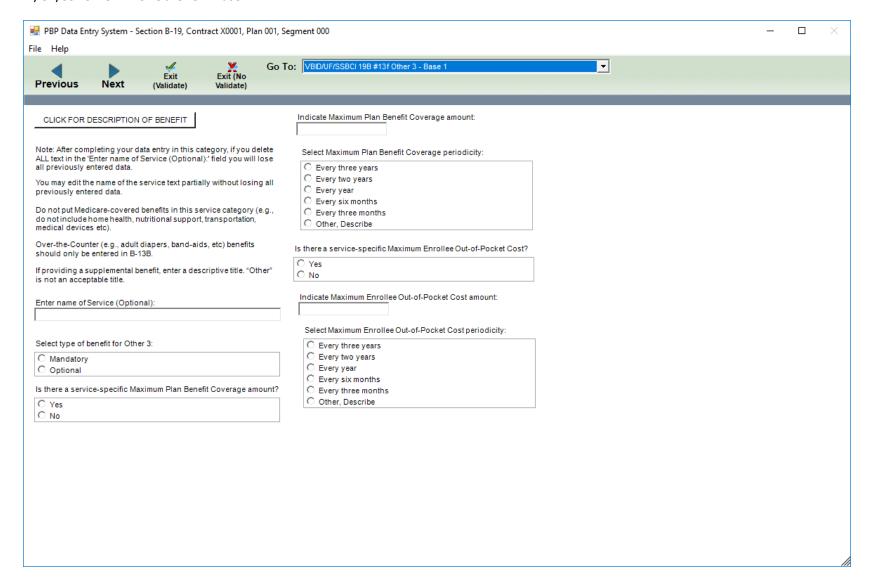
VBID/UF/SSBCI 19B #13e Other 2 - Base 2



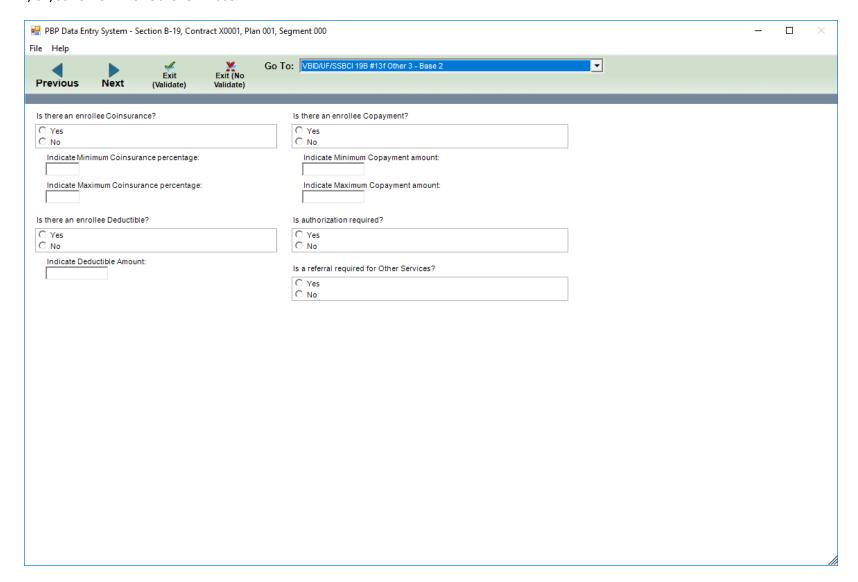
VBID/UF/SSBCI 19B #13e Other 2 – Base 3



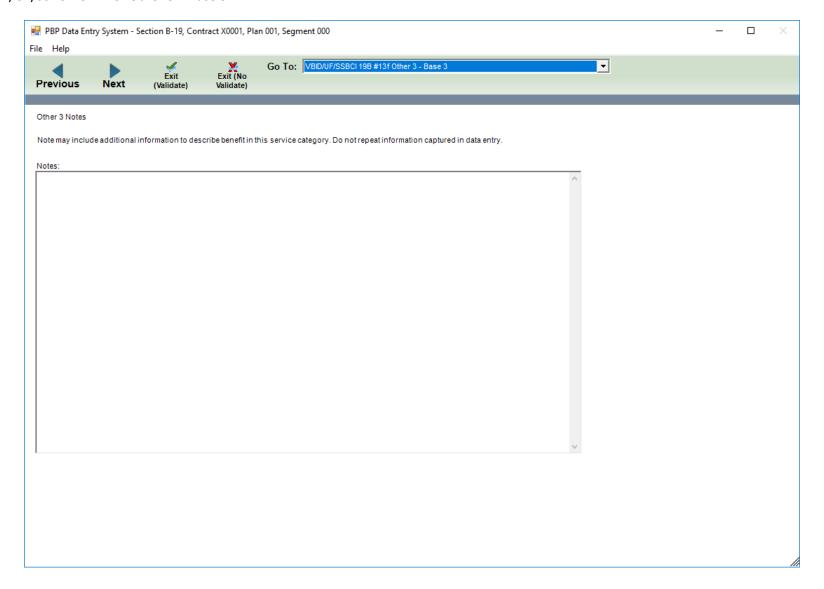
VBID/UF/SSBCI 19B #13f Other 3 - Base 1



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

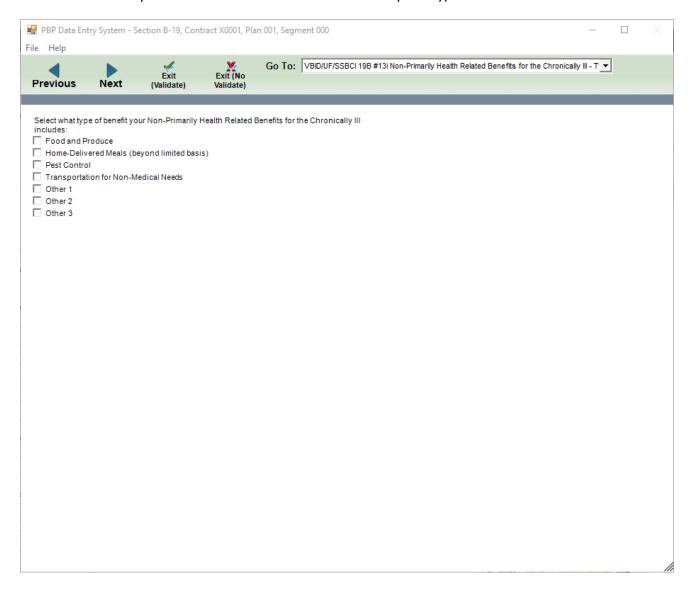


VBID/UF/SSBCI 19B #13f Other 3 - Base 3

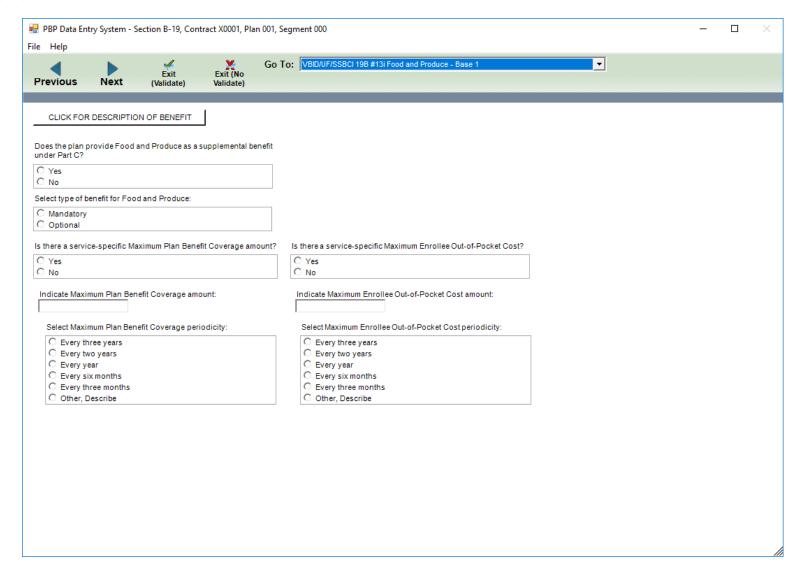


CY 2020 PBP Data Entry System Screens

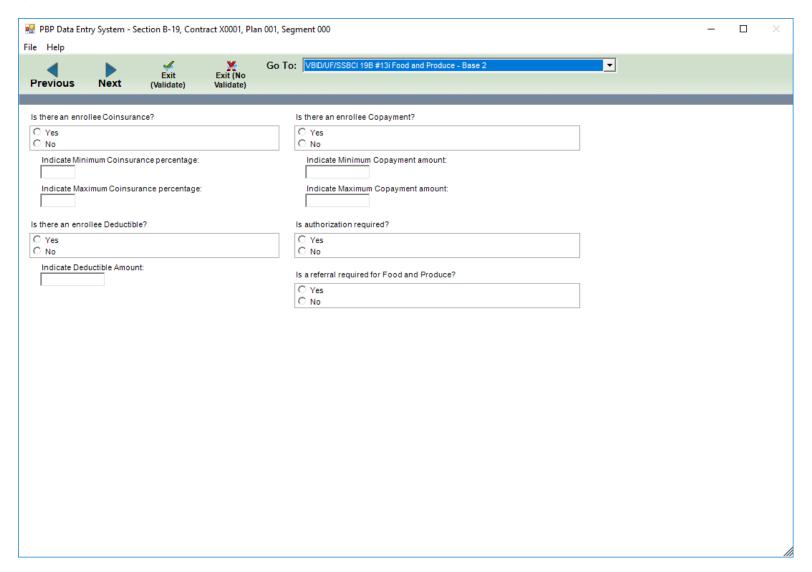
VBID/UF/SSBCI 19B #13i Non-Primarily Health Related Benefits for the Chronically III – Type



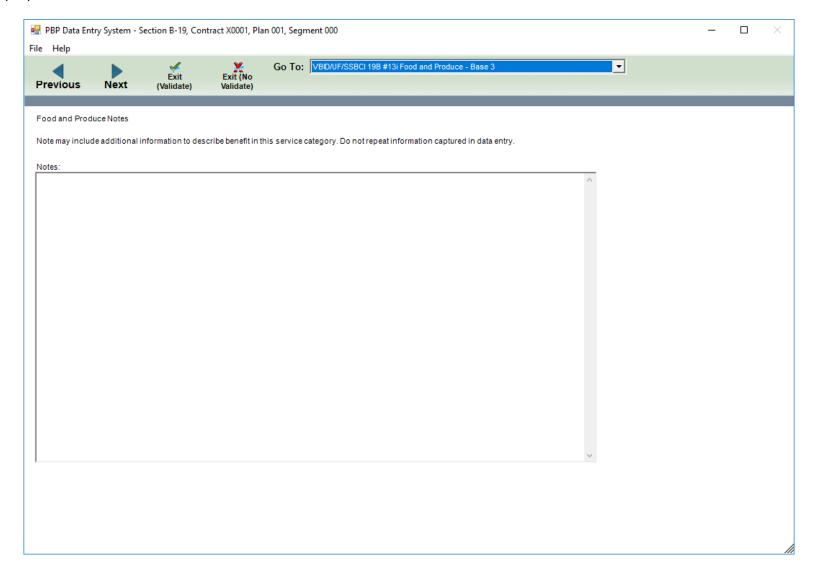
VBID/UF/SSBCI 19B #13i Food and Produce - Base 1



VBID/UF/SSBCI 19B #13i Food and Produce – Base 2

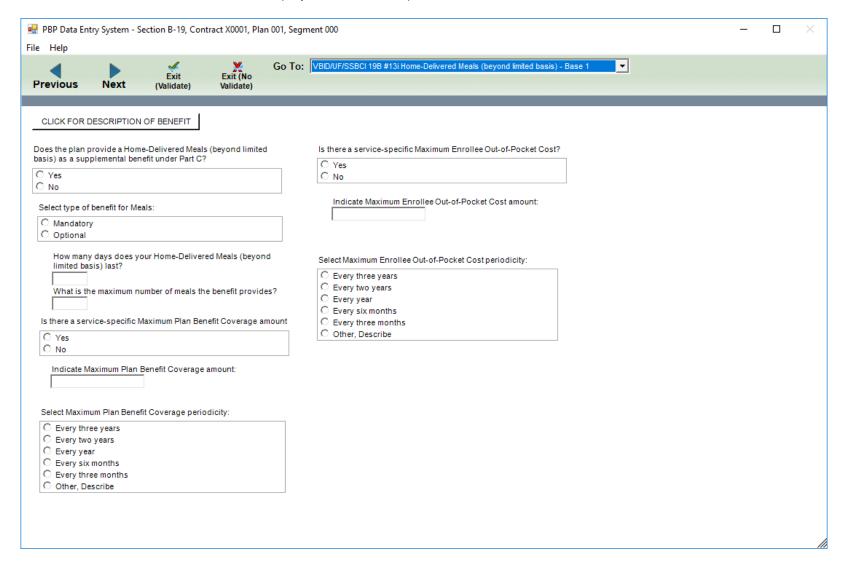


VBID/UF/SSBCI 19B #13i Food and Produce - Base 3



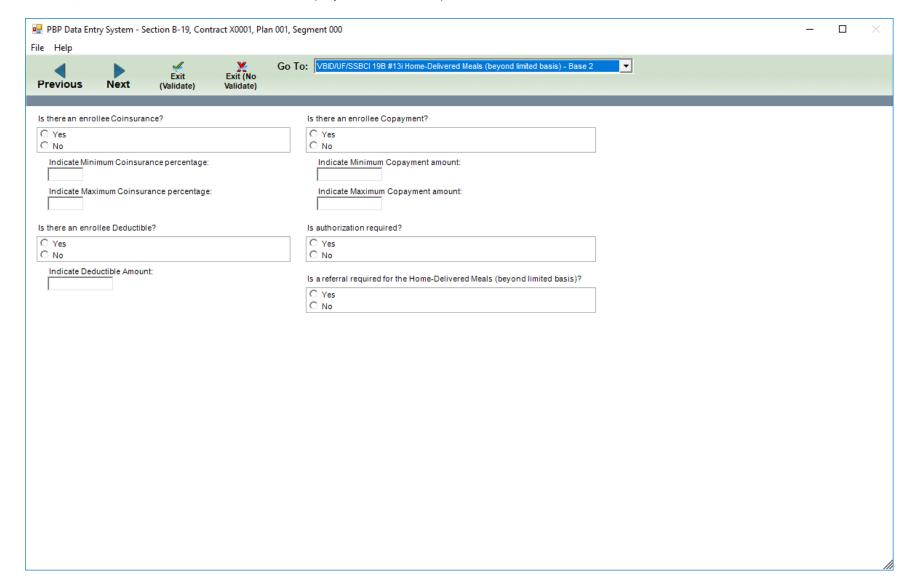
CY 2020 PBP Data Entry System Screens

VBID/UF/SSBCI 19B #13i Home-Delivered Meals (beyond limited basis) – Base 1

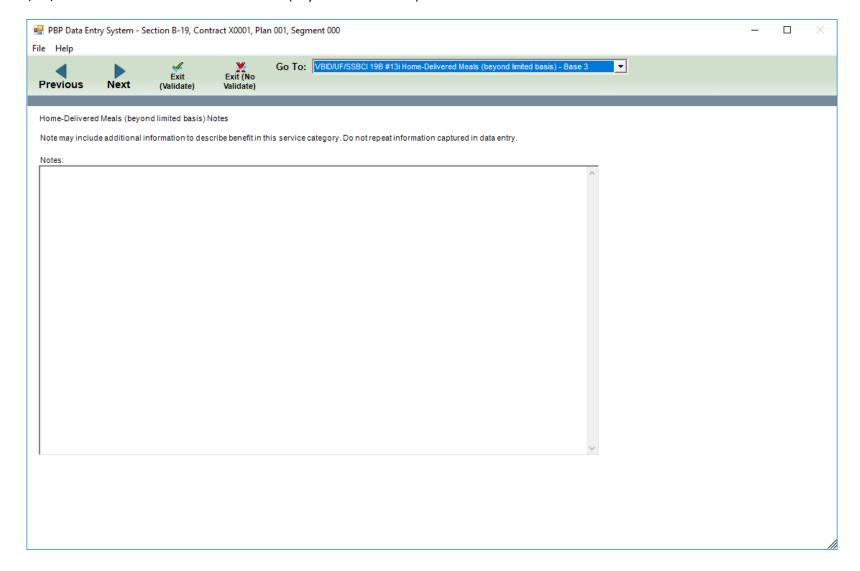


CY 2020 PBP Data Entry System Screens

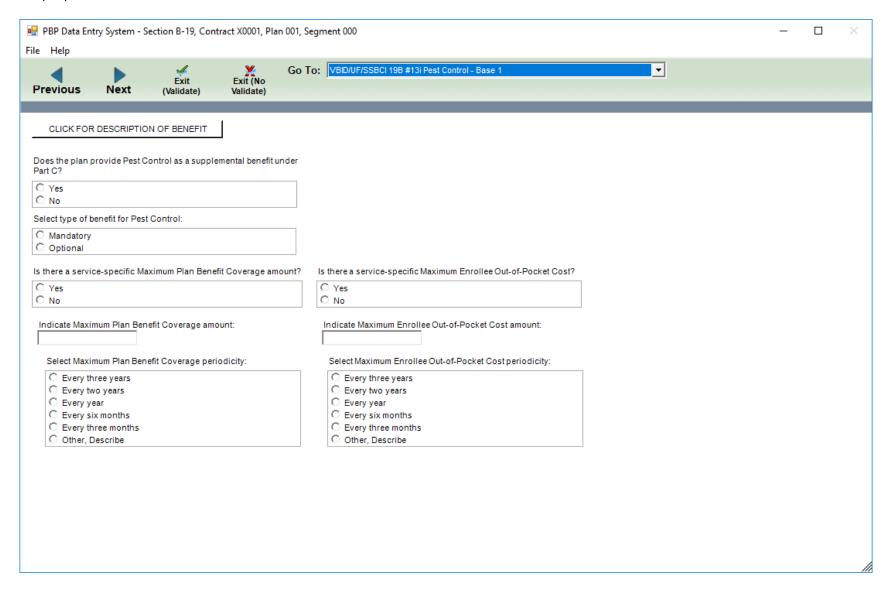
VBID/UF/SSBCI 19B #13i Home-Delivered Meals (beyond limited basis) – Base 2



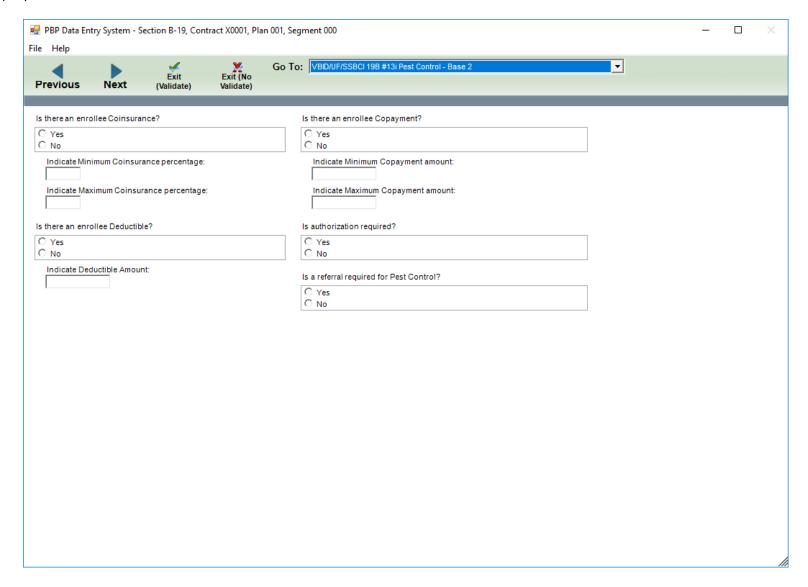
VBID/UF/SSBCI 19B #13i Home-Delivered Meals (beyond limited basis) - Base 3



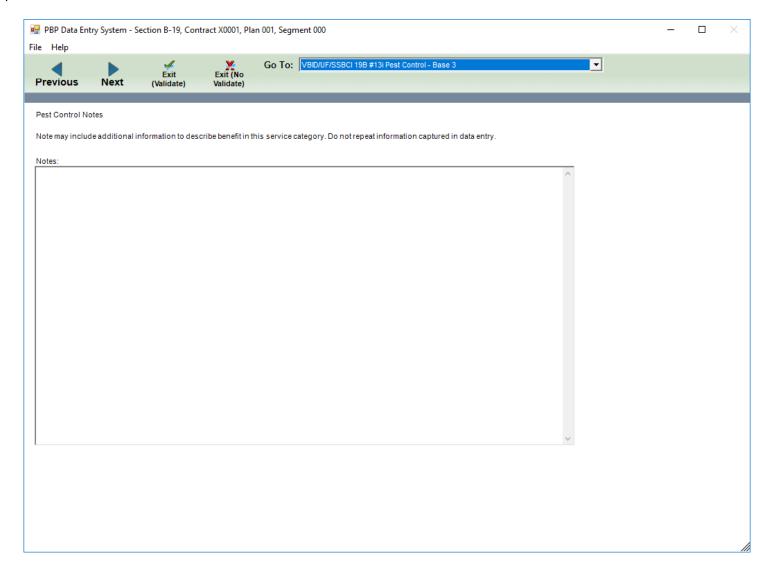
VBID/UF/SSBCI 19B #13i Pest Control - Base 1



VBID/UF/SSBCI 19B #13i Pest Control - Base 2



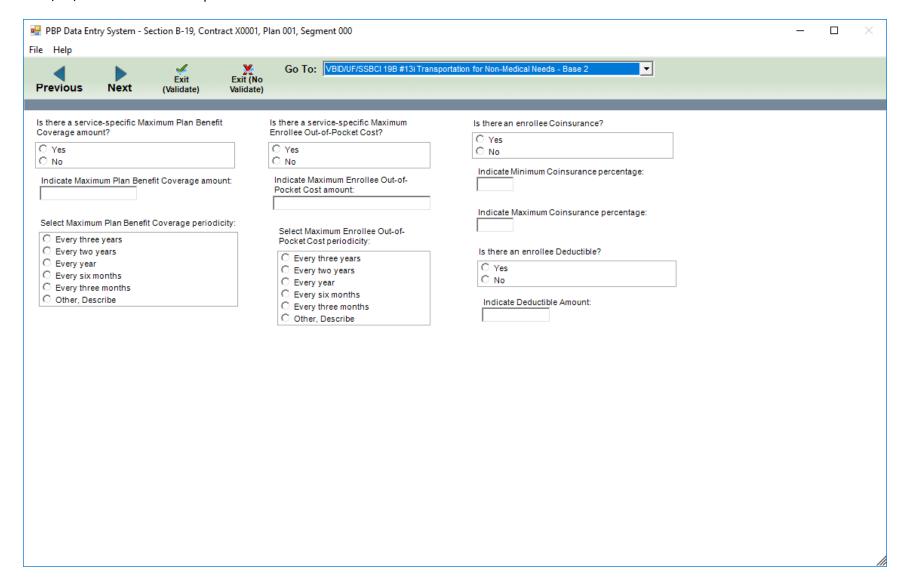
VBID/UF/SSBCI 19B #13i Pest Control – Base 3



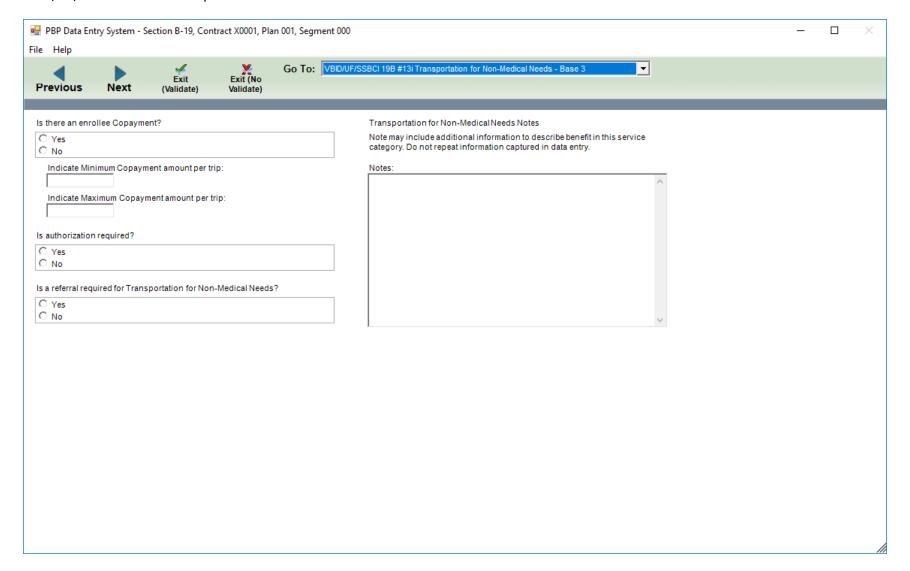
VBID/UF/SSBCI 19B #13i Transportation for Non-Medical Needs – Base 1

Previous Next (Validate) Validat	Go To: VBID/UF/SSBCI 19B #13i Transportation to e)	for Non-Medical Needs - Base 1	
CLICK FOR DESCRIPTION OF BENEFIT Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C? C Yes No Select enhanced benefit: Plan-approved Location Any Health-related Location Select type of benefit for Plan-approved Location: Mandatory Optional Is this benefit unlimited for number of trips for Plan-approved Location? Yes No Indicate number of trips for Plan-approved Location: Select Plan-approved Location Trips periodicity: Select Plan-approved Location Trips periodicity: Every three years Every two years Every six months Every three months Other, Describe	Select Type of Transportation for Non-Medical Needs for Plan-approved Location: C One-way Round Trip Days Other, Describe Indicate number of days for Plan-approved Location: Select Mode of Transportation for Non-Medical Need for Plan-approved Location: Taxi Bus/Subway Van Medical Transportation Other, Describe Select type of benefit for Any Health-related Location: Mandatory Optional Is this benefit unlimited for number of trips for Any Health-related Location? Yes No	Indicate number of trips for Any Health-related Location: Select Any Health-related Location Trips periodicity: Every three years Every two years Every year Every year Every year Other, Describe Select Type of Transportation for Non-Medical Needs for Any Health-related Location: One-way Round Trip Days Other, Describe Indicate number of days for Any Health-related Location: Select Mode of Transportation for Non-Medical Needs for Any Health-related Location: Taxi Bus/Subway Van Medical Transportation for Non-Medical Nee Other, Describe	

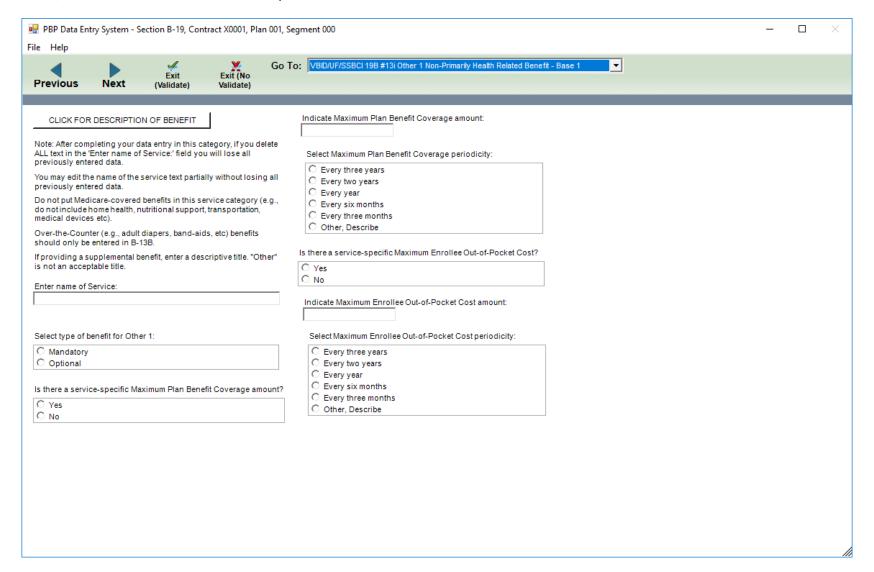
VBID/UF/SSBCI 19B #13i Transportation for Non-Medical Needs - Base 2



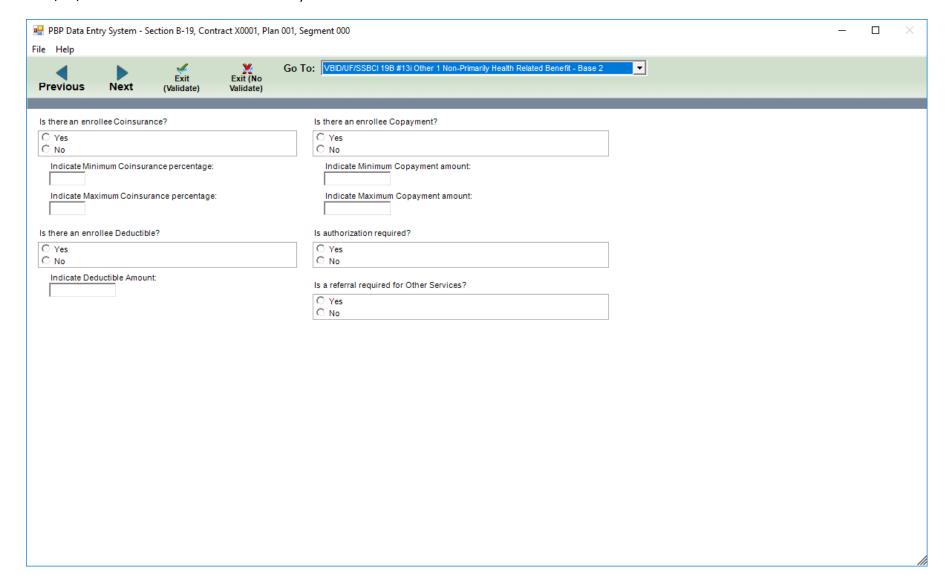
VBID/UF/SSBCI 19B #13i Transportation for Non-Medical Needs – Base 3



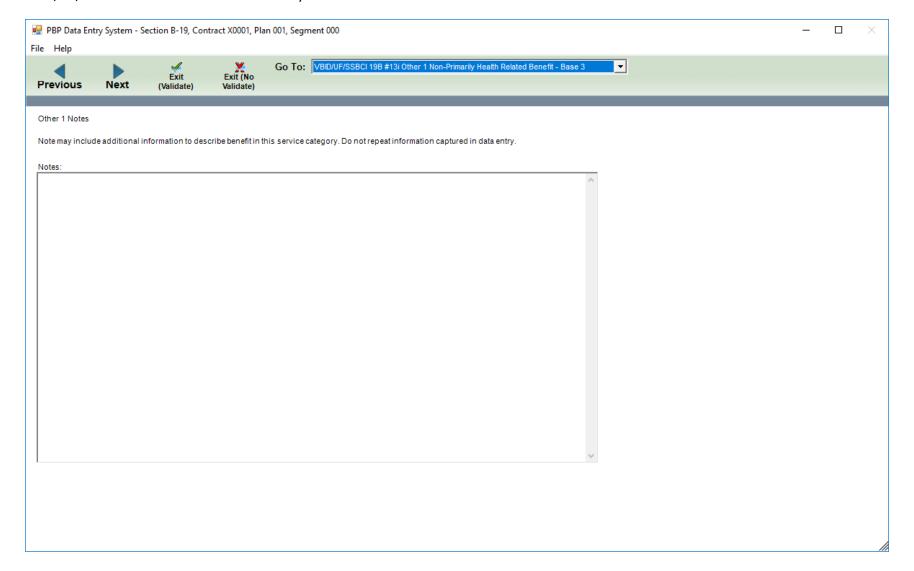
VBID/UF/SSBCI 19B #13i Other 1 Non-Primarily Health Related Benefit - Base 1



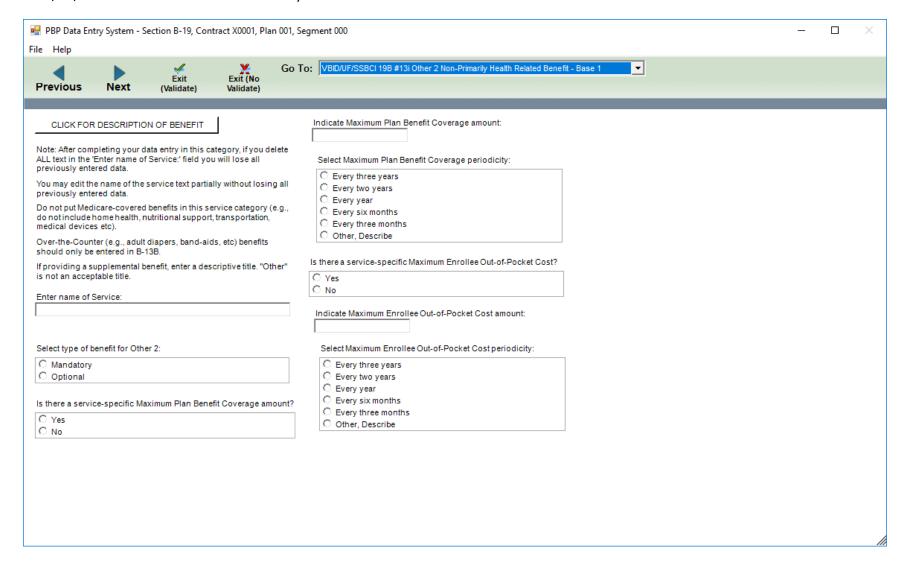
VBID/UF/SSBCI 19B #13i Other 1 Non-Primarily Health Related Benefit – Base 2



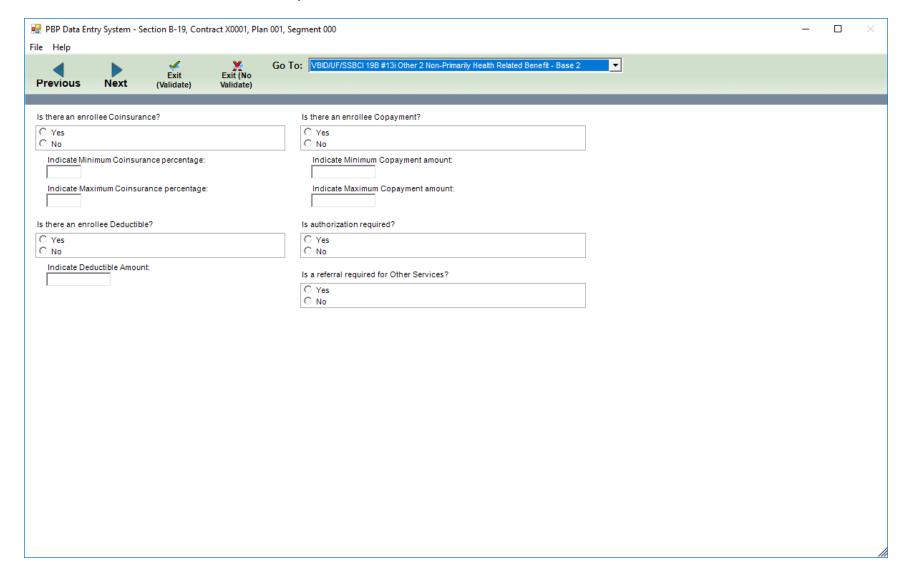
VBID/UF/SSBCI 19B #13i Other 1 Non-Primarily Health Related Benefit – Base 3



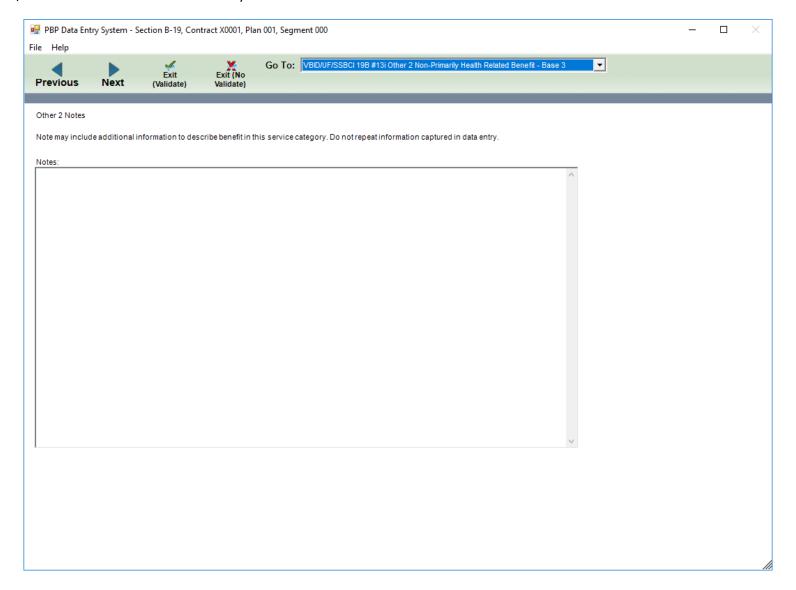
VBID/UF/SSBCI 19B #13i Other 2 Non-Primarily Health Related Benefit - Base 1



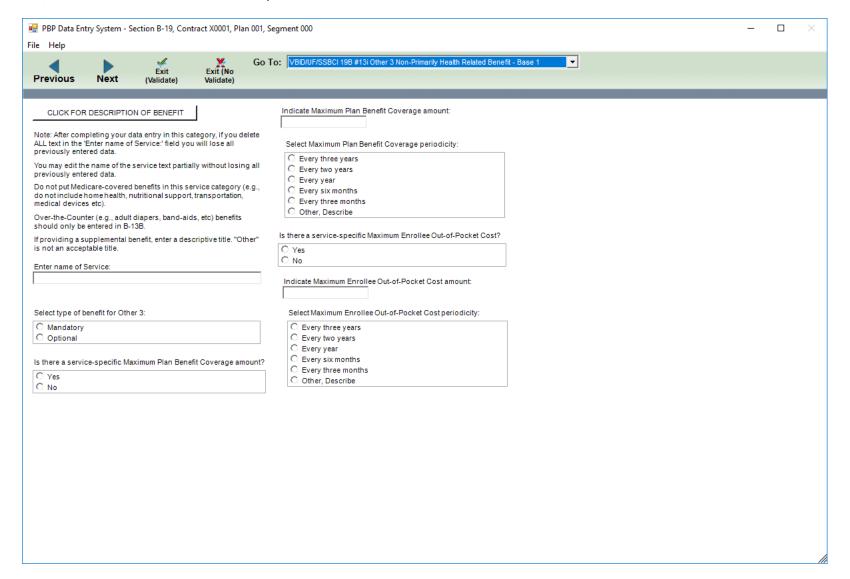
VBID/UF/SSBCI 19B #13i Other 2 Non-Primarily Health Related Benefit – Base 2



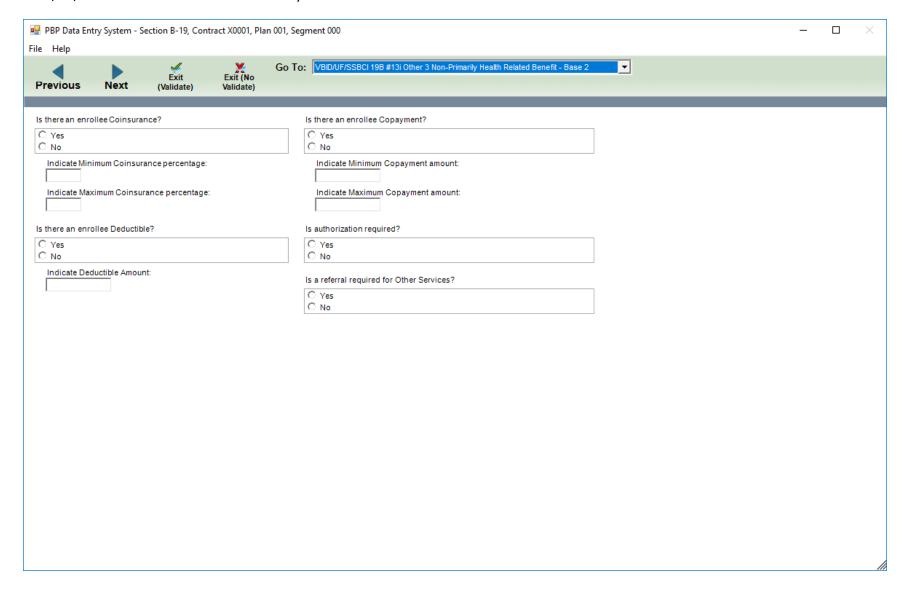
VBID/UF/SSBCI 19B #13i Other 2 Non-Primarily Health Related Benefit – Base 3



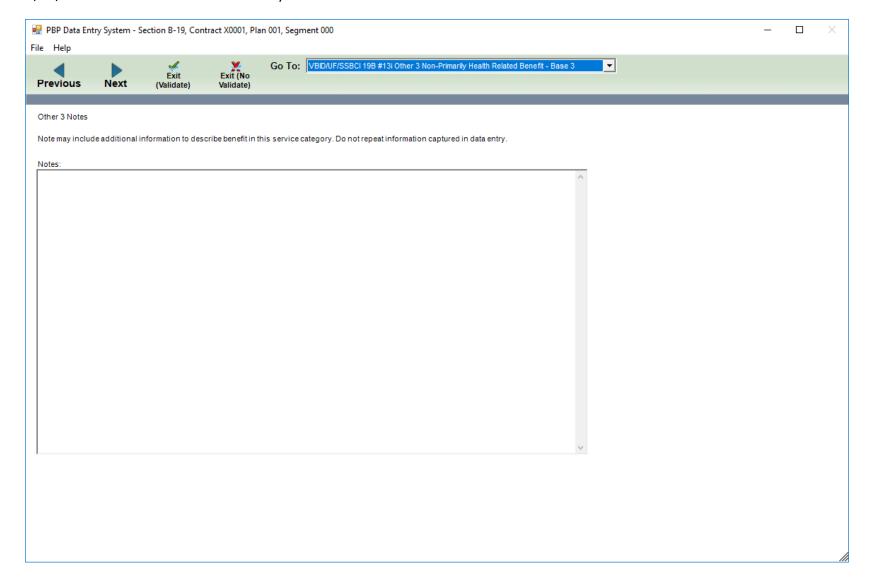
VBID/UF/SSBCI 19B #13i Other 3 Non-Primarily Health Related Benefit - Base 1



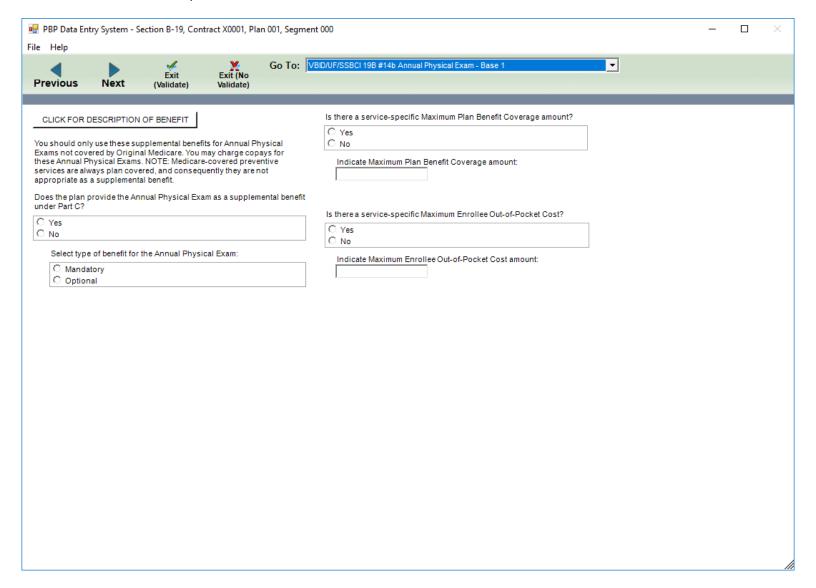
VBID/UF/SSBCI 19B #13i Other 3 Non-Primarily Health Related Benefit – Base 2



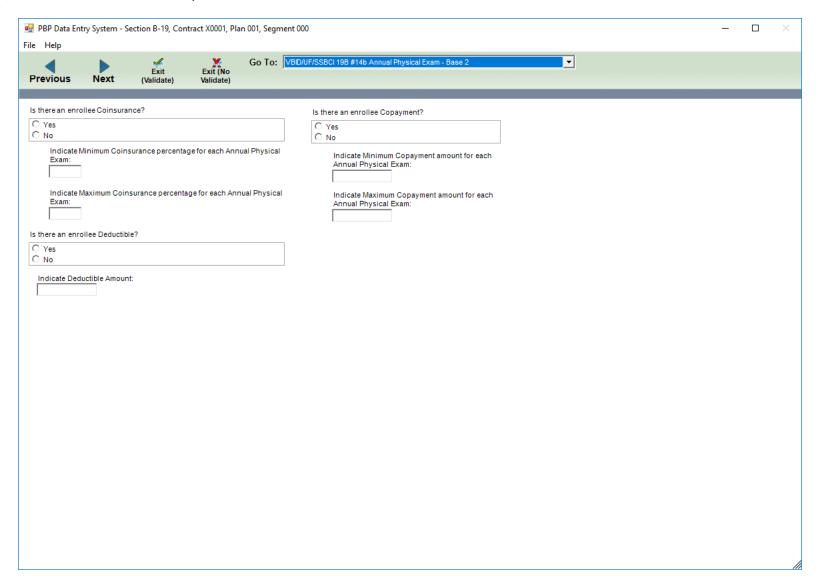
VBID/UF/SSBCI 19B #13i Other 3 Non-Primarily Health Related Benefit – Base 3



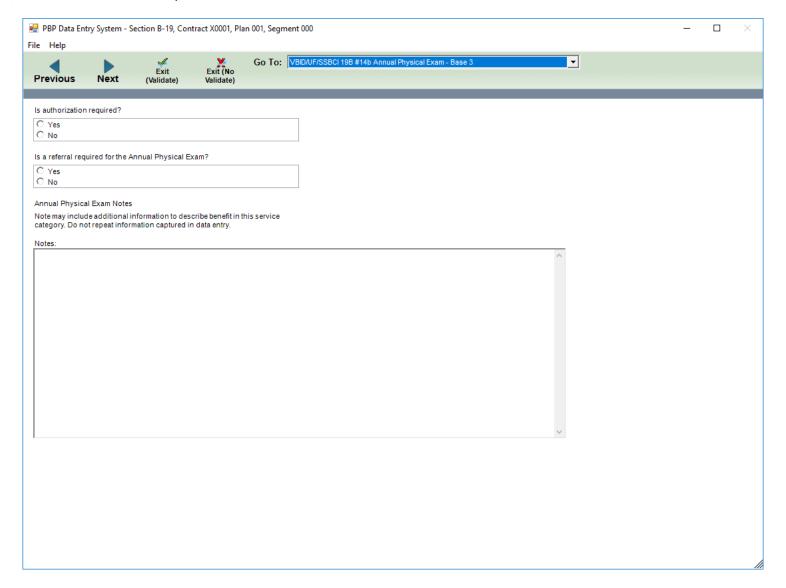
VBID/UF/SSBCI 19B #14b Annual Physical Exam - Base 1

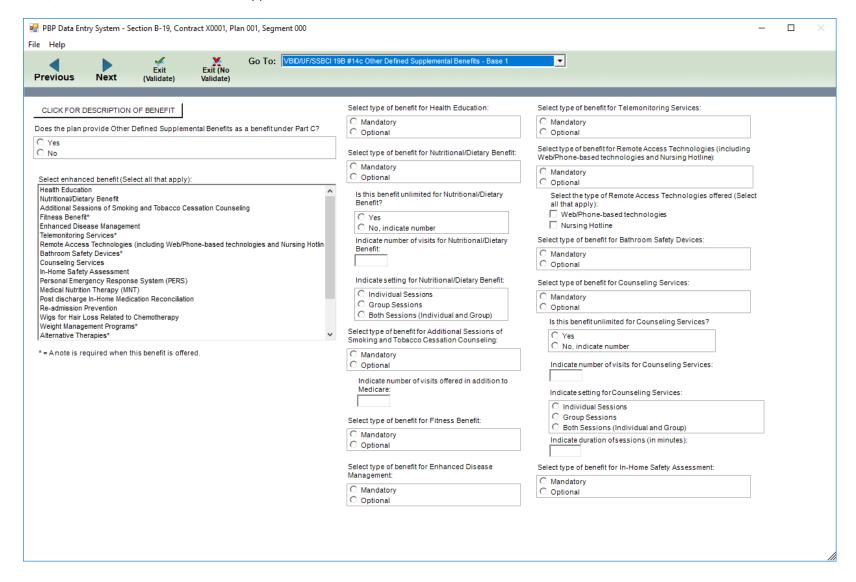


VBID/UF/SSBCI 19B #14b Annual Physical Exam - Base 2



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





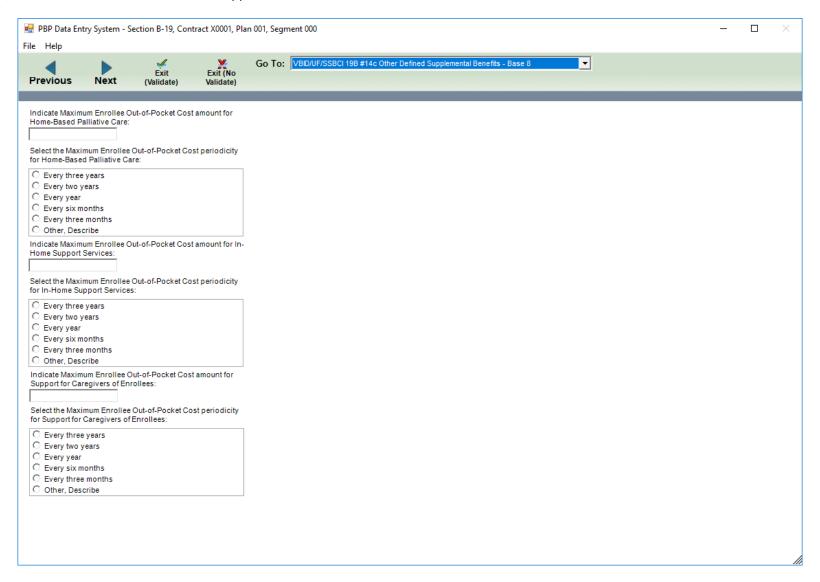
🖳 PBP Data Entry System - Section B-19, Contract X0001, Plan 0	01, Segment 000	×
File Help		
Previous Next (Validate) Exit (No Validate)	Go To: VBID/UF/SSBCI 19B #14c Other Defined Supplemental Benefits - Base 2	
Select type of benefit for Personal Emergency Response System (PERS):	Select type of benefit for Re-admission Prevention:	Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?
C Mandatory C Optional Select type of benefit for Medical Nutrition Therapy (MNT):	C Optional What does your Re-admission Prevention benefit include (check all that apply):	C Yes
C Mandatory C Optional	■ Meals appry). ■ Meals Medication Reconciliation ■ In-Home Safety Assessment	Select type of benefit for Therapeutic Massage: C Mandatory
Do you offer Additional Sessions for Medicare-covered diseases C Yes No	?	C Optional
Indicate the limitfor Additional Sessions: C Visits C Hours	Please describe the Meal benefit included in Re-admission Prevention:	Select type of benefit for Adult Day Health Services: C Mandatory C Optional
Indicate numerical limit on the services provided for Additional Sessions:	How many days does your Meal Benefit last? What is the maximum number of meals the benefit provides?	Select type of benefit for Home-Based Palliative Care:
Do you offer Coverage for Non-Medicare-covered diseases? (Specify the diseases and describe the coverage in the notes fie	Id) Select type of benefit for Wigs for Hair Loss Related to Chemotherapy: C Mandatory O Optional	© Optional Select type of benefit for In-Home Support Services:
Indicate units a limit will be provided in for Coverage for Non-Medicare covered diseases: C Visits	Select type of benefit for Weight Management Programs: C Mandatory C Optional	C Mandatory C Optional
C Hours Indicate numerical limit on the services provided for Coverage for Non-Medicare covered diseases:	Select type of benefit for Alternative Therapies: C Mandatory Optional	Select type of benefit for Support for Caregivers of Enrollees: C Mandatory
Select type of benefit for Post discharge In-Home Medication Reconciliation:	Is this benefit unlimited for Alternative Therapies?	O Optional
C Mandatory C Optional	C Yes C No, indicate number	
	Indicate number of visits offered for Alternative Therapies:	

File Help Previous	Next (Valid	kit late)	Exit (No Validate)	Go To	VBID/UF/SSBCI 19B #14c Other Defined Supplemental Benefits - Ba	se 3		
amount for Othe C Yes C No Select which Oth Maximum Plan E Health Education Nutritional/Dietary Additional Sessic Fitness Benefit Enhanced Diseas Telemonitoring St Remote Access Bathroom Safety Counseling Serv In-Home Safety A Personal Emerge Medical Nutrition Post discharge in Re-admission Price	y Benefit ons of Smoking and Ti see Management ervices Technologies (includir / Devices ices Assessment ency Response Syste Therapy (MNT) h-Home Medication Re evention ss Related to Chemot hent Programs	ntal Benefi	efits have a ct all that apply ssation Counsel	^	Indicate Maximum Plan Benefit Coverage amount for Health Education: Select Maximum Plan Benefit Coverage periodicity for Health Education: C Every three years C Every two years C Every two years C Every six months C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Nutritional/Dietary Benefit: Select Maximum Plan Benefit Coverage periodicity for Nutritional/Dietary Benefit: C Every three years C Every two years C Every two years C Every two months C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Additional Sessions of Smoking and Tobacco Cessation Counseling: Select Maximum Plan Benefit Coverage periodicity for Additional Sessions of Smoking and Tobacco Cessation Counseling: C Every three years C Every three years C Every two years C Every six months C Every six months C Every six months C Every six months C Every three months C Other, Describe	Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit: Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit: C Every three years C Every two years C Every six months C Every three months C Monthly C Other, Describe Indicate Maximum Plan Benefit Coverage amount for Enhanced Disease Management: Select Maximum Plan Benefit Coverage periodicity for Enhanced Disease Management: C Every three years C Every two years C Every six months C Every six months C Every three months O other, Describe Indicate Maximum Plan Benefit Coverage amount for Telemonitoring Services: Select Maximum Plan Benefit Coverage periodicity for Telemonitoring Services: C Every three years C Every three months C Every three months C Every three months C Every three months C Other, Describe		

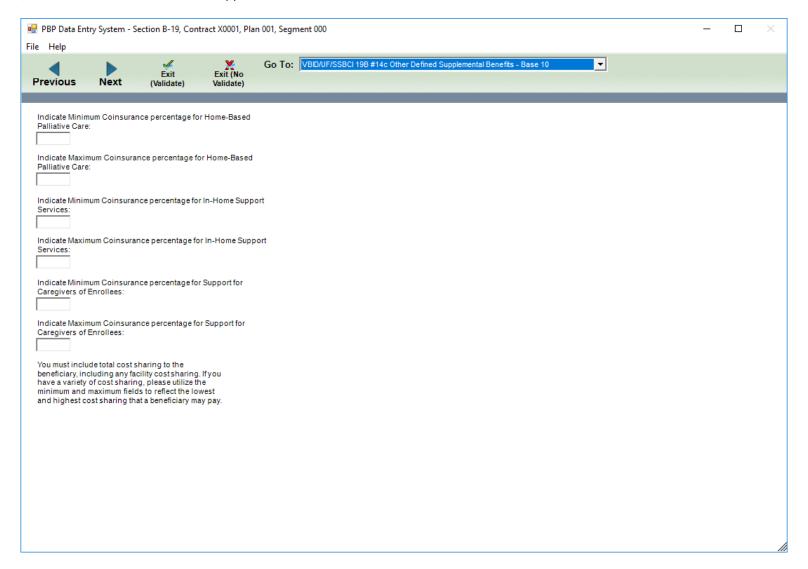
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Indicate Maximum Management Procession of Every three Control Every two your Every three Control Every thr	um Plan Benefit rograms: In Plan Benefit rograms: In Plan Benefit rograms: In Plan Benefit reapies: In Plan Benefit re		validate) unt for Weight unt for Weight unt for dicity for	l	indicate Maximum Plan Benefit Coverage amount for Adult Day lealth Services: Select Maximum Plan Benefit Coverage periodicity for Adult Day lealth Services: Every three years Every two years Every year Every six months Other, Describe Indicate Maximum Plan Benefit Coverage amount for Homelased Palliative Care: Every three years Every two years Every two years Every two years Every two years Every three months Other, Describe Indicate Maximum Plan Benefit Coverage amount for Homelased Palliative Care: Every three years Every two years Every two years Every two years Every three months Other, Describe Every three Maximum Plan Benefit Coverage amount for In-Homelapport Services: Every three years Every three months Other, Describe	for Caregivers of Enrollees: C Every three years Every two years Every year Every six months Other, Describe		

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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits? C Yes C No Select which Other Defined Supplemental Benefits have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply): Health Education Nutritional/Dietary Benefit Additional Sessions of Smoking and Tobacco Cessation Counsel Fitness Benefit Enhanced Disease Management Telemonitoring Services Remote Access Technologies (including Web/Phone-based technologies (Including	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Additional Sessions of Smoking and Tobacco Cessation Counseling: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Additional Sessions of Smoking and Tobacco Cessation Counseling: Every three years Every two years Every six months Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Fitness Benefit: Every three years Every two years Every year Every six months Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Enhanced Disease Management: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Enhanced Disease Management: Every three years Every two pears Every three months Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Telemonitoring Services: Select the Maximum Enrollee Out-of-Pocket Cost amount for Telemonitoring Services: Every three years Every two years Every two years Every two years Every three years Every two years Every two years Every three years Every two years Every two years Every three years Every two years Every three years Every three years Every two years Every three years Every three years Every three months Other, Describe Other, Describe	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Remote Access Technol (including Web/Phone-based technologies and Nursing Hotline): Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline): C Every three years C Every two years C Every two years C Every six months C Every three months C Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Bathroom Safety Devices: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Bathroom Safety Devices: C Every two years C Every two years C Every two years C Every three months C Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Counseling Services: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Counseling Services: C Every three years C Every three years C Every three years C Every three years C Every three months C Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for In-Home Safety Assessment: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for In-Home Safety Assessment: C Every three years 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 Other, Describe	logies			

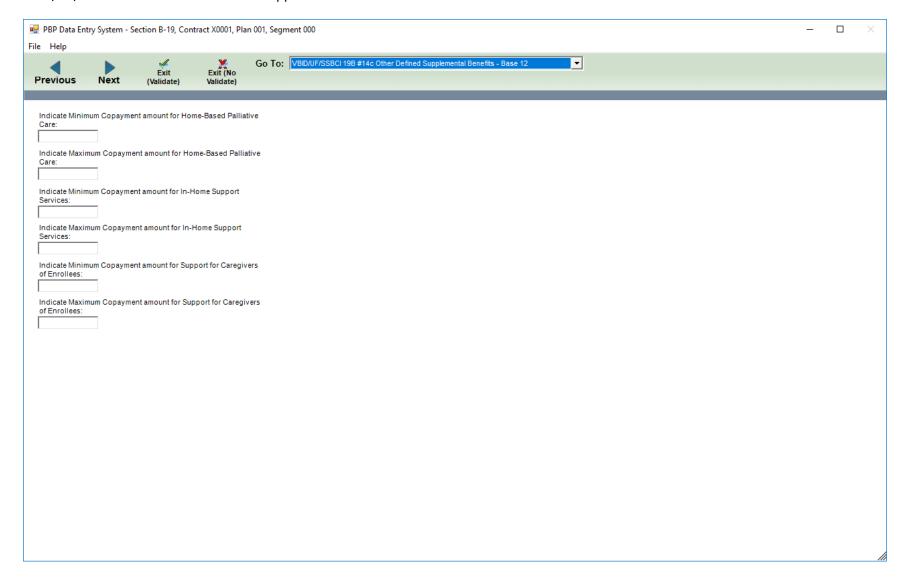
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Indicate Maximum Enrollee Out-of-Pocket Cost amount for Personal Emergency Response System (PERS): Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Personal Emergency Response System (PERS): Every three years Every two years Every two years Every yix months Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medical Nutrition Therapy (MNT): Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medical Nutrition Therapy (MNT): Every three years Every six months Every three months Describe Indicate Maximum Enrollee Out-of-Pocket Cost periodicity for Medical Nutrition Therapy (MNT): Select the Maximum Enrollee Out-of-Pocket Cost amount for Post discharge In-Home Medication Reconciliation: Select the Maximum Enrollee Out-of-Pocket Cost amount for Post discharge In-Home Medication Reconciliation: Every three years Every two years Every three years Every two years Every three years Every three years Every two years Every three years Every three years Every two years Every three years Every two years Every three years Every two years Every six months	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Readmission Prevention: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Re-admission Prevention: C Every three years Every three years Every two years Every six months Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Wigs for Hair Loss Related to Chemotherapy: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Wigs for Hair Loss Related to Chemotherapy: Every three years Every two years Every two years Every two years Devery three months Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Weight Management Programs: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Weight Management Programs: Every three years Every three years Every three years Every two years Every three years Every three years Every two years Every year Every six months	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Alternative Therapies: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Alternative Therapies: C Every three years Every two years Every six months Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Therapeutic Massage: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Therapeutic Massage: Every two years Every three months Other, Describe Indicate Maximum Enrollee Out-of-Pocket Cost amount for Adult Day Health Services: Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Adult Day Health Services: Every three years Every two years Every six months		
C Every three months C Other, Describe	C Every three months C Other, Describe	C Every three months C Other, Describe		

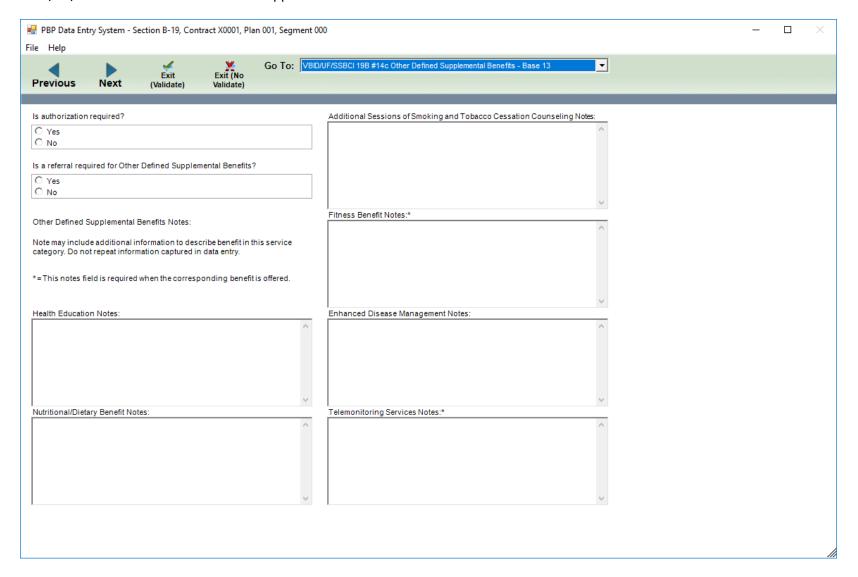


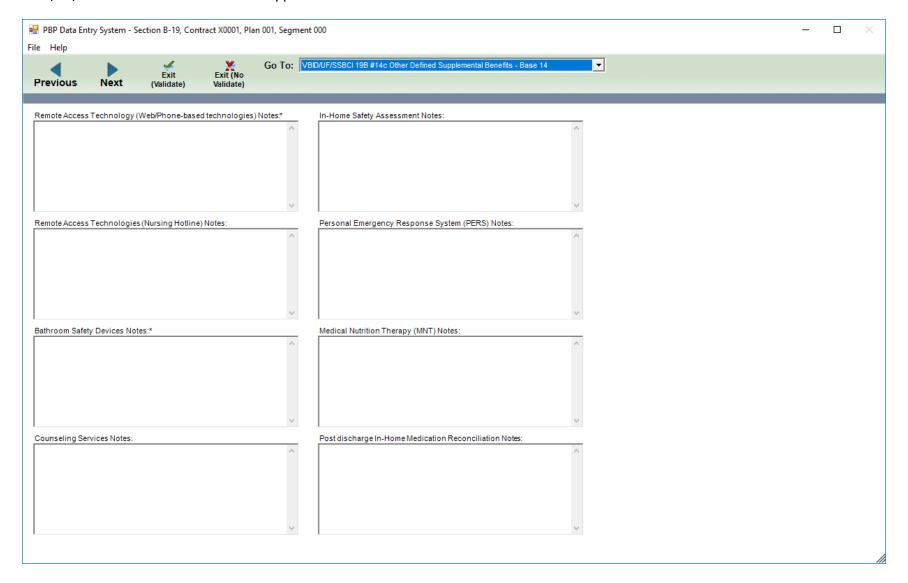
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Is there an enrollee Coinsurance?	Indicate Minimum Coinsurance percentage for Fitness Benefit:	Indicate Minimum Coinsurance percentage for Counseling Services: Indicate Maximum Coinsurance percentage for Counseling Services:	Indicate Minimum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy: Indicate Maximum Coinsurance percentage for Wigs for Hair Loss	
Select which Other Defined Supplemental Benefits have a Coinsurance (Select all that apply): Health Education	indicate nazimum contisulance percentage for raness benefit.	indicate maximum constituting percentage for course imp garvices.	Related to Chemotherapy:	
Nutritional/Dietary Benefit Additional Sessions of Smoking and Tobacco Cessation Counsel 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:	
Telemonitoring Services Remote Access Technologies (including Web/Phone-based techr Bathroom Safety Devices Counseling Services In-Home Safety Assessment	Indicate Maximum Coinsurance percentage for Enhanced Disease Management:	Indicate Maximum Coinsurance percentage for In-Home Safety Assessment: Indicate Minimum Coinsurance percentage for Personal	Indicate Maximum Coinsurance percentage for Weight Management Programs:	
REPORT OF THE PROPERTY OF T	Indicate Minimum Coinsurance percentage for Telemonitoring Services:	Emergency Response System (PERS):	Indicate Minimum Coinsurance percentage for Alternative Therapies:	
Wigs for Hair Loss Related to Chemotherapy Indicate Minimum Coinsurance percentage for Health Education:	Indicate Maximum Coinsurance percentage for Telemonitoring Services:	Emergency Response System (PERS): Indicate Minimum Coinsurance percentage for Medical Nutrition	Indicate Maximum Coinsurance percentage for Alternative Therapies:	
Indicate Maximum Coinsurance percentage for Health Education:	Indicate Minimum Coinsurance percentage for Remote Access Technologies (Web/Phone-based technologies):	Therapy (MNT):	Indicate Minimum Coinsurance percentage for Therapeutic Massage:	
Indicate Minimum Coinsurance percentage for Nutritional/Dietary	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Web/Phone-based technologies):	Indicate Maximum Coinsurance percentage for Medical Nutrition Therapy (MNT):	Indicate Maximum Coinsurance percentage for Therapeutic Massage:	
Benefit: Indicate Maximum Coinsurance percentage for Nutritional/Dietary	Indicate Minimum Coinsurance percentage for Remote Access Technologies (Nursing Hotline):	Indicate Minimum Coinsurance percentage for Post discharge In-Home Medication Reconciliation:	Indicate Minimum Coinsurance percentage for Adult Day Health Services:	
Benefit:	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Nursing Hotline):	Indicate Maximum Coinsurance percentage for Post discharge In-Home Medication Reconciliation:	Indicate Maximum Coinsurance percentage for Adult Day Health Services:	
Indicate Minimum Coinsurance percentage for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Indicate Minimum Coinsurance percentage for Bathroom Safety Devices:	Indicate Minimum Coinsurance percentage for Re-admission Prevention:		
Indicate Maximum Coinsurance percentage for Additional Sessions of Smoking and Tobacco Cessation Counseling.	Indicate Maximum Coinsurance percentage for Bathroom Safety Devices:	Indicate Maximum Coinsurance percentage for Re-admission Prevention:		

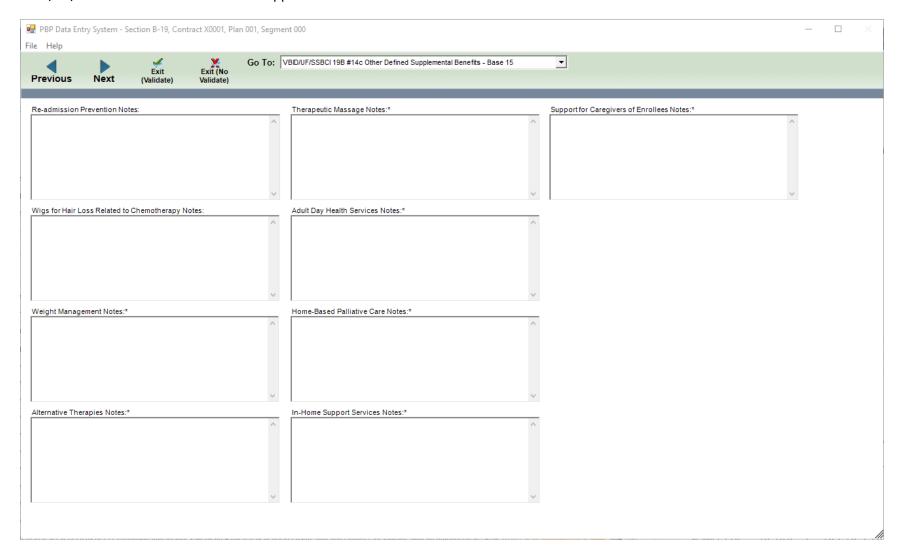


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Is there an enrollee Deductible? C Yes C No	Indicate Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Indicate Minimum Copayment amount for Bathroom Safety Devices:	Indicate Minimum Copayment amount for Re-admission Prevention:		
Indicate Deductible 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 enrollee Copayment? C Yes C No	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 Other Defined Supplemental Benefits have a Copayment (Select all that apply): Health Education	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:		
Nutritional/Dietary Benefit Additional Sessions of Smoking and Tobacco Cessation Counsel Fitness Benefit Enhanced Disease Management	Indicate Minimum Copayment amount for Enhanced Disease Management:	Indicate Minimum Copayment amount for In-Home Safety Assessment:	Indicate Minimum Copayment amount for Weight Management Programs:		
Telemonitoring Services Remote Access Technologies (including Web/Phone-based techn Bathroom Safety Devices Counseling Services	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:		
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:		
Re-admission Prevention Wigs for Hair Loss Related to Chemotherapy Weight Management Programs Alternative Therapies	Indicate Maximum Copayment amount for Telemonitoring Services:	Indicate Maximum Copayment amount for Personal Emergency Response System (PERS):	Indicate Maximum Copayment amount for Alternative Therapies:		
Indicate Minimum Copayment amount for Health Education:	Indicate Minimum Copayment amount for Remote Access Technologies (Web/Phone-based technologies):	Indicate Minimum Copayment amount for Medical Nutrition Therapy (MNT):	Indicate Minimum Copayment amount for Therapeutic Massage:		
Indicate Maximum Copayment amount for Health Education:	Indicate Maximum Copayment amount for Remote Access Technologies (WebiPhone-based technologies):	Indicate Maximum Copayment amount for Medical Nutrition Therapy (MNT):	Indicate Maximum Copayment amount for Therapeutic Massage:		
Indicate Minimum Copayment amount for Nutritional/Dietary Benef	Indicate Minimum Copayment amount for Remote Access Technologies (Nursing Hotline):	Indicate Minimum Copayment amount for Post discharge In-Home Medication Reconciliation:	Indicate Minimum Copayment amount for Adult Day Health Services:		
Indicate Maximum Copayment amount for Nutritional/Dietary Bene	Indicate Maximum Copayment amount for Remote Access Technologies (Nursing Hotline):	Indicate Maximum Copayment amount for Post discharge In-Home Medication Reconciliation:	Indicate Maximum Copayment amount for Adult Day Health Services:		

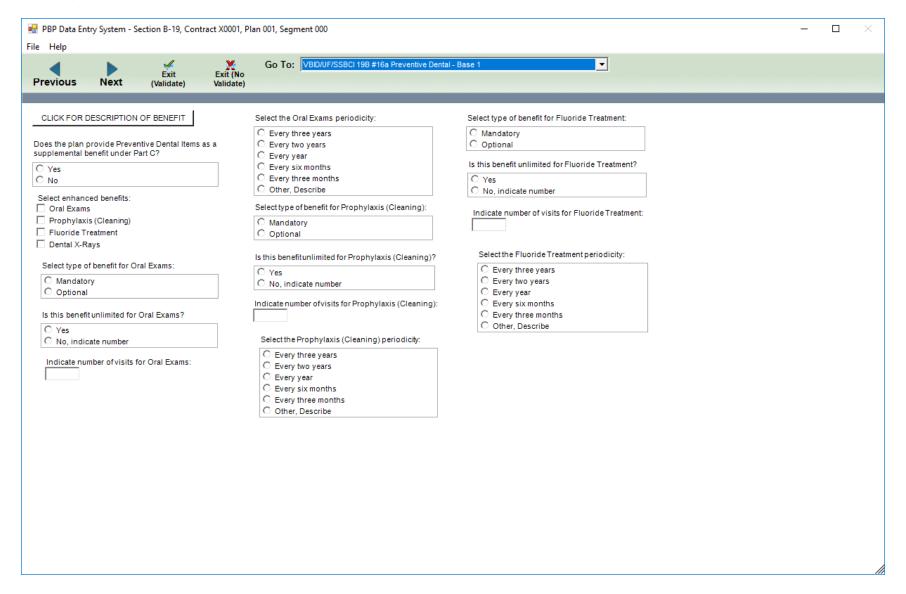




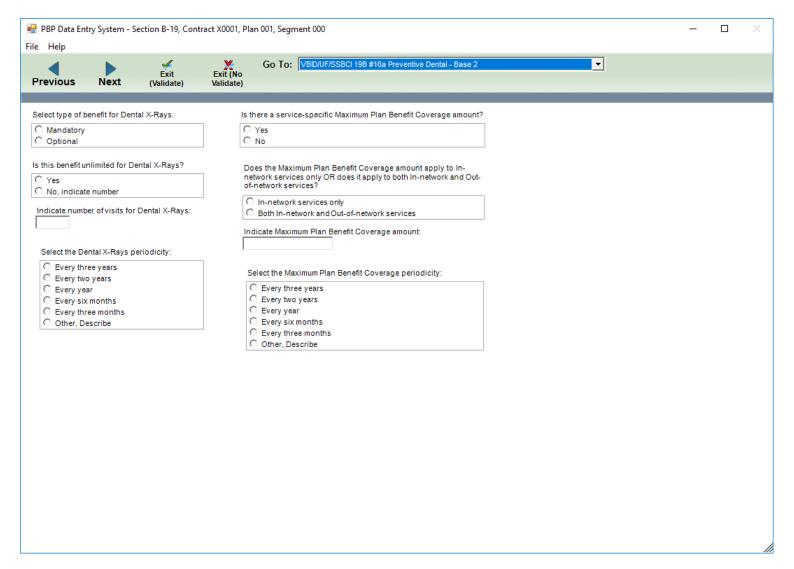




VBID/UF/SSBCI 19B #16a Preventive Dental - Base 1

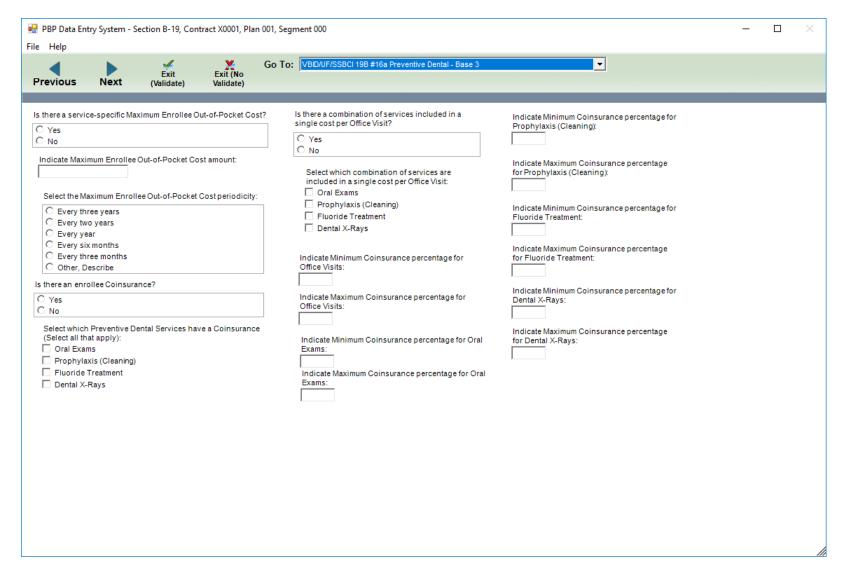


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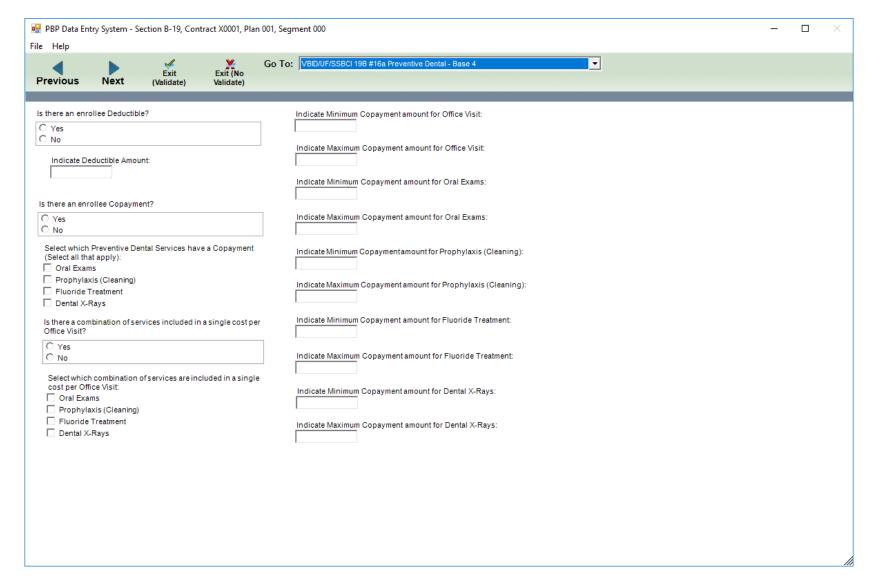


CY 2020 PBP Data Entry System Screens

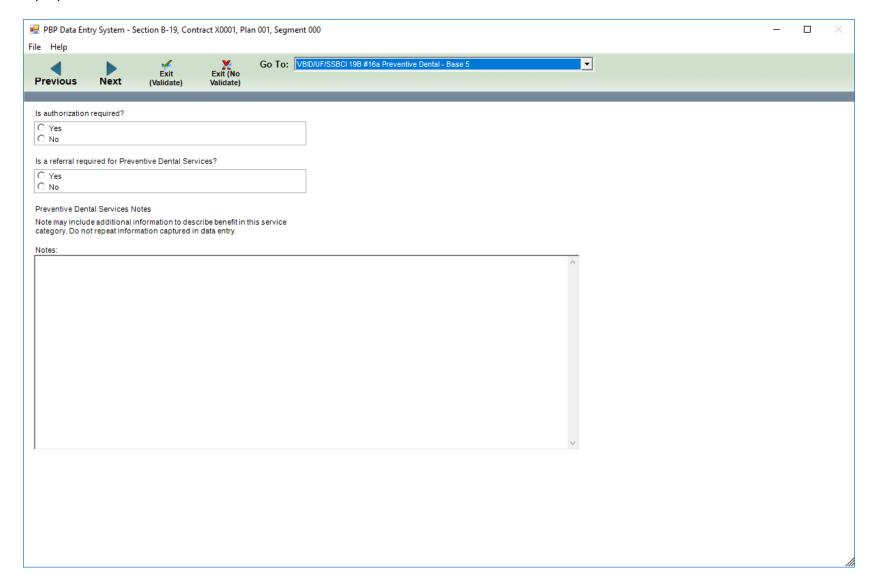
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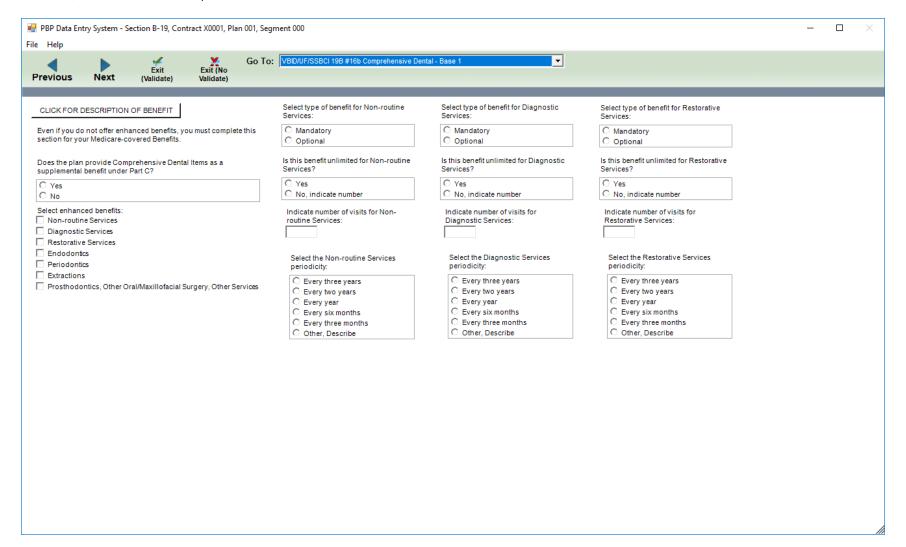
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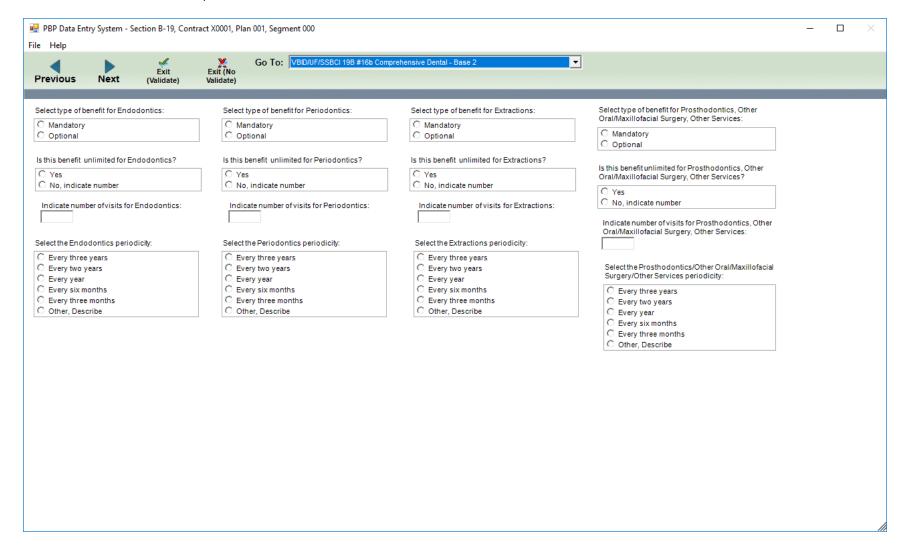
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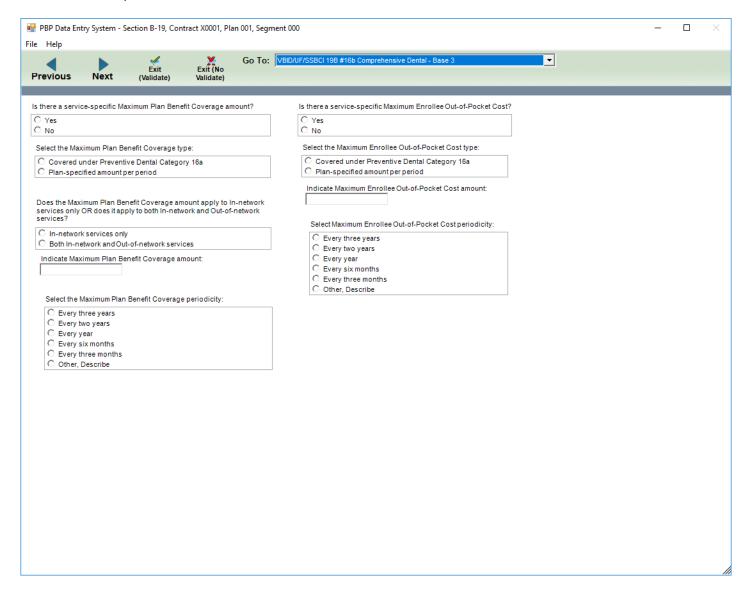


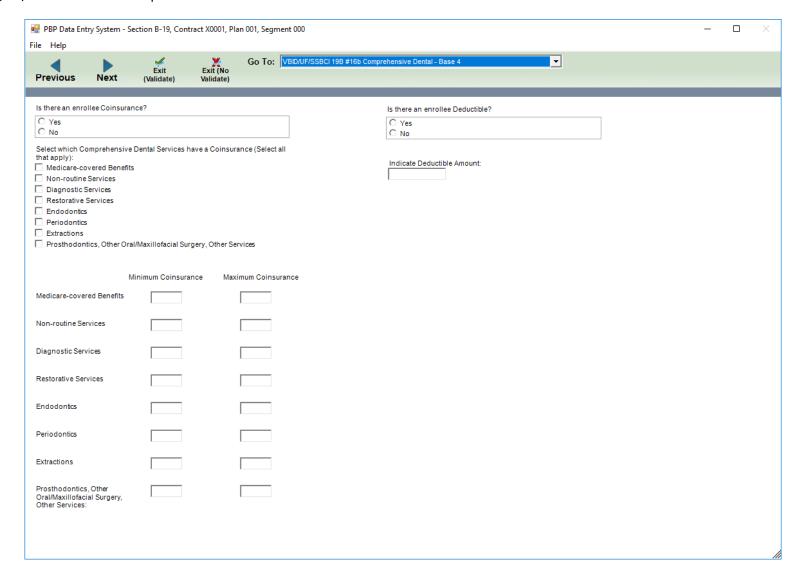
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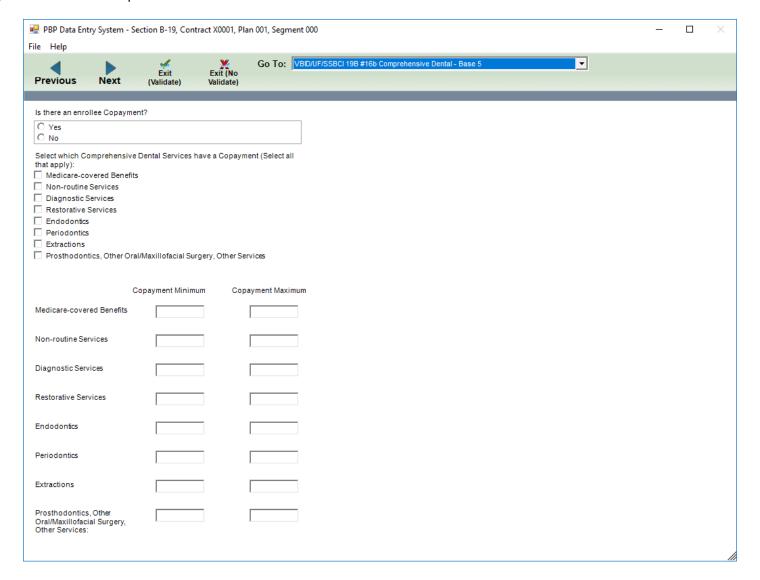


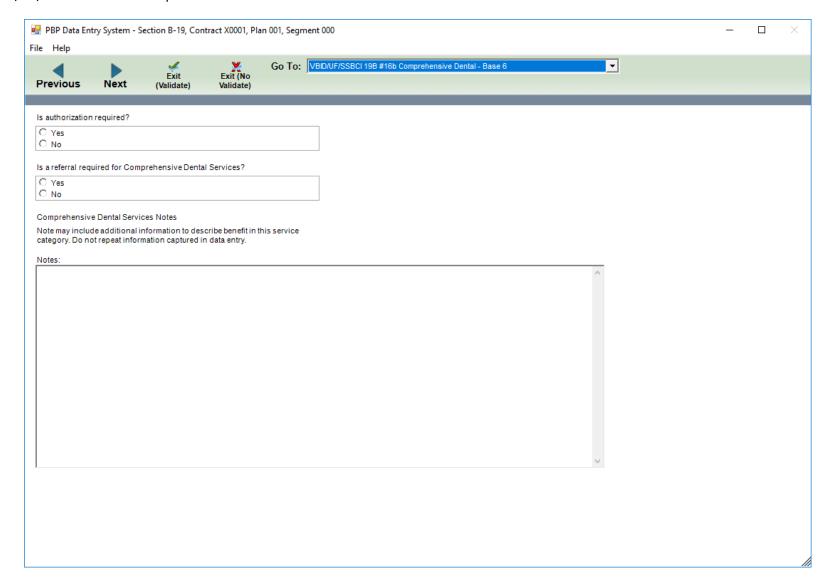
CY 2020 PBP Data Entry System Screens



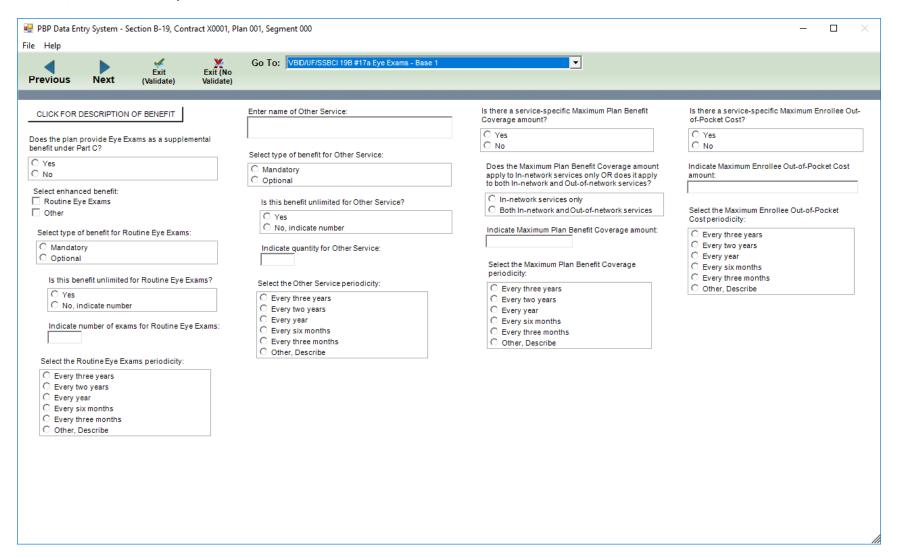




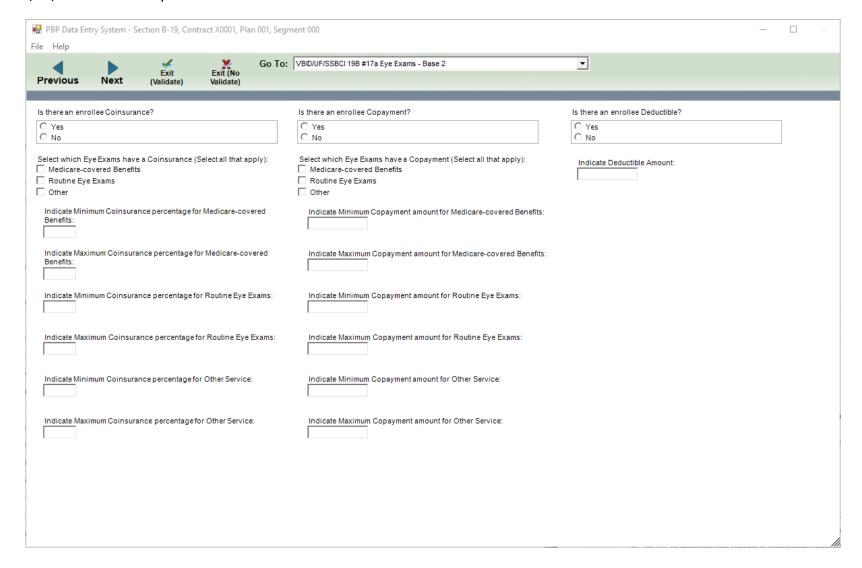




VBID/UF/SSBCI 19B #17a Eye Exams - Base 1



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



VBID 19B #17a Eye Exams - Base 3

