

CY 2020 PBP Data Entry System Screens

Plan Deductible LPPO/RPPO Base 1

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

File Help

Go To: Plan Deductible LPPO/RPPO Base 1

Previous Next Exit (Validate) Exit (No Validate)

Do you offer a Deductible?
 Yes
 No

What is the amount of your Deductible?
 Medicare-Defined Part A Deductible amount
 Medicare-Defined Part B Deductible amount
 Medicare-Defined Part A and B Deductible amount combined as a single deductible
 Other, Indicate amount

Indicate Deductible Amount:

How is your combined Medicare-defined Part A and B Deductible applied?
 Single Deductible
Differentially applied to Part A and Part B
 Medicare services, reflecting Original Medicare payment structure.

LPPO and RPPO plans must include ALL OON Medicare-covered Services in the Deductible; 14a preventive services may not be included in the In-Network deductible. If the plan chooses to use the 2020 Original Medicare amounts, please verify that any differential deductibles that are selected will not exceed the 2020 Original Medicare amounts that will be released by CMS.

Do you include 14a Medicare-covered Zero Dollar Preventive Services as part of your OON Medicare-covered Services Deductible?
 Yes
 No

Select the Service Categories that apply to your Deductible (Optional):
 In-Network Medicare-covered benefits
 In-Network Non-Medicare-covered benefits
 Out-of-Network Non-Medicare-covered benefits

Does the Deductible apply to all In-Network Medicare-covered benefits?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the In-Network Medicare-covered Service Categories to which the Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e: Mental Health Specialty Services

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Plan Deductible LPPO/RPPO Base 2

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

File Help

Go To: Plan Deductible LPPO/RPPO Base 2

Previous Next Exit (Validate) Exit (No Validate)

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Does the Deductible apply to all In-Network Non-Medicare-covered benefits?

Yes
 No

Select all of the In-Network Non-Medicare-covered Service Categories to which the Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services
- 10b: Transportation Services
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 13g: Dual Eligible SNPs with Highly Integrated Services
- 14b: Annual Physical Exam
- 14c: Other Defined Supplemental Benefits
- 15: Medicare Part B Rx Drugs
- 16a: Preventive Dental
- 16b: Comprehensive Dental
- 17a: Eye Exams
- 17b: Eyewear

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Does the Deductible apply to all Out-of-Network Non-Medicare-covered benefits?

Yes
 No

Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services
- 10b: Transportation Services
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 13g: Dual Eligible SNPs with Highly Integrated Services
- 14b: Annual Physical Exam
- 14c: Other Defined Supplemental Benefits
- 15: Medicare Part B Rx Drugs
- 16a: Preventive Dental
- 16b: Comprehensive Dental
- 17a: Eye Exams
- 17b: Eyewear

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Plan Deductible LPPO/RPPO Base 3

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

File Help

Go To: Plan Deductible LPPO/RPPO Base 3

Previous Next Exit (Validate) Exit (No Validate)

Do you have differential service category-level deductibles in addition to your In-Network Plan-level Deductible?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Service Categories to which the differential deductibles apply:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3: Cardiac and Pulmonary Rehabilitation Services
- 4c: Worldwide Emergency/Urgent Coverage
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e: Mental Health Specialty Services
- 7f: Podiatry Services
- 7g: Other Health Care Professional
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 7j: Additional Telehealth Services
- 7k: Opioid Treatment Services
- 8a: Diagnostic Procedures/Tests/Lab Services
- 8b: Outpatient Diagnostic/Therapeutic Radiological Services
- 9a1: Outpatient Hospital Services
- 9a2: Observation Services

CY 2020 PBP Data Entry System Screens

Plan Deductible LPPO/RPPO Base 4

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

File Help

Go To: Plan Deductible LPPO/RPPO Base 4

Previous Next Exit (Validate) Exit (No Validate)

Indicate Differential Deductible Amounts for Inpatient Hospital -Acute Services Tiers 1, 2, and 3, where appropriate: <input type="text"/> <input type="text"/> <input type="text"/>	Indicate Differential Deductible Amount for Cardiac and Pulmonary Rehabilitation Services: <input type="text"/>	Note: No single Differential Deductible can be greater than the deductible. The total of all of the Differential Deductibles can be greater than the deductible.
Indicate Differential Deductible Amounts for Inpatient Hospital Psychiatric Services Tiers 1, 2, and 3, where appropriate: <input type="text"/> <input type="text"/> <input type="text"/>	Indicate Differential Deductible Amount for Worldwide Emergency/Urgent Coverage: <input type="text"/>	
Indicate Differential Deductible Amounts for Skilled Nursing Facility (SNF) including Tiers 1, 2, and 3, where appropriate: <input type="text"/> <input type="text"/> <input type="text"/>	Indicate Differential Deductible Amount for Partial Hospitalization: <input type="text"/>	
	Indicate Differential Deductible Amount for Home Health Services: <input type="text"/>	
	Indicate Differential Deductible Amount for Primary Care Physician Services: <input type="text"/>	
	Indicate Differential Deductible Amount for Chiropractic Services: <input type="text"/>	
	Indicate Differential Deductible Amount for Occupational Therapy Services: <input type="text"/>	
	Indicate Differential Deductible Amount for Physician Specialist Services: <input type="text"/>	

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Plan Deductible LPPO/RPPO Base 5

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

File Help

Go To: Plan Deductible LPPO/RPPO Base 5

Previous
Next
Exit (Validate)
Exit (No Validate)

Indicate Differential Deductible Amount for Mental Health Specialty Services - Non-Psychiatric: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Outpatient Diagnostic and Therapeutic Radiological Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Ground Ambulance Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Dialysis Services: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Podiatry Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Outpatient Hospital Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Air Ambulance Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Acupuncture: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Other Health Care Professional Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Observation Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Transportation Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for OTC: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Psychiatric Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Ambulatory Surgical Center (ASC) Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Durable Medical Equipment (DME): <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Meal Benefit: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Physical Therapy and Speech-Language Pathology Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Outpatient Substance Abuse: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Prosthetics/Medical Supplies: <input style="width: 100%;" type="text"/>	
Indicate Differential Deductible Amount for Additional Telehealth Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Outpatient Blood Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Diabetic Supplies and Services: <input style="width: 100%;" type="text"/>	
Indicate Differential Deductible Amount for Opioid Treatment Services: <input style="width: 100%;" type="text"/>			
Indicate Differential Deductible Amount for Outpatient Diagnostic Procedures and Test and Lab Services: <input style="width: 100%;" type="text"/>			

CY 2020 PBP Data Entry System Screens

Plan Deductible LPPO/RPPO Base 6

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

File Help

◀ Previous
Next ▶
✓ Exit (Validate)
✗ Exit (No Validate)
Go To: Plan Deductible LPPO/RPPO Base 6

Indicate Differential Deductible Amount for Other 1: <input type="text"/>	Indicate Differential Deductible Amount for Kidney Disease Education Services: <input type="text"/>	Indicate Differential Deductible Amount for Other Medicare-covered Preventive Services: <input type="text"/>	Indicate Differential Deductible Amount for Hearing Exams: <input type="text"/>
Indicate Differential Deductible Amount for Other 2: <input type="text"/>	Indicate Differential Deductible Amount for Medicare-covered Glaucoma Screening Services: <input type="text"/>	Indicate Differential Deductible Amount for Medicare Part B Rx Drugs: <input type="text"/>	Indicate Differential Deductible Amount for Hearing Aids: <input type="text"/>
Indicate Differential Deductible Amount for Other 3: <input type="text"/>	Indicate Differential Deductible Amount for Medicare-covered Diabetes Self-management Training: <input type="text"/>	Indicate Differential Deductible Amount for Preventive Dental: <input type="text"/>	
Indicate Differential Deductible Amount for Dual Eligible SNPs with Highly Integrated Services: <input type="text"/>	Indicate Differential Deductible Amount for Medicare-covered Barium Enemas: <input type="text"/>	Indicate Differential Deductible Amount for Comprehensive Dental: <input type="text"/>	
Indicate Differential Deductible Amount for the Annual Physical Exam: <input type="text"/>	Indicate Differential Deductible Amount for Medicare-covered Digital Rectal Exams: <input type="text"/>	Indicate Differential Deductible Amount for Eye Exams: <input type="text"/>	
Indicate Differential Deductible Amount for Eligible Supplemental Benefits as Defined in Chapter 4: <input type="text"/>	Indicate Differential Deductible Amount for Medicare-covered EKG following Welcome Visit: <input type="text"/>	Indicate Differential Deductible Amount for Eyewear: <input type="text"/>	

CY 2020 PBP Data Entry System Screens

Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 1

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

File Help

Go To: Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 1

Do you offer a mandatory enhanced benefit enrollee deductible amount?

Yes
 No

Select the mandatory enhanced benefits that have an enrollee deductible:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3: Cardiac and Pulmonary Rehabilitation Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services
- 10b: Transportation Services
- 13a: Acupuncture
- 13c: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13c: Other 1
- 13c: Other 2

Indicate deductible for one or more of the following services	Deductible Amount
Inpatient Hospital-Acute	<input type="text"/>
Inpatient Hospital Psychiatric	<input type="text"/>
Skilled Nursing Facility (SNF)	<input type="text"/>
Cardiac and Pulmonary Rehabilitation Services	<input type="text"/>
Worldwide Emergency/Urgent Coverage	<input type="text"/>
Chiropractic Services	<input type="text"/>
Podiatry Services - Routine Foot Care	<input type="text"/>
Outpatient Blood Services	<input type="text"/>
Transportation Services	<input type="text"/>
Acupuncture	<input type="text"/>
Over-the-Counter (OTC) Items	<input type="text"/>
Meal Benefit	<input type="text"/>

CY 2020 PBP Data Entry System Screens

Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 2

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

File Help

Go To: Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 2

Previous Next Exit (Validate) Exit (No Validate)

Indicate deductible for one or more of the following services

	Deductible Amount
Other 1	<input type="text"/>
Other 2	<input type="text"/>
Other 3	<input type="text"/>
Dual Eligible SNP with Highly Integrated Services	<input type="text"/>
Annual Physical Exam	<input type="text"/>
Eligible Supplemental Benefits as Defined in Chapter 4	<input type="text"/>
Preventive Dental	<input type="text"/>
Comprehensive Dental	<input type="text"/>
Eye Exams	<input type="text"/>
Eyewear	<input type="text"/>
Hearing Exams	<input type="text"/>
Hearing Aids	<input type="text"/>

CY 2020 PBP Data Entry System Screens

Plan Deductible (In-Network)

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

File Help

Go To: Plan Deductible (In-Network)

Previous Next Exit (Validate) Exit (No Validate)

Is there an In-Network Plan Deductible?
 Yes
 No

Do you charge the Medicare-defined Part B Deductible amount?
 Yes
 No

Indicate In-Network Plan Deductible Amount:

Select the benefits that apply to the In-Network Deductible:
 In-Network Medicare-covered benefits
 In-Network Non-Medicare-covered benefits

Does the In-Network Deductible apply to all In-Network Medicare-covered plan services?
 Yes
 No

Does the In-Network Deductible apply to all In-Network Non-Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the In-Network Medicare-covered Service Categories to which the In-Network Plan Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the In-Network Non-Medicare-covered Service Categories to which the In-Network Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c: Worldwide Emergency/Urgent Coverage
- 6: Home Health Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7f: Podiatry Services

CY 2020 PBP Data Entry System Screens

Plan Deductible (Combined) – Base 1

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

File Help

Go To: Plan Deductible (Combined) - Base 1

Previous Next Exit (Validate) Exit (No Validate)

Is there a Combined (In-Network and Out-of-Network) Deductible?
 Yes
 No

Do you charge the Medicare-defined Part B Deductible amount?
 Yes
 No

Indicate Combined (In-Network and Out-of-Network) Deductible Amount:

Select the benefits that apply to the Combined Deductible:
 In-Network Medicare-covered benefits
 In-Network Non-Medicare-covered benefits
 Out-of-Network Medicare-covered benefits
 Out-of-Network Non-Medicare-covered benefits

Does the Combined Deductible apply to all In-Network Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the In-Network Medicare-covered Service Categories to which the Combined Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 5: Partial Hospitalization

Does the Combined Deductible apply to all In-Network Non-Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the In-Network Non-Medicare-covered Service Categories to which the Combined Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services
- 10b: Transportation Services

CY 2020 PBP Data Entry System Screens

Plan Deductible (Combined) – Base 2

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons. A "Go To:" dropdown menu is set to "Plan Deductible (Combined) - Base 2".

There are two main question areas, each with a "Yes" and "No" radio button option:

- Left Question:** "Does the Combined Deductible apply to all Out-Of-Network Medicare-covered plan services?"
- Right Question:** "Does the Combined Deductible apply to all Out-Of-Network Non-Medicare-covered plan services?"

Below each question is a text instruction: "Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard."

Each question is followed by a list of service categories to be selected:

- Left List (Medicare-covered):** 1a: Inpatient Hospital-Acute, 1b: Inpatient Hospital Psychiatric, 2: Skilled Nursing Facility (SNF), 3-1: Cardiac Rehabilitation Services, 3-2: Intensive Cardiac Rehabilitation Services, 3-3: Pulmonary Rehabilitation Services, 3-4: SET for PAD Services, 5: Partial Hospitalization, 6: Home Health Services, 7a: Primary Care Physician Services, 7b: Chiropractic Services, 7c: Occupational Therapy Services, 7d: Physician Specialist Services, 7e: Mental Health Specialty Services, 7f: Podiatry Services, 7g: Other Health Care Professional, 7h: Psychiatric Services, 7i: Physical Therapy and Speech-Language Pathology Services, 7j: Additional Telehealth Services, 7k: Opioid Treatment Services, 8a: Diagnostic Procedures/Tests/Lab Services, 8b1: Diagnostic Radiological Services.
- Right List (Non-Medicare-covered):** 1a: Inpatient Hospital-Acute, 1b: Inpatient Hospital Psychiatric, 2: Skilled Nursing Facility (SNF), 3-1: Cardiac Rehabilitation Services, 3-2: Intensive Cardiac Rehabilitation Services, 3-3: Pulmonary Rehabilitation Services, 3-4: SET for PAD Services, 4c: Worldwide Emergency/Urgent Coverage, 7b: Chiropractic Services, 7f: Podiatry Services, 9d: Outpatient Blood Services, 10b: Transportation Services, 13a: Acupuncture, 13b: Over-the-Counter (OTC) Items, 13c: Meal Benefit, 13d: Other 1, 13e: Other 2, 13f: Other 3, 13g: Dual Eligible SNPs with Highly Integrated Services, 14b: Annual Physical Exam, 14c: Other Defined Supplemental Benefits, 15: Medicare Part B Rx Drugs.

CY 2020 PBP Data Entry System Screens

Plan Deductible (Out-of-Network)

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: Plan Deductible (Out-of-Network)

Is there an Out-of-Network (OON) Plan Deductible?

Yes
 No

Do you charge the Medicare-defined Part B Deductible amount? Indicate Out-of-Network Plan Deductible Amount:

Yes
 No

Select the benefits that apply to the Out-of-Network Deductible:

Out-of-Network Medicare-covered benefits
 Out-of-Network Non-Medicare-covered benefits

Does the Out-of-Network Deductible apply to all Out-of-Network Medicare-covered plan services?

Yes
 No

Does the Out-of-Network Deductible apply to all Out-of-Network Non-Medicare-covered plan services?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Out-of-Network Medicare-covered Service Categories to which the Out-of-Network Plan Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Out-of-Network Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services
- 10b: Transportation Services

CY 2020 PBP Data Entry System Screens

Plan Deductible (Non-Network)

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

File Help

Go To: Plan Deductible (Non-Network)

Previous Next Exit (Validate) Exit (No Validate)

Is there a Plan Deductible?
 Yes
 No

Do you charge the Medicare-defined Part B Deductible amount?
 Yes
 No

Indicate Plan Deductible Amount:

Select the benefits that apply to the Deductible:
 Medicare-covered benefits
 Non-Medicare-covered benefits

Does the Deductible apply to all Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Medicare-covered Service Categories to which the Plan Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services

Does the Deductible apply to all Non-Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Non-Medicare-covered Service Categories to which the Deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services
- 10b: Transportation Services

CY 2020 PBP Data Entry System Screens

Max Enrollee Cost Limit (In-Network)

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

File Help

Go To: Max Enrollee Cost Limit (In-Network)

Previous Next Exit (Validate) Exit (No Validate)

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?

Yes
 No

Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?

Voluntary
 Mandatory

All MA plans must have a maximum out-of-pocket (MOOP) that covers all A/B services. For a list of the Voluntary and Mandatory Limits, please right-click on the "Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level?" question and view the Variable Help.

Note for D-SNPs: For purposes of submitting bids to CMS, D-SNPs must include Parts A, B, and Part D Medicare services in the PBP, along with approved optional and mandatory supplemental benefits. No Medicaid benefits may be included in the PBP. D-SNPs have the flexibility to establish \$0 as the MOOP amount, thereby guaranteeing there is no cost sharing for plan enrollees, including those who are liable for Medicare cost sharing. Otherwise, if the D-SNP does charge cost sharing for Medicare-covered services (or non-covered), it must track enrollees' out-of-pocket spending and it is up to the plan to develop the process and vehicle for doing so.

Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:

Note: For Regional PPOs, all Medicare Part A/B services must be included in the Maximum Enrollee Out-of-Pocket Cost.

Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits
 In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4a: Emergency Care/Post-Stabilization Care
- 4b: Urgently Needed Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the In-Network Non-Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c: Worldwide Emergency/Urgent Coverage
- 6: Home Health Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services

CY 2020 PBP Data Entry System Screens

Max Enrollee Cost Limit (Combined) – Base 1

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

File Help

Go To: Max Enrollee Cost Limit (Combined) - Base 1

Previous Next Exit (Validate) Exit (No Validate)

Is there a Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost?

Yes
 No

Is your Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost at the Voluntary or Mandatory Level? (Network PFFS plans only)

Voluntary
 Mandatory

All MA plans must have a maximum out-of-pocket (MOOP) that covers all A/B services. For a list of the Voluntary and Mandatory Limits, please right-click on the "Is your Combined Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level?" question and view the Variable Help.

Note for D-SNPs: For purposes of submitting bids to CMS, D-SNPs must include Parts A, B, and Part D Medicare services in the PBP, along with approved optional and mandatory supplemental benefits. No Medicaid benefits may be included in the PBP. D-SNPs have the flexibility to establish \$0 as the MOOP amount, thereby guaranteeing there is no cost sharing for plan enrollees, including those who are liable for Medicare cost sharing. Otherwise, if the D-SNP does charge cost sharing for Medicare-covered services (or non-covered), it must track enrollees' out-of-pocket spending and it is up to the plan to develop the process and vehicle for doing so.

Indicate Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost Amount:

Select the benefits that apply to the Combined Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits
 In-Network Non-Medicare-covered benefits
 Out-of-Network Medicare-covered benefits
 Out-of-Network Non-Medicare-covered benefits

Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the Combined Maximum Enrollee Out-of-Pocket Cost Amount:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4a: Emergency Care/Post-Stabilization Care
- 4b: Urgently Needed Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services

Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the In-Network Non-Medicare-covered Service Categories that are INCLUDED in the Combined Maximum Enrollee Out-of-Pocket Cost Amount:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services
- 10b: Transportation Services

CY 2020 PBP Data Entry System Screens

Max Enrollee Cost Limit (Combined) – Base 2

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons. A "Go To:" dropdown menu is set to "Max Enrollee Cost Limit (Combined) – Base 2".

Instructions: All MA plans must have a maximum out-of-pocket (MOOP) that covers all A/B services. For a list of the Voluntary and Mandatory Limits, please right-click on the "Is your Combined Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level?" question and view the Variable Help.

Two questions are presented side-by-side:

- Left Question:** Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Medicare-covered plan services?
 Yes
 No
- Right Question:** Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Non-Medicare-covered plan services?
 Yes
 No

Both questions include instructions: "Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard."

Below each question is a list of service categories to be selected:

- Left List (Medicare-covered):** Select all of the Out-of-Network Medicare-covered Service Categories that are INCLUDED in the Combined Maximum Enrollee Out-of-Pocket Cost Amount:
 - 1a: Inpatient Hospital-Acute
 - 1b: Inpatient Hospital Psychiatric
 - 2: Skilled Nursing Facility (SNF)
 - 3-1: Cardiac Rehabilitation Services
 - 3-2: Intensive Cardiac Rehabilitation Services
 - 3-3: Pulmonary Rehabilitation Services
 - 3-4: SET for PAD Services
 - 5: Partial Hospitalization
 - 6: Home Health Services
 - 7a: Primary Care Physician Services
 - 7b: Chiropractic Services
 - 7c: Occupational Therapy Services
 - 7d: Physician Specialist Services
- Right List (Non-Medicare-covered):** Select all of the Out-of-Network Non-Medicare-covered Service Categories that are INCLUDED in the Combined Maximum Enrollee Out-of-Pocket Cost Amount:
 - 1a: Inpatient Hospital-Acute
 - 1b: Inpatient Hospital Psychiatric
 - 2: Skilled Nursing Facility (SNF)
 - 3-1: Cardiac Rehabilitation Services
 - 3-2: Intensive Cardiac Rehabilitation Services
 - 3-3: Pulmonary Rehabilitation Services
 - 3-4: SET for PAD Services
 - 4c: Worldwide Emergency/Urgent Coverage
 - 7b: Chiropractic Services
 - 7f: Podiatry Services
 - 9d: Outpatient Blood Services
 - 10b: Transportation Services
 - 13a: Acupuncture

CY 2020 PBP Data Entry System Screens

Max Enrollee Cost Limit (Out-of-Network)

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

File Help

Go To: Max Enrollee Cost Limit (Out-of-Network)

Previous Next Exit (Validate) Exit (No Validate)

Is there an Out-of-Network Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

Is your Out-of-Network Maximum Enrollee Out-of-Pocket Cost Voluntary or Mandatory?
 Voluntary
 Mandatory

All MA plans must have a maximum out-of-pocket (MOOP) that covers all A/B services. For a list of the Voluntary and Mandatory Limits, please right-click on the "Is your Out-of-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level?" question and view the Variable Help.

Indicate the Out-of-Network Maximum Enrollee Out-of-Pocket Cost Amount:

Select the benefits that apply to the Out-of-Network Maximum Enrollee Out-of-Pocket cost:
 Out-of-Network Medicare-covered benefits
 Out-of-Network Non-Medicare-covered benefits

Note: For Regional PPOs, all Medicare Part A/B services must be included in the Maximum Enrollee Out-of-Pocket Cost.

Does the Out-of-Network Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Out-of-Network Medicare-covered Service Categories that are INCLUDED in the Out-of-Network Maximum Enrollee Out-of-Pocket Cost amount:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services

Does the Out-of-Network Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Non-Medicare-covered plan services?
 Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Out-of-Network Non-Medicare-covered Service Categories that are INCLUDED in the Out-of-Network Maximum Enrollee Out-of-Pocket Cost amount:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services

CY 2020 PBP Data Entry System Screens

Max Enrollee Cost Limit (Non-Network)

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

File Help

Go To: Max Enrollee Cost Limit (Non-Network)

Previous Next Exit (Validate) Exit (No Validate)

Is your Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level?

Voluntary
 Mandatory

All MA plans must have a maximum out-of-pocket (MOOP) that covers all A/B services. For a list of the Voluntary and Mandatory Limits, please right-click on the "Is your Combined Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory level?" question and view the Variable Help.

Indicate the Maximum Enrollee Out-of-Pocket Cost Amount:

Select the benefits that apply to the Maximum Enrollee Out-of-Pocket cost:

Medicare-covered benefits
 Non-Medicare-covered benefits

Does the Maximum Enrollee Out-of-Pocket Cost apply to all Medicare-covered plan services?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Medicare-covered Service Categories INCLUDED in the Maximum Enrollee Out-of-Pocket Cost Amount:

1a: Inpatient Hospital-Acute
1b: Inpatient Hospital Psychiatric
2: Skilled Nursing Facility (SNF)
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: Pulmonary Rehabilitation Services
3-4: SET for PAD Services

Does the Maximum Enrollee Out-of-Pocket Cost apply to all Non-Medicare-covered plan services?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Non-Medicare-covered Service Categories INCLUDED in the Maximum Enrollee Out-of-Pocket Cost Amount:

1a: Inpatient Hospital-Acute
1b: Inpatient Hospital Psychiatric
2: Skilled Nursing Facility (SNF)
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: Pulmonary Rehabilitation Services
3-4: SET for PAD Services
4c: Worldwide Emergency/Urgent Coverage
7b: Chiropractic Services
7f: Podiatry Services
9d: Outpatient Blood Services

CY 2020 PBP Data Entry System Screens

Max Plan Benefit Coverage

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

File Help

Go To: Max Plan Benefit Coverage

Previous Next Exit (Validate) Exit (No Validate)

The Maximum Plan Benefit Coverage refers to Non-Medicare-covered benefits.

Is there a Maximum Plan Benefit Coverage Amount?

Yes
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

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

Select the benefits that apply to the Maximum Plan Benefit Coverage Amount:

In-Network Non-Medicare-covered benefits
 Out-of-Network Non-Medicare-covered benefits

Does the Maximum Plan Benefit Coverage amount apply to all In-Network Non-Medicare-covered plan services?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the In-Network Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies:

1a: Inpatient Hospital-Acute
1b: Inpatient Hospital Psychiatric
2: Skilled Nursing Facility (SNF)
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: Pulmonary Rehabilitation Services

Does the Maximum Plan Benefit Coverage amount apply to all Out-of-Network Non-Medicare-covered plan services?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies:

1a: Inpatient Hospital-Acute
1b: Inpatient Hospital Psychiatric
2: Skilled Nursing Facility (SNF)
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: Pulmonary Rehabilitation Services
3-4: SET for PAD Services
4c: Worldwide Emergency/Urgent Coverage

CY 2020 PBP Data Entry System Screens

Max Plan Benefit Coverage (Non-Network)

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

File Help

Go To: Max Plan Benefit Coverage (Non-Network)

Previous Next Exit (Validate) Exit (No Validate)

The Maximum Plan Benefit Coverage refers to Non-Medicare-covered benefits.

Does the Maximum Plan Benefit Coverage amount apply to all Non-Medicare-covered plan services?

Is there a Maximum Plan Benefit Coverage Amount?

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies:

1a: Inpatient Hospital-Acute
1b: Inpatient Hospital Psychiatric
2: Skilled Nursing Facility (SNF)
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: Pulmonary Rehabilitation Services

CY 2020 PBP Data Entry System Screens

Plan Premium/Rebate Reduction

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: Plan Premium/Rebate Reduction

Indicate Plan Premium Amount (Part A/B):

Indicate Plan Premium Amount (B Only):

Are you using any of your plan's MA rebates to reduce the Part B Premium?
 Yes
 No

Indicate the Part B Premium reduction amount:

CY 2020 PBP Data Entry System Screens

MMP – Medicaid/plan covered cost sharing

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

File Help

Go To: MMP - Medicaid/plan covered cost sharing

Previous Next Exit (Validate) Exit (No Validate)

Do you offer any Non-Medicare-covered benefits (i.e., services not covered by Medicare)?

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the benefits that are covered under Medicaid:

- 1a1: Additional Days for Inpatient Hospital-Acute
- 1a2: Non-Medicare-covered Stay for Inpatient Hospital-Acute
- 1a3: Upgrades for Inpatient Hospital-Acute
- 1b1: Additional Days for Inpatient Hospital Psychiatric
- 1b2: Non-Medicare-covered Stay for Inpatient Hospital Psychiatric
- 2-1: Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)
- 2-2: Non-Medicare-covered Stay for Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c1: Worldwide Emergency Coverage
- 4c2: Worldwide Urgent Coverage
- 4c3: Worldwide Emergency Transportation
- 6-1: Additional Hours of Care
- 6-2: Personal Care Services
- 6-3: Other 1 for Home Health Services
- 6-4: Other 2 for Home Health Services
- 7b1: Routine Chiropractic Care
- 7b2: Other Chiropractic Services
- 7c: Occupational Therapy Services
- 7f: Podiatry Services
- 7I1: Other 1 for PT and SP Services
- 7I2: Other 2 for PT and SP Services
- 9d: Outpatient Blood Services

Select all of the benefits that are plan-covered supplemental benefits (i.e., services not covered by Medicare or Medicaid):

- 1a1: Additional Days for Inpatient Hospital-Acute
- 1a2: Non-Medicare-covered Stay for Inpatient Hospital-Acute
- 1a3: Upgrades for Inpatient Hospital-Acute
- 1b1: Additional Days for Inpatient Hospital Psychiatric
- 1b2: Non-Medicare-covered Stay for Inpatient Hospital Psychiatric
- 2-1: Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)
- 2-2: Non-Medicare-covered Stay for Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c1: Worldwide Emergency Coverage
- 4c2: Worldwide Urgent Coverage
- 4c3: Worldwide Emergency Transportation
- 6-1: Additional Hours of Care
- 6-2: Personal Care Services
- 6-3: Other 1 for Home Health Services
- 6-4: Other 2 for Home Health Services
- 7b1: Routine Chiropractic Care
- 7b2: Other Chiropractic Services
- 7c: Occupational Therapy Services
- 7f: Podiatry Services
- 7I1: Other 1 for PT and SP Services
- 7I2: Other 2 for PT and SP Services

CY 2020 PBP Data Entry System Screens

PFFS Balance Billing

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

File Help

Go To: PFFS Balance Billing

Previous Next Exit (Validate) Exit (No Validate)

Do you permit balance billing? Balance Billing is a percentage of plan payment rate provider may collect.

Yes
 No

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Enter Minimum percentage for balance billing:

What category of providers do you permit to balance bill?

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4a: Emergency Care/Post-Stabilization Care
- 4b: Urgently Needed Services
- 4c: Worldwide Emergency/Urgent Coverage
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e: Mental Health Specialty Services
- 7f: Podiatry Services
- 7g: Other Health Care Professional
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 7j: Additional Telehealth Services
- 7k: Opioid Treatment Services
- 8a: Diagnostic Procedures/Tests/Lab Services
- 8b: Outpatient Diagnostic/Therapeutic Radiological Services
- 9a: Outpatient Hospital Services

Enter Maximum percentage for balance billing:

CY 2020 PBP Data Entry System Screens

MSA Annual Deductible/Deposit

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with navigation buttons: "Previous" (left arrow), "Next" (right arrow), "Exit (Validate)" (checkmark), and "Exit (No Validate)" (X). A "Go To:" dropdown menu is set to "MSA Annual Deductible/Deposit". The main content area contains two input fields: "Indicate Annual MSA Deductible amount:" and "Indicate the Annual amount CMS will deposit into the Enrollee MSA".

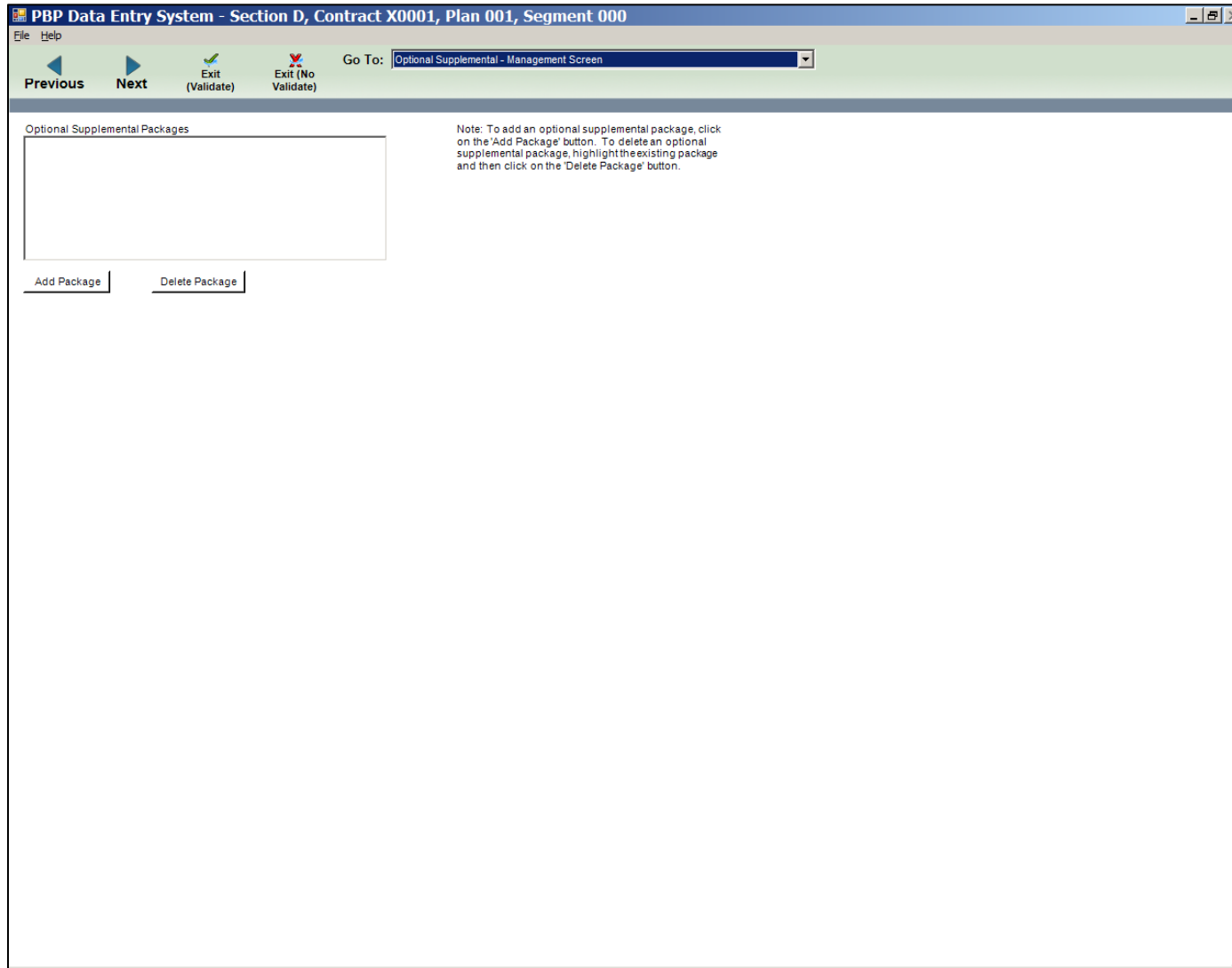
CY 2020 PBP Data Entry System Screens

Notes

The screenshot displays a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons. A "Go To:" dropdown menu is set to "Notes". Below the toolbar, a text area contains the instruction: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." Two empty text input fields, each labeled "Notes:", are provided for data entry.

CY 2020 PBP Data Entry System Screens

Optional Supplemental – Management Screen



CY 2020 PBP Data Entry System Screens

Optional Supplemental – Label and Premium

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

File Help

Go To: Optional Supplemental - Label and Premium

Previous Next Exit (Validate) Exit (No Validate)

Optional Supplemental Benefits ID:

Optional Supplemental Package Description:

Indicate Optional Supplemental Premium Amount:

Is there a Maximum Plan Benefit Coverage Amount for this package?
 Yes
 No

Indicate Maximum Plan Benefit Coverage Amount for this package:

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

Do the Optional Supplemental benefits in this package apply to the MOOP for this plan?
 Yes
 No

Is there an enrollee Deductible for this package?
 Yes
 No

Indicate Deductible Amount:

Select the benefits to which the deductible applies:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4a: Emergency Care/Post-Stabilization Care
- 4b: Urgently Needed Services
- 4c: Worldwide Emergency/Urgent Coverage
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e: Mental Health Specialty Services
- 7f: Podiatry Services
- 7g: Other Health Care Professional
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 7j: Additional Telehealth Services

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

Notes:

CY 2020 PBP Data Entry System Screens

Optional Supplemental – Service Categories

CY 2020 PBP Data Entry System Screens

Optional Supplemental – OON Optional

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with navigation buttons: "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "Optional Supplemental - OON Optional".

The main content area contains the following fields and questions:

- Does this category include Out-of-Network benefits?**
 Yes
 No
- Are the OON cost shares the same as the In-Network cost shares?**
 Yes
 No
- Is there an OON Coinsurance?**
 Yes
 No
- Enter Minimum Coinsurance Percentage:** [Text Input Field]
- Enter Maximum Coinsurance Percentage:** [Text Input Field]
- Is there an OON Copayment?**
 Yes
 No
- Enter Minimum Copayment Amount:** [Text Input Field]
- Enter Maximum Copayment Amount:** [Text Input Field]
- Notes:** [Text Area]

A note below the copayment fields reads: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."

CY 2020 PBP Data Entry System Screens

Optional Supplemental – OON Step-up

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

File Help

Go To: **Optional Supplemental - OON Step-up**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Does this category include Out-of-Network benefits?
 Yes
 No

Are the OON cost shares the same as the In-Network cost shares?
 Yes
 No

Is there an OON Coinsurance?
 Yes
 No

Enter Minimum Coinsurance Percentage:

Enter Maximum Coinsurance Percentage:

Is there an OON Copayment?
 Yes
 No

Enter Minimum Copayment Amount:

Enter Maximum Copayment Amount:

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

Notes:

CY 2020 PBP Data Entry System Screens

Step-up #7b Chiropractic Services – Base 1

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

File Help

Go To: **Step-up #7b Chiropractic Services - Base 1**

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?
 Yes
 No

Select enhanced benefit:
 Routine Care
 Other

Select type of benefit for Routine Care:
 Mandatory
 Optional

Is this benefit unlimited for Routine Care?
 Yes
 No, indicate number

Indicate number of visits for Routine Care:

Select Routine Care periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Is your Chiropractor Services benefit combined with either the Acupuncture or Alternative Therapies benefit, or both?
 Yes
 No

Select the enhanced benefits that are included in the combined benefit (Select all that apply):
 Routine Care
 Other

Enter Name of Other Service:

Select type of benefit for Other Service:
 Mandatory
 Optional

Is this benefit unlimited for Other Service?
 Yes
 No, indicate number

Indicate number of visits for Other Service:

Select Other Service periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

CY 2020 PBP Data Entry System Screens

Step-up #7b Chiropractic Services – Base 2

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

File Help

Go To: **Step-up #7b Chiropractic Services - Base 2**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which Chiropractic Services have a Coinsurance (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Chiropractic Services <input type="checkbox"/> Routine Care <input type="checkbox"/> Other</p> <p>Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits: <input type="text"/></p> <p>Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits: <input type="text"/></p> <p>Indicate the Minimum Coinsurance percentage per visit for Routine Care: <input type="text"/></p> <p>Indicate the Maximum Coinsurance percentage per visit for Routine Care: <input type="text"/></p> <p>Indicate the Minimum Coinsurance percentage per visit for Other Service: <input type="text"/></p> <p>Indicate the Maximum Coinsurance percentage per visit for Other Service: <input type="text"/></p>	<p>Is there an enrollee Copayment?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which Chiropractic Services have a Copayment (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Chiropractic Services <input type="checkbox"/> Routine Care <input type="checkbox"/> Other</p> <p>Indicate Minimum Copayment amount for Medicare-covered Benefits: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Medicare-covered Benefits: <input type="text"/></p> <p>Indicate Minimum Copayment amount per visit for Routine Care: <input type="text"/></p> <p>Indicate Maximum Copayment amount per visit for Routine Care: <input type="text"/></p> <p>Indicate Minimum Copayment amount per visit for Other Service: <input type="text"/></p> <p>Indicate Maximum Copayment amount per visit for Other Service: <input type="text"/></p>	<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Deductible Amount: <input type="text"/></p> <p>Is authorization required? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Is a referral required for Chiropractic Services? <input type="radio"/> Yes <input type="radio"/> No</p>
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CY 2020 PBP Data Entry System Screens

Step-up #7b Chiropractic Services – Base 3

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons. A "Go To:" dropdown menu is set to "Step-up #7b Chiropractic Services - Base 3". The main content area is titled "Chiropractic Services Notes" and contains the instruction: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." Below this is a large, empty text area labeled "Notes:" with a vertical scrollbar on the right side.

CY 2020 PBP Data Entry System Screens

Step-up #7f Podiatry Services – Base 1

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

File Help

Go To: Step-up #7f Podiatry Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Podiatry Services as a supplemental benefit under Part C?

Yes
 No

Select enhanced benefits:

Routine Foot Care

Select type of benefit for Routine Foot Care:

Mandatory
 Optional

Is this benefit unlimited for Routine Foot Care?

Yes
 No

Indicate number of Routine Foot Care visits:

Select the Routine Foot Care periodicity:

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

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

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

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

Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

CY 2020 PBP Data Entry System Screens

Step-up #7f Podiatry Services – Base 2

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

File Help

Go To: Step-up #7f Podiatry Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?
 Yes
 No

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

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Foot Care:

Indicate Maximum Coinsurance percentage for Routine Foot Care:

Is there an enrollee Copayment?
 Yes
 No

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

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

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

Indicate Minimum Copayment amount per visit for Routine Foot Care:

Indicate Maximum Copayment amount per visit for Routine Foot Care:

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

CY 2020 PBP Data Entry System Screens

Step-up #7f Podiatry Services – Base 3

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons. A "Go To:" dropdown menu is set to "Step-up #7f Podiatry Services - Base 3".

The main content area contains the following fields and instructions:

- Is authorization required?**
 Yes
 No
- Is a referral required for Podiatrist Services?**
 Yes
 No
- Podiatry Services Notes**
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.
Notes:

CY 2020 PBP Data Entry System Screens

Step-up #10b Transportation Services – Base 1

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

File Help

Go To: Step-up #10b Transportation Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Transportation Services as a supplemental benefit under Part 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:

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

Select Type of Transportation for Plan-approved Location:

One-way
 Round Trip
 Days
 Other, Describe

Indicate number of days for Plan-approved Location:

Select Mode of Transportation for Plan-approved Location:

Taxi
 Rideshare Services
 Bus/Subway
 Van
 Medical Transport
 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 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 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

Step-up #10b Transportation Services – Base 2

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

File Help

Go To: Step-up #10b Transportation Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Plan Benefit Coverage amount:</p> <input type="text"/>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <input type="text"/>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Minimum Coinsurance percentage:</p> <input type="text"/>
<p>Select Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Indicate Maximum Coinsurance percentage:</p> <input type="text"/>
		<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Deductible Amount:</p> <input type="text"/>

CY 2020 PBP Data Entry System Screens

Step-up #10b Transportation Services – Base 3

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

File Help

Go To: Step-up #10b Transportation Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?
 Yes
 No

Indicate Minimum Copayment amount per trip:

Indicate Maximum Copayment amount per trip:

Is authorization required?
 Yes
 No

Is a referral required for Transportation Services?
 Yes
 No

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

Notes:

CY 2020 PBP Data Entry System Screens

Step-up #16a Preventive Dental – Base 1

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

File Help

Go To: **Step-up #16a Preventive Dental - Base 1**

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?

Yes
 No

Select enhanced benefits:

Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Select type of benefit for Oral Exams:

Mandatory
 Optional

Is this benefit unlimited for Oral Exams?

Yes
 No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

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

Select type of benefit for Prophylaxis (Cleaning):

Mandatory
 Optional

Is this benefit unlimited for Prophylaxis (Cleaning)?

Yes
 No, indicate number

Indicate number of visits for Prophylaxis (Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

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

Select type of benefit for Fluoride Treatment:

Mandatory
 Optional

Is this benefit unlimited for Fluoride Treatment?

Yes
 No, indicate number

Indicate number of visits for Fluoride Treatment:

Select the Fluoride Treatment periodicity:

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

CY 2020 PBP Data Entry System Screens

Step-up #16a Preventive Dental – Base 2

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

File Help

Go To: Step-up #16a Preventive Dental - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

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

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

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

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

Indicate Maximum Plan Benefit Coverage amount:
[]

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

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

CY 2020 PBP Data Entry System Screens

Step-up #16a Preventive Dental – Base 3

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

File Help

Go To: **Step-up #16a Preventive Dental - Base 3**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <input type="text"/>	<p>Is there a combination of services included in a single cost per Office Visit?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which combination of services are included in a single cost per Office Visit:</p> <p><input type="checkbox"/> Oral Exams <input type="checkbox"/> Prophylaxis (Cleaning) <input type="checkbox"/> Fluoride Treatment <input type="checkbox"/> Dental X-Rays</p> <p>Indicate Coinsurance percentage for Office Visit:</p> <input type="text"/>	<p>Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):</p> <input type="text"/>
<p>Select the Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Indicate Minimum Coinsurance percentage for Oral Exams:</p> <input type="text"/>	<p>Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):</p> <input type="text"/>
<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which Preventive Dental Services have a Coinsurance (Select all that apply):</p> <p><input type="checkbox"/> Oral Exams <input type="checkbox"/> Prophylaxis (Cleaning) <input type="checkbox"/> Fluoride Treatment <input type="checkbox"/> Dental X-Rays</p>	<p>Indicate Maximum Coinsurance percentage for Oral Exams:</p> <input type="text"/>	<p>Indicate Minimum Coinsurance percentage for Fluoride Treatment:</p> <input type="text"/>
		<p>Indicate Maximum Coinsurance percentage for Fluoride Treatment:</p> <input type="text"/>
		<p>Indicate Minimum Coinsurance percentage for Dental X-Rays:</p> <input type="text"/>
		<p>Indicate Maximum Coinsurance percentage for Dental X-Rays:</p> <input type="text"/>

CY 2020 PBP Data Entry System Screens

Step-up #16a Preventive Dental – Base 4

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

File Help

Go To: Step-up #16a Preventive Dental - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Select which Preventive Dental Services have a Copayment (Select all that apply):
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Is there a combination of services included in a single cost per Office Visit?
 Yes
 No

Select which combination of services are included in a single cost per Office Visit:
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Indicate Copayment amount for Office Visit:

Indicate Minimum Copayment amount for Oral Exams:

Indicate Maximum Copayment amount for Oral Exams:

Indicate Minimum Copayment amount for Prophylaxis (Cleaning):

Indicate Maximum Copayment amount for Prophylaxis (Cleaning):

Indicate Minimum Copayment amount for Fluoride Treatment:

Indicate Maximum Copayment amount for Fluoride Treatment:

Indicate Minimum Copayment amount for Dental X-Rays:

Indicate Maximum Copayment amount for Dental X-Rays:

CY 2020 PBP Data Entry System Screens

Step-up #16a Preventive Dental – Base 5

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with navigation buttons: "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "Step-up #16a Preventive Dental - Base 5".

The main content area contains the following sections:

- Is authorization required?** with radio buttons for "Yes" and "No".
- Is a referral required for Preventive Dental Services?** with radio buttons for "Yes" and "No".
- Preventive Dental Services Notes** with a text area and a note: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."
- Notes:** with a large, empty text area for additional information.

CY 2020 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 1

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

File Help

Go To: Step-up #16b Comprehensive Dental - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?

Yes
 No

Select enhanced benefits:

- Non-routine Services
- Diagnostic Services
- Restorative Services
- Endodontics
- Periodontics
- Extractions
- Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Non-routine Services	Diagnostic Services	Restorative Services
Select type of benefit for Non-routine Services: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select type of benefit for Diagnostic Services: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select type of benefit for Restorative Services: <input type="radio"/> Mandatory <input type="radio"/> Optional
Is this benefit unlimited for Non-routine Services? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Diagnostic Services? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Restorative Services? <input type="radio"/> Yes <input type="radio"/> No, indicate number
Indicate number of visits for Non-routine Services: <input type="text"/>	Indicate number of visits for Diagnostic Services: <input type="text"/>	Indicate number of visits for Restorative Services: <input type="text"/>
Select the Non-routine Services periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Select the Diagnostic Services periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Select the Restorative Services periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe

CY 2020 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 2

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

File Help

Go To: **Step-up #16b Comprehensive Dental - Base 2**

Previous Next Exit (Validate) Exit (No Validate)

<p>Select type of benefit for Endodontics:</p> <p><input type="radio"/> Mandatory <input type="radio"/> Optional</p>	<p>Select type of benefit for Periodontics:</p> <p><input type="radio"/> Mandatory <input type="radio"/> Optional</p>	<p>Select type of benefit for Extractions:</p> <p><input type="radio"/> Mandatory <input type="radio"/> Optional</p>	<p>Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:</p> <p><input type="radio"/> Mandatory <input type="radio"/> Optional</p>
<p>Is this benefit unlimited for Endodontics?</p> <p><input type="radio"/> Yes <input type="radio"/> No, indicate number</p>	<p>Is this benefit unlimited for Periodontics?</p> <p><input type="radio"/> Yes <input type="radio"/> No, indicate number</p>	<p>Is this benefit unlimited for Extractions?</p> <p><input type="radio"/> Yes <input type="radio"/> No, indicate number</p>	<p>Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?</p> <p><input type="radio"/> Yes <input type="radio"/> No, indicate number</p>
<p>Indicate number of visits for Endodontics:</p> <p><input type="text"/></p>	<p>Indicate number of visits for Periodontics:</p> <p><input type="text"/></p>	<p>Indicate number of visits for Extractions:</p> <p><input type="text"/></p>	<p>Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:</p> <p><input type="text"/></p>
<p>Select the Endodontics periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Select the Periodontics periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Select the Extractions periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>

CY 2020 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 3

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

File Help

Go To: Step-up #16b Comprehensive Dental - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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

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

Select the Maximum Plan Benefit Coverage type:
 Covered under Preventive Dental Category 16a
 Plan-specified amount per period

Select the Maximum Enrollee Out-of-Pocket Cost type:
 Covered under Preventive Dental Category 16a
 Plan-specified amount per period

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Plan Benefit Coverage amount:

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

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

CY 2020 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 4

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

File Help

Go To: **Step-up #16b Comprehensive Dental - Base 4**

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?
 Yes
 No

Is there an enrollee Deductible?
 Yes
 No

Select which Comprehensive Dental Services have a Coinsurance (Select all that apply):

- Medicare-covered Benefits
- Non-routine Services
- Diagnostic Services
- Restorative Services
- Endodontics
- Periodontics
- Extractions
- Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Indicate Deductible Amount:

	Minimum Coinsurance	Maximum Coinsurance
Medicare-covered Benefits	<input type="text"/>	<input type="text"/>
Non-routine Services	<input type="text"/>	<input type="text"/>
Diagnostic Services	<input type="text"/>	<input type="text"/>
Restorative Services	<input type="text"/>	<input type="text"/>
Endodontics	<input type="text"/>	<input type="text"/>
Periodontics	<input type="text"/>	<input type="text"/>
Extractions	<input type="text"/>	<input type="text"/>
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	<input type="text"/>	<input type="text"/>

CY 2020 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 5

Is there an enrollee Copayment?

Yes
 No

Select which Comprehensive Dental Services have a Copayment (Select all that apply):

- Medicare-covered Benefits
- Non-routine Services
- Diagnostic Services
- Restorative Services
- Endodontics
- Periodontics
- Extractions
- Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

	Copayment Minimum	Copayment Maximum
Medicare-covered Benefits	<input type="text"/>	<input type="text"/>
Non-routine Services	<input type="text"/>	<input type="text"/>
Diagnostic Services	<input type="text"/>	<input type="text"/>
Restorative Services	<input type="text"/>	<input type="text"/>
Endodontics	<input type="text"/>	<input type="text"/>
Periodontics	<input type="text"/>	<input type="text"/>
Extractions	<input type="text"/>	<input type="text"/>
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	<input type="text"/>	<input type="text"/>

CY 2020 PBP Data Entry System Screens

Step-up #16b Comprehensive Dental – Base 6

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with navigation buttons: "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "Step-up #16b Comprehensive Dental - Base 6".

The main content area contains the following sections:

- Is authorization required?** with radio buttons for "Yes" and "No".
- Is a referral required for Comprehensive Dental Services?** with radio buttons for "Yes" and "No".
- Comprehensive Dental Services Notes** with a sub-note: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."
- Notes:** a large text area for additional information.

CY 2020 PBP Data Entry System Screens

Step-up #17a Eye Exams – Base 1

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

File Help

Go To: **Step-up #17a Eye Exams - Base 1**

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Eye Exams as a supplemental benefit under Part C?
 Yes
 No

Select enhanced benefit:
 Routine Eye Exams
 Other

Select type of benefit for Routine Eye Exams:
 Mandatory
 Optional

Is this benefit unlimited for Routine Eye Exams?
 Yes
 No, indicate number

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Enter name of Other Service:

Select type of benefit for Other Service:
 Mandatory
 Optional

Is this benefit unlimited for Other Service?
 Yes
 No, indicate number

Indicate quantity for Other Service:

Select the Other Service periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

CY 2020 PBP Data Entry System Screens

Step-up #17a Eye Exams – Base 2

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

File Help

Go To: **Step-up #17a Eye Exams - Base 2**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Is there an enrollee Copayment?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>Select which Eye Exams have a Coinsurance (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Benefits <input type="checkbox"/> Routine Eye Exams <input type="checkbox"/> Other</p>	<p>Select which Eye Exams have a Copayment (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Benefits <input type="checkbox"/> Routine Eye Exams <input type="checkbox"/> Other</p>	<p>Indicate Deductible Amount:</p> <p><input type="text"/></p>
<p>Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:</p> <p><input type="text"/></p>	<p>Indicate Minimum Copayment amount for Medicare-covered Benefits:</p> <p><input type="text"/></p>	
<p>Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:</p> <p><input type="text"/></p>	<p>Indicate Maximum Copayment amount for Medicare-covered Benefits:</p> <p><input type="text"/></p>	
<p>Indicate Minimum Coinsurance percentage for Routine Eye Exams:</p> <p><input type="text"/></p>	<p>Indicate Minimum Copayment amount for Routine Eye Exams:</p> <p><input type="text"/></p>	
<p>Indicate Maximum Coinsurance percentage for Routine Eye Exams:</p> <p><input type="text"/></p>	<p>Indicate Maximum Copayment amount for Routine Eye Exams:</p> <p><input type="text"/></p>	
<p>Indicate Minimum Coinsurance percentage for Other Service:</p> <p><input type="text"/></p>	<p>Indicate Minimum Copayment amount for Other Service:</p> <p><input type="text"/></p>	
<p>Indicate Maximum Coinsurance percentage for Other Service:</p> <p><input type="text"/></p>	<p>Indicate Maximum Copayment amount for Other Service:</p> <p><input type="text"/></p>	

CY 2020 PBP Data Entry System Screens

Step-up #17a Eye Exams – Base 3

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with navigation buttons: "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "Step-up #17a Eye Exams - Base 3".

The main content area contains the following sections:

- Is authorization required?** with radio buttons for "Yes" and "No" and an adjacent text input field.
- Is a referral required for Eye Exams?** with radio buttons for "Yes" and "No" and an adjacent text input field.
- Eye Exams Notes** section with a note: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."
- Notes:** a large, empty text area for additional information.

CY 2020 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 1

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

File Help

Go To: Step-up #17b Eyewear - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.

Does the plan provide Eyewear as a supplemental benefit under Part C?

Yes
 No

Select enhanced benefits:

- Contact lenses
- Eyeglasses (lenses and frames)
- Eyeglass lenses
- Eyeglass frames
- Upgrades

Select type of benefit for Contact lenses:

Mandatory
 Optional

Is this benefit unlimited for Contact lenses?

Yes
 No, indicate number

Indicate quantity (number of pairs) for Contact lenses:

Select Contact lenses periodicity:

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

Select type of benefit for Eyeglasses (lenses and frames):

Mandatory
 Optional

Is this benefit unlimited for Eyeglasses (lenses and frames)?

Yes
 No, indicate number

Indicate quantity for Eyeglasses (lenses and frames):

Select Eyeglasses (lenses and frames) periodicity:

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

CY 2020 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 2

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

File Help

Go To: **Step-up #17b Eyewear - Base 2**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Select type of benefit for Eyeglass lenses:
 Mandatory
 Optional

Select type of benefit for Eyeglass frames:
 Mandatory
 Optional

Is this benefit unlimited for Eyeglass lenses?
 Yes
 No, indicate number

Is this benefit unlimited for Eyeglass frames?
 Yes
 No, indicate number

Indicate quantity (number of pairs) for Eyeglass lenses:

Indicate quantity for Eyeglass frames:

Select Eyeglass lenses periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Select Eyeglass frames periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Select type of benefit for Upgrades:
 Mandatory
 Optional

CY 2020 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 3

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

File Help

Go To: **Step-up #17b Eyewear - Base 3**

Previous Next Exit (Validate) Exit (No Validate)

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select the Maximum Plan Benefit Coverage type:</p> <p><input type="radio"/> Covered under Eye Exams Category 17a <input type="radio"/> Plan-specified amount per period</p> <p>Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?</p> <p><input type="radio"/> In-network services only <input type="radio"/> Both In-network and Out-of-network services</p> <p>Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Combined Maximum Plan Benefit Coverage amount:</p> <input type="text"/>	<p>Select the Combined Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p> <p>Select the type of Eyewear with Individual Max Plan Benefit Coverage amount:</p> <p><input type="checkbox"/> Contact lenses <input type="checkbox"/> Eyeglasses (lenses and frames) <input type="checkbox"/> Eyeglass lenses <input type="checkbox"/> Eyeglass frames <input type="checkbox"/> Upgrades</p> <p>Indicate Max Plan Benefit Coverage amount for Contact lenses:</p> <input type="text"/>	<p>Indicate Max Plan Benefit Coverage amount for Eyeglasses (lenses and frames):</p> <input type="text"/>	<p>Indicate Max Plan Benefit Coverage amount for Eyeglass frames:</p> <input type="text"/>
	<p>Select the Individual Maximum Plan Benefit Coverage periodicity for Contact lenses:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglasses (lenses and frames):</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglass frames:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>
		<p>Indicate Max Plan Benefit Coverage amount for Eyeglass lenses:</p> <input type="text"/>	<p>Indicate Max Plan Benefit Coverage amount for Upgrades:</p> <input type="text"/>
		<p>Select the Individual Maximum Plan Benefit Coverage periodicity for Eyeglass lenses:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Select the Individual Maximum Plan Benefit Coverage periodicity for Upgrades:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>

CY 2020 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 4

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

File Help

Go To: **Step-up #17b Eyewear - Base 4**

Previous Next Exit (Validate) Exit (No Validate)

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Coinsurance percentage for Medicare-covered Benefits: <input type="text"/>	Indicate Minimum Coinsurance percentage for Eyeglass frames: <input type="text"/>
Select the Maximum Enrollee Out-of-Pocket Cost type: <input type="radio"/> Covered under Eye Exams Category 17a <input type="radio"/> Plan-specified amount per period	Indicate Maximum Coinsurance percentage for Medicare-covered Benefits: <input type="text"/>	Indicate Maximum Coinsurance percentage for Eyeglass frames: <input type="text"/>
Indicate Maximum Enrollee Out-of-Pocket Cost amount: <input type="text"/>	Indicate Minimum Coinsurance percentage for Contact lenses: <input type="text"/>	Indicate Minimum Coinsurance percentage for Upgrades: <input type="text"/>
Select Maximum Enrollee Out-of-Pocket Cost periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Other, Describe	Indicate Maximum Coinsurance percentage for Contact lenses: <input type="text"/>	Indicate Maximum Coinsurance percentage for Upgrades: <input type="text"/>
Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Coinsurance percentage for Eyeglasses (lenses and frames): <input type="text"/>	
Select which Eyewear Benefits have a Coinsurance (Select all that apply): <input type="checkbox"/> Medicare-covered Benefits <input type="checkbox"/> Contact lenses <input type="checkbox"/> Eyeglasses (lenses and frames) <input type="checkbox"/> Eyeglass lenses <input type="checkbox"/> Eyeglass frames <input type="checkbox"/> Upgrades	Indicate Maximum Coinsurance percentage for Eyeglasses (lenses and frames): <input type="text"/>	Indicate Minimum Coinsurance percentage for Eyeglass lenses: <input type="text"/>
	Indicate Maximum Coinsurance percentage for Eyeglass lenses: <input type="text"/>	

CY 2020 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 5

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

File Help

Go To: **Step-up #17b Eyewear - Base 5**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Select which Eyewear Benefits have a Copayment (Select all that apply):
 Medicare-covered Benefits
 Contact lenses
 Eyeglasses (lenses and frames)
 Eyeglass lenses
 Eyeglass frames
 Upgrades

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Contact lenses:

Indicate Maximum Copayment amount for Contact lenses:

Indicate Minimum Copayment amount for Eyeglasses (lenses and frames):

Indicate Maximum Copayment amount for Eyeglasses (lenses and frames):

Indicate Minimum Copayment amount for Eyeglass lenses:

Indicate Maximum Copayment amount for Eyeglass lenses:

Indicate Minimum Copayment amount for Eyeglass frames:

Indicate Maximum Copayment amount for Eyeglass frames:

Indicate Minimum Copayment amount for Upgrades:

Indicate Maximum Copayment amount for Upgrades:

CY 2020 PBP Data Entry System Screens

Step-up #17b Eyewear – Base 6

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

File Help

Go To: Step-up #17b Eyewear - Base 6

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?
 Yes
 No

Is a referral required for Eyewear?
 Yes
 No

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

Notes:

CY 2020 PBP Data Entry System Screens

Step-up #18a Hearing Exams – Base 1

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

File Help

Go To: Step-up #18a Hearing Exams - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.

Does the plan provide Hearing Exams as a supplemental benefit under Part C?

Yes
 No

Select enhanced benefits:

Routine Hearing Exams
 Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Exams:

Mandatory
 Optional

Is this benefit unlimited for Routine Hearing Exams?

Yes
 No, indicate number

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

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

Select type of benefit for Fitting/Evaluation for Hearing Aid:

Mandatory
 Optional

Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?

Yes
 No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

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

CY 2020 PBP Data Entry System Screens

Step-up #18a Hearing Exams – Base 2

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

File Help

Go To: **Step-up #18a Hearing Exams - Base 2**

Previous Next Exit (Validate) Exit (No Validate)

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:</p> <p><input type="text"/></p>
<p>Does the Maximum Plan Benefit Coverage amount apply to In-network services only OR does it apply to both In-network and Out-of-network services?</p> <p><input type="radio"/> In-network services only <input type="radio"/> Both In-network and Out-of-network services</p>	<p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <p><input type="text"/></p>	<p>Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:</p> <p><input type="text"/></p>
<p>Indicate Maximum Plan Benefit Coverage amount:</p> <p><input type="text"/></p>	<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Indicate Minimum Coinsurance percentage for Routine Hearing Exams:</p> <p><input type="text"/></p>
<p>Select the Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe</p>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Indicate Maximum Coinsurance percentage for Routine Hearing Exams:</p> <p><input type="text"/></p>
<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p>Select which Hearing Exam Benefits have a Coinsurance (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Benefits <input type="checkbox"/> Routine Hearing Exams <input type="checkbox"/> Fitting/Evaluation for Hearing Aid</p>	<p>Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:</p> <p><input type="text"/></p>
<p>Indicate Deductible Amount:</p> <p><input type="text"/></p>		<p>Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:</p> <p><input type="text"/></p>

CY 2020 PBP Data Entry System Screens

Step-up #18a Hearing Exams – Base 3

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

File Help

Go To: Step-up #18a Hearing Exams - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?
 Yes
 No

Is authorization required?
 Yes
 No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:
[]

Indicate Maximum Copayment amount for Medicare-covered Benefits:
[]

Indicate Minimum Copayment amount for Routine Hearing Exams:
[]

Indicate Maximum Copayment amount for Routine Hearing Exams:
[]

Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:
[]

Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:
[]

Is a referral required for Hearing Exams?
 Yes
 No

CY 2020 PBP Data Entry System Screens

Step-up #18a Hearing Exams – Base 4

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

File Help

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

Hearing Exams Notes

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

Notes:

[Empty text area with vertical scrollbar]

CY 2020 PBP Data Entry System Screens

Step-up #18b Hearing Aids – Base 1

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

File Help

Go To: **Step-up #18b Hearing Aids - Base 1**

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Hearing Aids as a supplemental benefit under Part C?
 Yes
 No

Select enhanced benefits:
 Hearing Aids (all types)
 Hearing Aids - Inner Ear
 Hearing Aids - Outer Ear
 Hearing Aids - Over the Ear

Select type of benefit for Hearing Aids (all types):	Select type of benefit for Hearing Aids - Inner Ear:	Select type of benefit for Hearing Aids - Outer Ear:
<input type="radio"/> Mandatory <input type="radio"/> Optional	<input type="radio"/> Mandatory <input type="radio"/> Optional	<input type="radio"/> Mandatory <input type="radio"/> Optional
Is this benefit unlimited for Hearing Aids (all types)? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Hearing Aids - Inner Ear? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Hearing Aids - Outer Ear? <input type="radio"/> Yes <input type="radio"/> No, indicate number
Indicate quantity for Hearing Aids (all types): <input type="text"/>	Indicate quantity for Hearing Aids - Inner Ear: <input type="text"/>	Indicate quantity for Hearing Aids - Outer Ear: <input type="text"/>
Select Hearing Aids (all types) periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Select Hearing Aids - Inner Ear periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe	Select Hearing Aids - Outer Ear periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, Describe

CY 2020 PBP Data Entry System Screens

Step-up #18b Hearing Aids – Base 2

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

File Help

Go To: **Step-up #18b Hearing Aids - Base 2**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

Select type of benefit for Hearing Aids - Over the Ear:
 Mandatory
 Optional

Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?
 Per ear
 One single ear
 Both ears combined

Is this benefit unlimited for Hearing Aids - Over the Ear?
 Yes
 No, indicate number

Select the Maximum Plan Benefit Coverage type:
 Covered under Hearing Exams Category - 18a
 Plan-specified amount per period

Indicate quantity for Hearing Aids - Over the Ear:

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

Select Hearing Aids - Over the Ear periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, Describe

Indicate Maximum Plan Benefit Coverage amount:

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

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

CY 2020 PBP Data Entry System Screens

Step-up #18b Hearing Aids – Base 3

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

File Help

Go To: **Step-up #18b Hearing Aids - Base 3**

Previous **Next** **Exit (Validate)** **Exit (No Validate)**

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

Select the Maximum Enrollee Out-of-Pocket Cost type:
 Covered under Hearing Exams Category - 18a
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?
 Yes
 No

Select which Hearing Aids Benefits have a Coinsurance (Select all that apply):
 Hearing Aids - Inner Ear
 Hearing Aids - Outer Ear
 Hearing Aids - Over the Ear

Indicate Minimum Coinsurance percentage for Hearing Aids (all types):

Indicate Minimum Coinsurance percentage for Hearing Aids - Over the Ear:

Indicate Maximum Coinsurance percentage for Hearing Aids (all types):

Indicate Maximum Coinsurance percentage for Hearing Aids - Over the Ear:

Indicate Minimum Coinsurance percentage for Hearing Aids - Inner Ear:

Indicate Maximum Coinsurance percentage for Hearing Aids - Inner Ear:

Indicate Minimum Coinsurance percentage for Hearing Aids - Outer Ear:

Indicate Maximum Coinsurance percentage for Hearing Aids - Outer Ear:

CY 2020 PBP Data Entry System Screens

Step-up #18b Hearing Aids – Base 4

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

File Help

Go To: Step-up #18b Hearing Aids - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?
 Yes
 No

Indicate Minimum Copayment amount per Hearing Aid - Outer Ear:

Is there an enrollee Deductible?
 Yes
 No

Select which Hearing Aids Benefits have a Copayment (Select all that apply):
 Hearing Aid - Inner Ear
 Hearing Aid - Outer Ear
 Hearing Aids - Over the Ear

Indicate Maximum Copayment amount per Hearing Aid - Outer Ear:

Indicate Deductible Amount:

Indicate Minimum Copayment amount per two Hearing Aids - Outer Ear:

Indicate Minimum Copayment amount per Hearing Aid (all types):

Indicate Maximum Copayment amount per two Hearing Aids - Outer Ear:

Indicate Minimum Copayment amount per Hearing Aid - Over the Ear:

Indicate Minimum Copayment amount per Hearing Aid - Inner Ear:

Indicate Maximum Copayment amount per Hearing Aid - Over the Ear:

Indicate Maximum Copayment amount per Hearing Aid - Inner Ear:

Indicate Minimum Copayment amount per two Hearing Aids - Over the Ear:

Indicate Minimum Copayment amount per two Hearing Aids - Inner Ear:

Indicate Maximum Copayment amount per two Hearing Aids - Over the Ear:

Indicate Maximum Copayment amount per two Hearing Aids - Inner Ear:

CY 2020 PBP Data Entry System Screens

Step-up #18b Hearing Aids – Base 5

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with navigation buttons: "Previous" (left arrow), "Next" (right arrow), "Exit (Validate)" (checkmark), and "Exit (No Validate)" (X). A "Go To:" dropdown menu is set to "Step-up #18b Hearing Aids - Base 5".

The main content area contains the following sections:

- Is authorization required?** with radio buttons for "Yes" and "No".
- Is a referral required for Hearing Aids?** with radio buttons for "Yes" and "No".
- Hearing Aids Notes** section with a note: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."
- Notes:** a large, empty text area with a vertical scrollbar on the right side.