

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 1

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

File Help

Go To: #1a Inpatient Hospital-Acute - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Additional Days  
 Non-Medicare-covered Stay  
 Upgrades

Select type of benefit for Additional Days:

Mandatory  
 Optional

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

Indicate number of Additional Days per benefit period:

Select type of benefit for Non-Medicare-covered stay:

Mandatory  
 Optional

Select type of benefit for Upgrades:

Mandatory  
 Optional

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 2

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

File Help

Go To: #1a Inpatient Hospital-Acute - Base 2

---

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

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

Yes  
 No

Indicate the 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  
 Every Benefit Period  
 Every Stay  
 Other, Describe

Does this plan's Medicare-covered benefit costsharing vary by hospital(s) in which an enrollee obtains care?

Yes  
 No

How many costsharing tiers do you offer?

What is your lowest cost tier?

Tier 1  
 Tier 2  
 Tier 3

Is there an enrollee Coinsurance?

Yes  
 No

Medicare-covered Coinsurance Cost Sharing for Tier 1:

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 3

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

File Help

Go To: #1a Inpatient Hospital-Acute - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Medicare-covered Coinsurance Cost Sharing for Tier 2:  
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

Coinsurance % Interval	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare-covered Coinsurance Cost Sharing for Tier 3:  
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)  
 Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

Coinsurance % Interval	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 4

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

File Help
Go To: #1a Inpatient Hospital-Acute - Base 4

◀ Previous
Next ▶

✔ Exit (Validate)
✘ Exit (No Validate)

**Medicare-covered Lifetime Reserve Days Tier 1**

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

	Interval Days	
	Coinsurance %	End Day
Interval 1:	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>

**Medicare-covered Lifetime Reserve Days Tier 2**

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

	Interval Days	
	Coinsurance %	End Day
Interval 1:	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>

**Medicare-covered Lifetime Reserve Days Tier 3**

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

	Interval Days	
	Coinsurance %	End Day
Interval 1:	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 5

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

File Help

Go To: #1a Inpatient Hospital-Acute - Base 5

Previous Next Exit (Validate) Exit (No Validate)

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

Yes  
 No

How many cost sharing tiers do you offer?  
[ ]

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

Additional Days Coinsurance Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

Additional Days Coinsurance Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 6

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

File Help

Go To: #1a Inpatient Hospital-Acute - Base 6

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Coinsurance Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay?  
 Yes  
 No

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

Is the Coinsurance structure for Upgrades the same as the Coinsurance structure for the Medicare-covered stay?  
 Yes  
 No

Indicate Coinsurance percentage for Upgrades:  
[ ]

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 7

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

File Help

Go To: #1a Inpatient Hospital-Acute - Base 7

Previous Next Exit (Validate) Exit (No Validate)

If you do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D.  
MA Organizations are not permitted to tier deductibles.

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount for Tier 1:  
[ ]

Indicate Deductible Amount for Tier 2:  
[ ]

Indicate Deductible Amount for Tier 3:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

Medicare-covered Copayment Cost Sharing for Tier 1:

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

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

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

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

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

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 8

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

File Help

Go To: #1a Inpatient Hospital-Acute - Base 8

---

Medicare-covered Copayment Cost Sharing for Tier 2:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare-covered Copayment Cost Sharing for Tier 3:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>



# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 9

File Help
Go To: #1a Inpatient Hospital-Acute - Base 9

<p>Medicare-covered Lifetime Reserve Days Tier 1</p> <p>Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:</p> <p> <input type="radio"/> Zero (No Copayment per Day)  <input type="radio"/> One  <input type="radio"/> Two  <input type="radio"/> Three                 </p> <p>Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th colspan="3" style="text-align: center; border-bottom: 1px solid black;">Interval Days</th> </tr> <tr> <th style="border-bottom: 1px solid black;">Copay Amount</th> <th style="border-bottom: 1px solid black;">Begin Day</th> <th style="border-bottom: 1px solid black;">End Day</th> <th></th> </tr> </thead> <tbody> <tr> <td>Interval 1:</td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> </tr> <tr> <td>Interval 2:</td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> </tr> <tr> <td>Interval 3:</td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> </tr> </tbody> </table>		Interval Days			Copay Amount	Begin Day	End Day		Interval 1:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	Interval 2:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	Interval 3:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<p>Medicare-covered Lifetime Reserve Days Tier 2</p> <p>Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:</p> <p> <input type="radio"/> Zero (No Copayment per Day)  <input type="radio"/> One  <input type="radio"/> Two  <input type="radio"/> Three                 </p> <p>Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th colspan="3" style="text-align: center; border-bottom: 1px solid black;">Interval Days</th> </tr> <tr> <th style="border-bottom: 1px solid black;">Copay Amount</th> <th style="border-bottom: 1px solid black;">Begin Day</th> <th style="border-bottom: 1px solid black;">End Day</th> <th></th> </tr> </thead> <tbody> <tr> <td>Interval 1:</td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> </tr> <tr> <td>Interval 2:</td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> </tr> <tr> <td>Interval 3:</td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> </tr> </tbody> </table>		Interval Days			Copay Amount	Begin Day	End Day		Interval 1:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	Interval 2:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	Interval 3:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<p>Medicare-covered Lifetime Reserve Days Tier 3</p> <p>Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:</p> <p> <input type="radio"/> Zero (No Copayment per Day)  <input type="radio"/> One  <input type="radio"/> Two  <input type="radio"/> Three                 </p> <p>Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th colspan="3" style="text-align: center; border-bottom: 1px solid black;">Interval Days</th> </tr> <tr> <th style="border-bottom: 1px solid black;">Copay Amount</th> <th style="border-bottom: 1px solid black;">Begin Day</th> <th style="border-bottom: 1px solid black;">End Day</th> <th></th> </tr> </thead> <tbody> <tr> <td>Interval 1:</td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> </tr> <tr> <td>Interval 2:</td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> </tr> <tr> <td>Interval 3:</td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> <td><input style="width: 30px;" type="text"/></td> </tr> </tbody> </table>		Interval Days			Copay Amount	Begin Day	End Day		Interval 1:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	Interval 2:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	Interval 3:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>
	Interval Days																																																													
Copay Amount	Begin Day	End Day																																																												
Interval 1:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>																																																											
Interval 2:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>																																																											
Interval 3:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>																																																											
	Interval Days																																																													
Copay Amount	Begin Day	End Day																																																												
Interval 1:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>																																																											
Interval 2:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>																																																											
Interval 3:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>																																																											
	Interval Days																																																													
Copay Amount	Begin Day	End Day																																																												
Interval 1:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>																																																											
Interval 2:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>																																																											
Interval 3:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>																																																											

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 10

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

File Help

Go To: #1a Inpatient Hospital-Acute - Base 10

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 1:  
Indicate the number of day intervals for Additional Days:  
 Zero (No Copayment per Day)  
 One  
 Two  
 Three

Additional Days Copayment Cost Sharing for Tier 2:  
Indicate the number of day intervals for Additional Days:  
 Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:	Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:	Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:	Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 11

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

File Help

Go To: #1a Inpatient Hospital-Acute - Base 11

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Yes  
 No

Indicate Copayment amount for the Non-Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1a Inpatient Hospital-Acute – Base 12

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

File Help

Go To: #1a Inpatient Hospital-Acute - Base 12

Previous Next Exit (Validate) Exit (No Validate)

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

Yes  
 No

Indicate Copayment amount for Upgrades per stay:

Indicate Copayment amount for Upgrades per day:

What is your Inpatient Hospital-Acute benefit period?

Original Medicare  
 Annual  
 Per Admission or Per Stay  
 Other, Describe

If "Other, Describe" is selected enter description below:

Do you charge cost sharing on the day of discharge?

Yes  
 No

Is authorization required?

Yes  
 No

Is a referral required for Inpatient Hospital-Acute Services?

Yes  
 No

Inpatient Hospital-Acute 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

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

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

File Help

Go To: #1a Inpatient Hospital-Acute (B Only) - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer Inpatient Hospital-Acute Services as a benefit?

Yes  
 No

Select type of benefit for Inpatient Hospital-Acute Services:

Mandatory  
 Optional

Does this benefit have unlimited days?

Yes  
 No, indicate number

Indicate number of days per period:

Select the days periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 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  
 Every Benefit Period  
 Every Stay  
 Other, Describe

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #1a Inpatient Hospital-Acute (B Only) - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

Indicate the 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  
 Every Benefit Period  
 Every Stay  
 Other, Describe

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage per stay:

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

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

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

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

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

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #1a Inpatient Hospital-Acute (B Only) - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?  
 Yes  
 No  
Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No  
Indicate Copayment amount per stay:

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

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

Copayment Amt Interval	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Do you charge cost sharing on the day of discharge?  
 Yes  
 No

Is authorization required?  
 Yes  
 No

Is a referral required for Inpatient Hospital-Acute Services?  
 Yes  
 No

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #1a Inpatient Hospital-Acute (B Only) - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Inpatient Hospital-Acute Notes

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

Notes:

[Empty text box for notes]



# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 1

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?  
 Yes  
 No

Select enhanced benefit:  
 Additional Days  
 Non-Medicare-covered Stay

Select type of benefit for Additional Days:  
 Mandatory  
 Optional

Is this benefit unlimited for Additional Days?  
 Yes  
 No, indicate number

Indicate number of Additional Days per benefit period:

Select type of benefit for Non-Medicare-covered stay:  
 Mandatory  
 Optional

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

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

Select the Maximum Enrollee Out-of-Pocket Cost type:  
 Covered under Inpatient Hospital Services Category 1a  
 Plan-specified amount per period

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  
 Every Benefit Period  
 Every Stay  
 Other, Describe

# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 2

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Medicare-covered benefit costsharing vary by hospital(s) in which an enrollee obtains care?

Yes  
 No

How many costsharing tiers do you offer?

What is your lowest cost tier?

Tier 1  
 Tier 2  
 Tier 3

Is there an enrollee Coinsurance?

Yes  
 No

Medicare-covered Coinsurance Cost Sharing for Tier 1:

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 3

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Medicare-covered Coinsurance Cost Sharing for Tier 2:

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare-covered Coinsurance Cost Sharing for Tier 3:

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

Yes  
 No

Indicate Coinsurance percentage for the Medicare-covered stay:

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinsurance % Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 4

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

File Help
Go To: #1b Inpatient Hospital Psychiatric - Base 4

◀ Previous
Next ▶

✔ Exit (Validate)
✘ Exit (No Validate)

Medicare-covered Lifetime Reserve Days Tier 1

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)

One

Two

Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

	Coinsurance %	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare-covered Lifetime Reserve Days Tier 2

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)

One

Two

Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

	Coinsurance %	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare-covered Lifetime Reserve Days Tier 3

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)

One

Two

Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

	Coinsurance %	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 5

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 5

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?  
 Yes  
 No

How many cost sharing tiers do you offer?  
[ ]

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

Additional Days Coinsurance Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

Additional Days Coinsurance Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 6

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 6

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Coinsurance Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

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

Yes  
 No

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

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 7

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 7

Previous Next Exit (Validate) Exit (No Validate)

If you do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D.  
MA Organizations are not permitted to tier deductibles.

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount for Tier 1:  
[ ]

Indicate Deductible Amount for Tier 2:  
[ ]

Indicate Deductible Amount for Tier 3:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

Medicare-covered Copayment Cost Sharing for Tier 1:

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

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

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

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

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

# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 8

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 8

---

Medicare-covered Copayment Cost Sharing for Tier 2:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare-covered Copayment Cost Sharing for Tier 3:

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

Yes  
 No

Indicate Copayment amount for the Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>



# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 9

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 9

---

Medicare-covered Lifetime Reserve Days Tier 1

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

Interval Days		
Copay Amount	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>

Medicare-covered Lifetime Reserve Days Tier 2

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

Interval Days		
Copay Amount	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>

Medicare-covered Lifetime Reserve Days Tier 3

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

Interval Days		
Copay Amount	Begin Day	End Day
Interval 1:	<input type="text"/>	<input type="text"/>
Interval 2:	<input type="text"/>	<input type="text"/>
Interval 3:	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 10

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 10

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 1:  
Indicate the number of day intervals for Additional Days:  
 Zero (No Copayment per Day)  
 One  
 Two  
 Three

Additional Days Copayment Cost Sharing for Tier 2:  
Indicate the number of day intervals for Additional Days:  
 Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:	Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:	Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:	Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 11

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 11

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Yes  
 No

Indicate Copayment amount for the Non-Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

Copayment Amt Interval 1	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 2	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Copayment Amt Interval 3	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #1b Inpatient Hospital Psychiatric – Base 12

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

File Help

Go To: #1b Inpatient Hospital Psychiatric - Base 12

Previous Next Exit (Validate) Exit (No Validate)

What is your Inpatient Hospital Psychiatric benefit period?

Original Medicare  
 Annual  
 Per Admission or Per Stay  
 Other, Describe

If "Other, Describe" is selected enter description below:

Do you charge cost sharing on the day of discharge?

Yes  
 No

Is authorization required?

Yes  
 No

Is a referral required for Inpatient Psychiatric Hospital Services?

Yes  
 No

Inpatient Hospital Psychiatric Notes

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

Notes:

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer Inpatient Psychiatric Hospital Services as a benefit?

Yes  
 No

Select type of benefit for Inpatient Psychiatric Hospital Services:

Mandatory  
 Optional

Does this benefit have unlimited days?

Yes  
 No, indicate number

Indicate number of days per period:

Select the days periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every Benefit Period  
 Every Stay  
 Other, Describe

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

Yes  
 No

Select the Maximum Plan Benefit Coverage type:

Covered under Inpatient Hospital Services Category 1a  
 Plan-specified amount per period

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  
 Every Benefit Period  
 Every Stay  
 Other, Describe

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 2

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 the Inpatient Hospital Services Category 1a  
 Plan-specified amount per period

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  
 Every Benefit Period  
 Every Stay  
 Other, Describe

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?  
 Yes  
 No

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

Indicate Coinsurance percentage per stay:

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

Coinsurance % Interval	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #1b Inpatient Hospital Psychiatric (B Only) - 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  
Indicate Copayment amount per stay:  
  
Indicate the number of day intervals for the stay:  
 Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):  
Copayment Amt Interval 1:  Begin Day Interval 1:  End Day Interval 1:   
Copayment Amt Interval 2:  Begin Day Interval 2:  End Day Interval 2:   
Copayment Amt Interval 3:  Begin Day Interval 3:  End Day Interval 3:

Do you charge cost sharing on the day of discharge?  
 Yes  
 No

Is authorization required?  
 Yes  
 No

Is a referral required for Inpatient Psychiatric Hospital Services?  
 Yes  
 No



# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 5

Previous Next Exit (Validate) Exit (No Validate)

Inpatient Hospital Psychiatric Notes

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

Notes:

# CY 2020 PBP Data Entry System Screens

#2 SNF – Base 1

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

File Help

Go To: #2 SNF - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefits:

Additional days beyond Medicare-covered  
 Non-Medicare-covered stay (MMP Only)

Select type of benefit for Additional Days beyond Medicare-covered:

Mandatory  
 Optional

Is this benefit unlimited for Additional Days?

Yes  
 No, indicate number

Indicate the number of Additional Days beyond Medicare-covered per benefit period:

Select type of benefit for the Non-Medicare-covered stay:

Mandatory  
 Optional

Do you allow less than 3 day inpatient hospital stay prior to SNF admission?

Yes  
 No

Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):

Zero  
 One  
 Two

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

# CY 2020 PBP Data Entry System Screens

## #2 SNF – Base 2

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

File Help

Go To: #2 SNF - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?  
 Yes  
 No

How many cost sharing tiers do you offer?

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Medicare-covered Coinsurance Cost Sharing for Tier 1:

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

Indicate Coinsurance percentage for the Medicare-covered stay:

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

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

Coinsurance % Interval 1:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #2 SNF – Base 3

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

File Help

Go To: #2 SNF - Base 3

Previous Next Exit (Validate) Exit (No Validate)

**Medicare-covered Coinsurance Cost Sharing for Tier 2:**

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

Yes  
 No

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

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinurance % Interval 1: [ ] Begin Day Interval 1: [ ] End Day Interval 1: [ ]  
Coinurance % Interval 2: [ ] Begin Day Interval 2: [ ] End Day Interval 2: [ ]  
Coinurance % Interval 3: [ ] Begin Day Interval 3: [ ] End Day Interval 3: [ ]

**Medicare-covered Coinsurance Cost Sharing for Tier 3:**

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

Yes  
 No

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

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

Coinurance % Interval 1: [ ] Begin Day Interval 1: [ ] End Day Interval 1: [ ]  
Coinurance % Interval 2: [ ] Begin Day Interval 2: [ ] End Day Interval 2: [ ]  
Coinurance % Interval 3: [ ] Begin Day Interval 3: [ ] End Day Interval 3: [ ]

# CY 2020 PBP Data Entry System Screens

#2 SNF – Base 4

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

File Help

Go To: #2 SNF - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Does this plan's Additional Days cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?

Yes  
 No

How many costsharing tiers do you offer?  
[ ]

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

Additional Days Coinsurance Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

Additional Days Coinsurance Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

# CY 2020 PBP Data Entry System Screens

#2 SNF – Base 5

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

File Help

Go To: #2 SNF - Base 5

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Coinsurance Cost Sharing for Tier 3:  
Indicate the number of day intervals for Additional Days:  
 Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

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

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

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

Is the Coinsurance structure for the Non-Medicare-covered stay the same as the Coinsurance structure for the Medicare-covered stay?  
 Yes  
 No

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

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

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

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

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

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

# CY 2020 PBP Data Entry System Screens

#2 SNF – Base 6

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

File Help

Go To: #2 SNF - Base 6

Previous Next Exit (Validate) Exit (No Validate)

If you do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D.  
MA Organizations are not permitted to tier deductibles.

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount Tier 1:  
[ ]

Indicate Deductible Amount Tier 2:  
[ ]

Indicate Deductible Amount Tier 3:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

Medicare-covered Copayment Cost Sharing for Tier 1:  
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)  
 Yes  
 No

Indicate Copayment amount for Medicare-covered stay:  
[ ]

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

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

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

# CY 2020 PBP Data Entry System Screens

#2 SNF – Base 7

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

File Help

Go To: #2 SNF - Base 7

Previous Next Exit (Validate) Exit (No Validate)

**Medicare-covered Copayment Cost Sharing for Tier 2:**

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

Yes  
 No

Indicate Copayment amount for Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

**Medicare-covered Copayment Cost Sharing for Tier 3:**

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

Yes  
 No

Indicate Copayment amount for Medicare-covered stay:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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



# CY 2020 PBP Data Entry System Screens

#2 SNF – Base 8

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

File Help

Go To: #2 SNF - Base 8

Previous Next Exit (Validate) Exit (No Validate)

**Additional Days Copayment Cost Sharing for Tier 1:**

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

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

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

**Additional Days Copayment Cost Sharing for Tier 2:**

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

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

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

# CY 2020 PBP Data Entry System Screens

#2 SNF – Base 9

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

File Help

Go To: #2 SNF - Base 9

Previous Next Exit (Validate) Exit (No Validate)

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

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

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

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

Yes  
 No

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

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

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

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

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

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

# CY 2020 PBP Data Entry System Screens

## #2 SNF – Base 10

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

File Help

Go To: #2 SNF - Base 10

Previous Next Exit (Validate) Exit (No Validate)

What is your SNF benefit period?

Original Medicare  
 Annual  
 Per Admission or Per Stay  
 Other, Describe

If "Other, Describe" is selected enter description below:

Do you charge cost sharing on the day of discharge?

Yes  
 No

Is authorization required?

Yes  
 No

Is a referral required for SNF Services?

Yes  
 No

SNF 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

## #2 SNF (B Only) – Base 1

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

File Help

Go To: #2 SNF (B Only) - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer SNF Care as a benefit?

Yes  
 No

Select type of benefit for SNF Care:

Mandatory  
 Optional

Does this benefit have unlimited days?

Yes  
 No, indicate number

Indicate number of days per period:

Select the days periodicity:

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

Do you allow less than 3 day Inpatient hospital stay prior to SNF admission?

Yes  
 No

Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):

Zero  
 One  
 Two

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  
 Every Stay  
 Other, Describe

# CY 2020 PBP Data Entry System Screens

## #2 SNF (B Only) – Base 2

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

File Help

Go To: #2 SNF (B Only) - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

Indicate amount for Maximum Enrollee Out-of-Pocket Cost:

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance percentage:

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

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

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

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

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

# CY 2020 PBP Data Entry System Screens

## #2 SNF (B Only) – Base 3

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

File Help

Go To: #2 SNF (B Only) - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment amount per Stay:

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

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

Copayment Amt Interval	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #2 SNF (B Only) – Base 4

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

File Help

Go To: #2 SNF (B Only) - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?  
 Yes  
 No

Is a referral required for SNF Services?  
 Yes  
 No

Skilled Nursing Facility (B-Only) 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

## #3 Cardiac and Pulmonary Rehabilitation Services – Base 1

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

File Help

Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Additional Cardiac Rehabilitation Services  
 Additional Intensive Cardiac Rehabilitation Services  
 Additional Pulmonary Rehabilitation Services  
 Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services

Select type of benefit for Additional Cardiac Rehabilitation Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Cardiac Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Cardiac Rehabilitation Services:

Select the Additional Cardiac Rehabilitation Services periodicity:

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

Select type of benefit for Additional Intensive Cardiac Rehabilitation Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Intensive Cardiac Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Intensive Cardiac Rehabilitation Services:

Select the Additional Intensive Cardiac Rehabilitation Services periodicity:

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

Select type of benefit for Additional Pulmonary Rehabilitation Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Pulmonary Rehabilitation Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Pulmonary Rehabilitation Services:

Select the Additional Pulmonary Rehabilitation Services periodicity:

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

Select type of benefit for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:

Mandatory  
 Optional

Is this benefit unlimited for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services?

Yes  
 No, indicate number

Indicate number of visits for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:

Select the Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services periodicity:

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



# CY 2020 PBP Data Entry System Screens

## #3 Cardiac and Pulmonary Rehabilitation Services – Base 2

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

File Help

Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 2

---

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Select which Cardiac and Pulmonary Rehabilitation Services have a Coinsurance (Select all that apply):

- Medicare-covered Cardiac Rehabilitation Services
- Medicare-covered Intensive Cardiac Rehabilitation Services
- Medicare-covered Pulmonary Rehabilitation Services
- Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
- Additional Cardiac Rehabilitation Services
- Additional Intensive Cardiac Rehabilitation Services
- Additional Pulmonary Rehabilitation Services
- Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services

	Minimum Coinsurance	Maximum Coinsurance
Indicate Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services:	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
Indicate Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services:	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
Indicate Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
Indicate Coinsurance percentage for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
Indicate Coinsurance percentage for Additional Cardiac Rehabilitation Services:	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
Indicate Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
Indicate Coinsurance percentage for Additional Pulmonary Rehabilitation Services:	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>
Indicate Coinsurance percentage for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>

# CY 2020 PBP Data Entry System Screens

## #3 Cardiac and Pulmonary Rehabilitation Services – Base 3

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

File Help

Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 3

<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Deductible Amount: <input style="width: 50px;" type="text"/></p> <p>Is there an enrollee Copayment?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Cardiac Rehabilitation Services</p> <p><input type="checkbox"/> Medicare-covered Intensive Cardiac Rehabilitation Services</p> <p><input type="checkbox"/> Medicare-covered Pulmonary Rehabilitation Services</p> <p><input type="checkbox"/> Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services</p> <p><input type="checkbox"/> Additional Cardiac Rehabilitation Services</p> <p><input type="checkbox"/> Additional Intensive Cardiac Rehabilitation Services</p> <p><input type="checkbox"/> Additional Pulmonary Rehabilitation Services</p> <p><input type="checkbox"/> Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services</p>	<p>Indicate Copayment amount for Medicare-covered Cardiac Rehabilitation Services:</p> <p>Indicate Copayment amount for Medicare-covered Intensive Cardiac Rehabilitation Services:</p> <p>Indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services:</p> <p>Indicate Copayment amount for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:</p> <p>Indicate Copayment amount for Additional Cardiac Rehabilitation Services:</p> <p>Indicate Copayment amount for Additional Intensive Cardiac Rehabilitation Services:</p> <p>Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:</p> <p>Indicate Copayment amount for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:</p>	<p>Minimum Copayment</p> <p>Maximum Copayment</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr> </table>																

# CY 2020 PBP Data Entry System Screens

## #3 Cardiac and Pulmonary Rehabilitation Services – Base 4

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section B-3, 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 "#3 Cardiac and Pulmonary Rehabilitation Services - Base 4".

The main content area contains the following sections:

- Is authorization required?** with radio buttons for "Yes" and "No".
- Is a referral required for Cardiac and Pulmonary Rehabilitation Services?** with radio buttons for "Yes" and "No".
- Cardiac and Pulmonary Rehabilitation Services Notes**  
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.

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #4a Emergency Care/Post-Stabilization Care - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate the maximum per visit amount:

Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?

Yes  
 No

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

Days  
 Hours

Enter number of Days or Hours:

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #4a Emergency Care/Post-Stabilization Care - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?  
 Yes  
 No

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

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

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

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

Enter number of Days or Hours:  
[ ]

Does the Emergency Care/Post-Stabilization Care cost sharing count towards any plan-level deductible?  
 Yes  
 No

Authorization is not applicable for this Service Category.  
Referral is not applicable for this Service Category.  
Emergency Care/Post-Stabilization Care 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

## #4b Urgently Needed Services – Base 1

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

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

Covered under Emergency Care/Post-Stabilization Care Service Category 4a  
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate the maximum per visit amount:

Is the Coinsurance for Medicare-covered Benefits waived if admitted to hospital?

Yes  
 No

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

Days  
 Hours

Enter number of Days or Hours:

# CY 2020 PBP Data Entry System Screens

## #4b Urgently Needed Services – Base 2

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

File Help

Go To: #4b Urgently Needed Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?  
 Yes  
 No

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

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

Does the Urgently Needed Services cost sharing count towards any plan-level deductible?  
 Yes  
 No

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

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

Enter number of Days or Hours:  
[ ]

# CY 2020 PBP Data Entry System Screens

## #4b Urgently Needed Services – Base 3

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

File Help

Go To: #4b Urgently Needed Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Authorization is not applicable for this Service Category.

Referral is not applicable for this Service Category.

Urgently Needed 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

## #4c Worldwide Emergency/Urgent Coverage – Base 1

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

File Help

Go To: #4c Worldwide Emergency/Urgent Coverage - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?

Yes  
 No

Select enhanced benefit:

Worldwide Emergency Coverage  
 Worldwide Urgent Coverage  
 Worldwide Emergency Transportation

Select type of benefit for Worldwide Emergency Coverage:

Mandatory  
 Optional

Select type of benefit for Worldwide Urgent Coverage:

Mandatory  
 Optional

Select type of benefit for Worldwide Emergency Transportation:

Mandatory  
 Optional

Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?

Yes  
 No

Is the service-specific Maximum Plan Benefit Coverage amount unlimited?

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

# CY 2020 PBP Data Entry System Screens

## #4c Worldwide Emergency/Urgent Coverage – Base 2

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

File Help

Go To: #4c Worldwide Emergency/Urgent Coverage - 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 Worldwide Services have a Coinsurance (Select all that apply):</p> <p><input type="checkbox"/> Worldwide Emergency Coverage <input type="checkbox"/> Worldwide Urgent Coverage <input type="checkbox"/> Worldwide Emergency Transportation</p> <p>Indicate Minimum Coinsurance percentage for Worldwide Emergency Coverage: <input type="text"/></p> <p>Indicate Maximum Coinsurance percentage for Worldwide Emergency Coverage: <input type="text"/></p> <p>Is this Coinsurance waived for Worldwide Emergency Coverage if admitted to hospital? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Minimum Coinsurance percentage for Worldwide Urgent Coverage: <input type="text"/></p> <p>Indicate Maximum Coinsurance percentage for Worldwide Urgent Coverage: <input type="text"/></p> <p>Is this Coinsurance waived for Worldwide Urgent Coverage if admitted to hospital? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Minimum Coinsurance percentage for Worldwide Emergency Transportation: <input type="text"/></p> <p>Indicate Maximum Coinsurance percentage for Worldwide Emergency Transportation: <input type="text"/></p> <p>Is this Coinsurance waived for Worldwide Emergency Transportation if admitted to hospital? <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>Select which Worldwide Services have a Copayment (Select all that apply):</p> <p><input type="checkbox"/> Worldwide Emergency Coverage <input type="checkbox"/> Worldwide Urgent Coverage <input type="checkbox"/> Worldwide Emergency Transportation</p> <p>Indicate Minimum Copayment amount for Worldwide Emergency Coverage: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Worldwide Emergency Coverage: <input type="text"/></p> <p>Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Minimum Copayment amount for Worldwide Urgent Coverage: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Worldwide Urgent Coverage: <input type="text"/></p> <p>Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Minimum Copayment amount for Worldwide Emergency Transportation: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Worldwide Emergency Transportation: <input type="text"/></p> <p>Is this Copayment waived for Worldwide Emergency Transportation if admitted to hospital? <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>Indicate Deductible Amount: <input type="text"/></p>
---	---	---

# CY 2020 PBP Data Entry System Screens

## #4c Worldwide Emergency/Urgent Coverage – Base 3

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: #4c Worldwide Emergency/Urgent Coverage - Base 3

Authorization is not applicable for this Service Category.

Referral is not applicable for this Service Category.

Worldwide Emergency/Urgent Coverage 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

## #5 Partial Hospitalization – Base 1

**PBP Data Entry System - Section B-5, Contract X0001, Plan 001, Segment 000**

File Help

Go To: #5 Partial Hospitalization - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

# CY 2020 PBP Data Entry System Screens

## #5 Partial Hospitalization – Base 2

PBP Data Entry System - Section B-5, Contract X0001, Plan 001, Segment 000

File Help

Go To: #5 Partial Hospitalization - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount for Medicare-covered Benefits per day:  
[Text Input]

Indicate Maximum Copayment amount for Medicare-covered Benefits per day:  
[Text Input]

Is authorization required?

Yes  
 No

Is a referral required for Partial Hospitalization?

Yes  
 No

Partial Hospitalization Notes

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

Notes:  
[Text Area]

# CY 2020 PBP Data Entry System Screens

## #6 Home Health Services – Base 1

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

File Help

Go To: #6 Home Health Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category, except for MMPs.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

\_\_\_\_\_

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

\_\_\_\_\_

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

\_\_\_\_\_

# CY 2020 PBP Data Entry System Screens

## #6 Home Health Services – Base 2

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

File Help

Go To: #6 Home Health Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# CY 2020 PBP Data Entry System Screens

## #6 Home Health Services – Base 3

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section B-6, 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 "#6 Home Health Services - Base 3".

The main content area contains the following fields and instructions:

- Is authorization required?** with radio buttons for "Yes" and "No" and an adjacent text input field.
- Is a referral required for Home Health Services?** with radio buttons for "Yes" and "No" and an adjacent text input field.
- Home Health Services Notes** section with the instruction: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."
- A large **Notes:** text area with a vertical scrollbar.



# CY 2020 PBP Data Entry System Screens

## #6 Home Health Services – MMP – Base 1

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

File Help

Go To: #6 Home Health Services - MMP - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare-covered Home Health Services?

Yes  
 No

Select Non-Medicare-covered Home Health Services:

Additional Hours of Care  
 Personal Care Services  
 Other 1  
 Other 2

Enter name of Other 1 Service:  
[Text Box]

Enter name of Other 2 Service:  
[Text Box]

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:  
[Text Box]

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 limit on the services provided?

Yes  
 No

Select Non-Medicare-covered Home Health Services where limit applies:

Additional Hours of Care  
 Personal Care Services  
 Other 1  
 Other 2

Indicate units a limit will be provided in for Additional Hours of Care:

Sessions  
 Visits  
 Hours  
 Points  
 Meals

Indicate units a limit will be provided in for Personal Care Services:

Sessions  
 Visits  
 Hours  
 Points  
 Meals  
 Items/Other, Describe

Indicate numerical limit on the services provided for Additional Hours of Care:  
[Text Box]

Indicate numerical limit on the services provided for Personal Care Services:  
[Text Box]

Select limit on services periodicity for Additional Hours of Care:

Every day  
 Every week  
 Every month  
 Every year  
 Other, Describe

Select limit on services periodicity for Personal Care Services:

Every day  
 Every week  
 Every month  
 Every year  
 Other, Describe

# CY 2020 PBP Data Entry System Screens

## #6 Home Health Services – MMP – Base 2

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

File Help

Go To: #6 Home Health Services - MMP - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 1:  
 Sessions  
 Visits  
 Hours  
 Points  
 Meals  
 Items/Other, Describe

Indicate numerical limit on the services provided for Other 1:

Select limit on services periodicity for Other 1:  
 Every day  
 Every week  
 Every month  
 Every year  
 Other, Describe

Indicate units a limit will be provided in for Other 2:  
 Sessions  
 Visits  
 Hours  
 Points  
 Meals  
 Items/Other, Describe

Indicate numerical limit on the services provided for Other 2:

Select limit on services periodicity for Other 2:  
 Every day  
 Every week  
 Every month  
 Every year  
 Other, Describe

Is there an enrollee Coinsurance?  
 Yes  
 No

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

Indicate coinsurance percentage for one or more of the following services:

	Minimum Coinsurance	Maximum Coinsurance
Additional Hours of Care	<input type="text"/>	<input type="text"/>
Personal Care Services	<input type="text"/>	<input type="text"/>
Other 1:	<input type="text"/>	<input type="text"/>
Other 2:	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #6 Home Health Services – MMP – Base 3

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

File Help

Go To: #6 Home Health Services - MMP - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?  
 Yes  
 No

Is authorization required?  
 Yes  
 No

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

Is a referral required for Services?  
 Yes  
 No

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

Indicate copayment amount for one or more of the following services:

	Minimum Copayment	Maximum Copayment
Additional Hours of Care:	<input type="text"/>	<input type="text"/>
Personal Care Services:	<input type="text"/>	<input type="text"/>
Other 1:	<input type="text"/>	<input type="text"/>
Other 2:	<input type="text"/>	<input type="text"/>

Notes:

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

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

# CY 2020 PBP Data Entry System Screens

## #7a Primary Care Physician Services – Base 1

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

File Help

Go To: #7a Primary Care Physician Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category

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

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

Yes  
 No

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# CY 2020 PBP Data Entry System Screens

## #7a Primary Care Physician Services – Base 2

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

File Help

Go To: #7a Primary Care Physician Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Authorization is not applicable for this Service Category.

Referral is not applicable for this service category.

Primary Care Physician Services 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 for notes]

# CY 2020 PBP Data Entry System Screens

## #7b Chiropractic Services – Base 1

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

File Help

Go To: #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

## #7b Chiropractic Services – Base 2

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

File Help

Go To: #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:</p> <input type="text"/> <p>Indicate Maximum Coinsurance percentage per visit for Medicare-covered Benefits:</p> <input type="text"/> <p>Indicate the Minimum Coinsurance percentage per visit for Routine Care:</p> <input type="text"/> <p>Indicate the Maximum Coinsurance percentage per visit for Routine Care:</p> <input type="text"/> <p>Indicate the Minimum Coinsurance percentage per visit for Other Service:</p> <input type="text"/> <p>Indicate the Maximum Coinsurance percentage per visit for Other Service:</p> <input type="text"/>	<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:</p> <input type="text"/> <p>Indicate Maximum Copayment amount for Medicare-covered Benefits:</p> <input type="text"/> <p>Indicate Minimum Copayment amount per visit for Routine Care:</p> <input type="text"/> <p>Indicate Maximum Copayment amount per visit for Routine Care:</p> <input type="text"/> <p>Indicate Minimum Copayment amount per visit for Other Service:</p> <input type="text"/> <p>Indicate Maximum Copayment amount per visit for Other Service:</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"/> <p>Is authorization required?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Is a referral required for Chiropractic Services?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
---	---	---

# CY 2020 PBP Data Entry System Screens

## #7b Chiropractic Services – Base 3

The screenshot shows a software window titled "PBP Data Entry System - Section B-7, 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 "#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 input field labeled "Notes:".



# CY 2020 PBP Data Entry System Screens

## #7c Occupational Therapy Services – Base 1

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

File Help

Go To: #7c Occupational Therapy Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

Enhanced Benefits are not applicable for this Service Category, except for MMPs.

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

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

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

You must include total cost sharing to the beneficiary, including any facility cost sharing.

Is there an enrollee Coinsurance?

Yes  No

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

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

Is there an enrollee Deductible?

Yes  No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  No

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

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

# CY 2020 PBP Data Entry System Screens

## #7c Occupational Therapy Services – Base 2

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section B-7, 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 "#7c Occupational Therapy Services - Base 2".

The main content area contains the following fields and sections:

- Is authorization required?** with radio buttons for "Yes" and "No".
- Is a referral required for Occupational Therapy Services?** with radio buttons for "Yes" and "No".
- Occupational Therapy Services Notes** section with a text area for notes. The text area is currently empty.

Below the notes section, there is a large, empty white area, likely a placeholder for additional information or a summary.

# CY 2020 PBP Data Entry System Screens

## #7c Occupational Therapy Services – MMP – Base 1

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

File Help

Go To: #7c Occupational Therapy Services - MMP - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare-covered Occupational Therapy Service?

Yes  
 No

Enter name of Non-Medicare-covered Occupational Therapy Service:

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 an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage:

Indicate Maximum Coinsurance percentage:

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount:

Indicate Maximum Copayment amount:

# CY 2020 PBP Data Entry System Screens

## #7c Occupational Therapy Services – MMP – Base 2

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section B-7, 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 "#7c Occupational Therapy Services - MMP - Base 2".

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 Services?** with radio buttons for "Yes" and "No" and an adjacent text input field.
- Occupational Therapy Services MMP Notes**
  - Instruction: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."
  - A text area labeled "Notes:" for entering information.

# CY 2020 PBP Data Entry System Screens

## #7d Physician Specialist Services – Base 1

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

File Help

Go To: #7d Physician Specialist Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# CY 2020 PBP Data Entry System Screens

## #7d Physician Specialist Services – Base 2

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

File Help

Go To: #7d Physician Specialist Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?  
 Yes  
 No

Is a referral required for Physician Specialist Services?  
 Yes  
 No

Physician Specialist 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

## #7e Mental Health Specialty Services – Base 1

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: #7e Mental Health Specialty Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

# CY 2020 PBP Data Entry System Screens

## #7e Mental Health Specialty Services – Base 2

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

File Help

Go To: #7e Mental Health Specialty Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?  
 Yes  
 No

Is there an enrollee Copayment?  
 Yes  
 No

Select which Mental Health Specialty Services have a Coinsurance (Select all that apply):  
 Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Select which Mental Health Specialty Services have a Copayment (Select all that apply):  
 Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum Coinsurance percentage for Medicare-covered Group Sessions:

Indicate Minimum Copayment amount for Medicare-covered Group Sessions:

Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for Medicare-covered Group Sessions:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:



# CY 2020 PBP Data Entry System Screens

## #7e Mental Health Specialty Services – Base 3

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

File Help

Go To: #7e Mental Health Specialty Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?

Yes

No

Is a referral required for Mental Health Specialty Services - Non-Physician?

Yes

No

Mental Health Specialty 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

## #7f Podiatry Services – Base 1

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

File Help

Go To: #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

## #7f Podiatry Services – Base 2

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

File Help

Go To: #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

## #7f Podiatry Services – Base 3

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section B-7, 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 "#7f Podiatry Services - Base 3".

The main content area contains the following sections:

- Is authorization required?** with radio buttons for "Yes" and "No".
- Is a referral required for Podiatrist Services?** with radio buttons for "Yes" and "No".
- Podiatry Services Notes** section with a text area for notes. The text above the area reads: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." The text area is currently empty.

# CY 2020 PBP Data Entry System Screens

## #7g Other Health Care Professional – Base 1

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

File Help

Go To: #7g Other Health Care Professional - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# CY 2020 PBP Data Entry System Screens

## #7g Other Health Care Professional – Base 2

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

File Help

Go To: #7g Other Health Care Professional - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?  
 Yes  
 No

Is a referral required for Other Health Care Professional Services?  
 Yes  
 No

Other Health Care Professional 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

## #7h Psychiatric Services – Base 1

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: #7h Psychiatric Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select 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

## #7h Psychiatric Services – Base 2

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

File Help

Go To: #7h Psychiatric Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?

Yes  
 No

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

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate Maximum Coinsurance percentage for Medicare-covered Individual Sessions:

Indicate Minimum Coinsurance percentage for Medicare-covered Group Sessions:

Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions:

Is there an enrollee Copayment?

Yes  
 No

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

Medicare-covered Individual Sessions  
 Medicare-covered Group Sessions

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:

Indicate Minimum Copayment amount for Medicare-covered Group Sessions:

Indicate Maximum Copayment amount for Medicare-covered Group Sessions:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:



# CY 2020 PBP Data Entry System Screens

## #7h Psychiatric Services – Base 3

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section B-7, 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 "#7h Psychiatric Services - Base 3".

The main content area contains the following sections:

- Is authorization required?** with radio buttons for "Yes" and "No".
- Is a referral required for Psychiatric Services?** with radio buttons for "Yes" and "No".
- Psychiatric Services Notes** section with a text area for notes. A note below the text area reads: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." The text area is currently empty.

# CY 2020 PBP Data Entry System Screens

## #7i PT and SP Services – Base 1

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

File Help

Go To: #7i PT and SP Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category, except for MMPs.

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

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

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

You must include total cost sharing to the beneficiary, including any facility cost sharing.

Is there an enrollee Coinsurance?

Yes  
 No

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

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

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# CY 2020 PBP Data Entry System Screens

## #7i PT and SP Services – Base 2

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

File Help

Go To: #7i PT and SP Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?

Yes

No

Is a referral required for Physical Therapy and Speech-Language Pathology Services?

Yes

No

PT and SP 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

#7i PT and ST – MMP – Base 1

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

File Help

Go To: #7i PT and ST - MMP - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare-covered Physical and/or Speech Therapy services?

Yes  
 No

Select Non-Medicare-covered Physical and/or Speech Therapy Services:

Other 1  
 Other 2

Enter name of Other 1 Service:  
\_\_\_\_\_  
Enter name of Other 2 Service:  
\_\_\_\_\_

Is there an enrollee Coinsurance?

Yes  
 No

Select which Non-Medicare-covered Physical and/or Speech Therapy services have a Coinsurance (select all that apply):

Other 1  
 Other 2

Indicate coinsurance percentage for one or more of the following services:	Minimum Coinsurance	Maximum Coinsurance
Other 1:	<input type="text"/>	<input type="text"/>
Other 2:	<input type="text"/>	<input type="text"/>

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

# CY 2020 PBP Data Entry System Screens

#7i PT and ST – MMP – Base 2

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

File Help

Go To: #7i PT and ST - MMP - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?  
 Yes  
 No

Is authorization required?  
 Yes  
 No

Select which Non-Medicare-covered Physical and/or Speech Therapy services have a Copayment (select all that apply):  
 Other 1  
 Other 2

Is a referral required for Services?  
 Yes  
 No

Indicate copayment amount for one or more of the following services:

	Minimum Copayment	Maximum Copayment
Other 1:	<input type="text"/>	<input type="text"/>
Other 2:	<input type="text"/>	<input type="text"/>

PT and SP Services MMP 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

## #7j Additional Telehealth Services – Base 1

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

File Help

Go To: #7j Additional Telehealth Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

Do you offer an Additional Telehealth benefit for Part B services?

Yes  
 No

Is the Additional Telehealth benefit unlimited?

Yes  
 No

Indicate number of visits for Additional Telehealth Services:

Select the Medicare-covered benefits that will have Additional Telehealth available:

- 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
- 4: Emergency Care/Post-Stabilization Care
- 4b: Urgently Needed Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e1: Individual Sessions for Mental Health Specialty Services
- 7e2: Group Sessions for Mental Health Specialty Services
- 7f: Podiatry Services
- 7g: Other Health Care Professional
- 7h1: Individual Sessions for Psychiatric Services
- 7h2: Group Sessions for Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 7k: Opioid Treatment Services
- 8a1: Diagnostic Procedures/Tests
- 8a2: Lab Services
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Ray Services
- 9a1: Outpatient Hospital Services
- 9a2: Observation Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c1: Individual Sessions for Outpatient Substance Abuse
- 9c2: Group Sessions for Outpatient Substance Abuse

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

Every year  
 Every six months  
 Every three months  
 Other, Describe

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Every year  
 Every six months  
 Every three months  
 Other, Describe

# CY 2020 PBP Data Entry System Screens

## #7j Additional Telehealth Services – Base 2

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

File Help

Go To: #7j Additional Telehealth Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?  
 Yes  
 No

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

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

Is there an enrollee Copayment?  
 Yes  
 No

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

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

# CY 2020 PBP Data Entry System Screens

## #7j Additional Telehealth Services – Base 3

The screenshot shows a web-based data entry form within a browser window titled "PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a navigation toolbar with buttons for "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)". A "Go To:" dropdown menu is set to "#7j Additional Telehealth Services - Base 3".

The main content area contains the following sections:

- Is authorization required for Additional Telehealth Services?**  
 Yes  
 No
- Is a referral required for Additional Telehealth Services?**  
 Yes  
 No
- Additional Telehealth 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

## #7k Opioid Treatment Services – Base 1

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

File Help

Go To: #7k Opioid Treatment Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

# CY 2020 PBP Data Entry System Screens

## #7k Opioid Treatment Services – Base 2

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section B-7, 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 "#7k Opioid Treatment Services - Base 2".

The main content area contains the following sections:

- Is authorization required?** with radio buttons for "Yes" and "No".
- Is a referral required for Opioid Treatment Services?** with radio buttons for "Yes" and "No".
- Opioid Treatment Services Notes** with a text area. The instructions state: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." The text area is currently empty.

# CY 2020 PBP Data Entry System Screens

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

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

File Help

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

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes

No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

Indicate Minimum Coinsurance percentage for Medicare-covered Lab Services:

Is there an enrollee Coinsurance?

Yes  No

Indicate Maximum Coinsurance percentage for Medicare-covered Lab Services:

Select which Outpatient Diag Procs/Tests/Lab Services have a Coinsurance (Select all that apply):

Medicare-covered Diagnostic Procedures/Tests

Medicare-covered Lab Services

Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests:

Indicate Maximum Coinsurance percentage for Medicare-covered Diagnostic Procedures/Tests:

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 3

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 Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):

Medicare-covered Diagnostic Procedures/Tests  
 Medicare-covered Lab Services

Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:

Indicate Minimum Copayment amount for Medicare-covered Lab Services:

Indicate Maximum Copayment amount for Medicare-covered Lab Services:

If a member receives multiple services at the same location on the same day, does only the maximum copay apply?

Yes  
 No

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?  
 Yes  
 No

Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?  
 Yes  
 No

Outpatient Diag/Procs/Tests/Lab Services Notes:  
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Diagnostic Procedures/Tests Notes:

Lab Services Notes:

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Select which Outpatient Diag/Therapeutic Rad Services have a Coinsurance (Select all that apply):

Medicare-covered Diagnostic Radiological Services  
 Medicare-covered Therapeutic Radiological Services  
 Medicare-covered X-Ray Services

Indicate Minimum Coinsurance percentage for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):

Indicate Maximum Coinsurance percentage for Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):

Indicate Minimum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services:

Indicate Maximum Coinsurance percentage for other Medicare-covered Therapeutic Radiological Services:

Indicate Minimum Coinsurance percentage for Medicare-covered X-Ray Services:

Indicate Maximum Coinsurance percentage for Medicare-covered X-Ray Services:

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 2

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 Outpatient Diag/Therapeutic Rad Services have a Copayment (Select all that apply):  
 Medicare-covered Diagnostic Radiological Services  
 Medicare-covered Therapeutic Radiological Services  
 Medicare-covered X-Ray Services

Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):  
\_\_\_\_\_

Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):  
\_\_\_\_\_

Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:  
\_\_\_\_\_

Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:  
\_\_\_\_\_

Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:  
\_\_\_\_\_

Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:  
\_\_\_\_\_

If a member receives multiple services at the same location on the same day, does only the maximum copay apply?  
 Yes  
 No



# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?  
 Yes  
 No

Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?  
 Yes  
 No

Outpatient Diag/Therapeutic Rad Services Notes  
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Diagnostic Radiological Services (e.g., CT, MRI, etc.) Notes:

Therapeutic Radiological Services Notes:

X-Ray Services Notes:

# CY 2020 PBP Data Entry System Screens

## #9a Outpatient Hospital Services – Base 1

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

File Help

Go To: #9a Outpatient Hospital Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

[CLICK FOR DESCRIPTION OF BENEFIT](#)

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Select which Services have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply):

Medicare-covered Outpatient Hospital Services  
 Medicare-covered Observation Services

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Outpatient Hospital Services:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Outpatient Hospital Services:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Observation Services:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Observation Services:

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

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

Is there an enrollee Coinsurance?

Yes  
 No

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

Medicare-covered Outpatient Hospital Services  
 Medicare-covered Observation Services

Indicate Minimum Coinsurance percentage for Medicare-covered Outpatient Hospital Services:

Indicate Maximum Coinsurance percentage for Medicare-covered Outpatient Hospital Services:

Indicate Minimum Coinsurance percentage for Medicare-covered Observation Services:

Indicate Maximum Coinsurance percentage for Medicare-covered Observation Services:

# CY 2020 PBP Data Entry System Screens

## #9a Outpatient Hospital Services – Base 2

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

File Help

Go To: #9a Outpatient Hospital Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

<p>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which Services have a Deductible (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Outpatient Hospital Services <input type="checkbox"/> Medicare-covered Observation Services</p> <p>Indicate Deductible Amount for Medicare-covered Outpatient Hospital Services:</p> <input type="text"/>	<p>Is there an enrollee Copayment?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which Services have a Copayment (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Outpatient Hospital Services <input type="checkbox"/> Medicare-covered Observation Services</p> <p>Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:</p> <input type="text"/>	<p>Is authorization required for Medicare-covered Outpatient Hospital Services?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Is authorization required for Medicare-covered Observation Services?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Is a referral required for Medicare-covered Outpatient Hospital Services?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Is a referral required for Medicare-covered Observation Services?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>Indicate Deductible Amount for Medicare-covered Observation Services:</p> <input type="text"/>	<p>Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:</p> <input type="text"/>	
	<p>Indicate Minimum Copayment amount per visit for Medicare-covered Observation Services:</p> <input type="text"/>	
	<p>Indicate Maximum Copayment amount per visit for Medicare-covered Observation Services:</p> <input type="text"/>	

# CY 2020 PBP Data Entry System Screens

## #9a Outpatient Hospital Services – Base 3

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

File Help

Go To: #9a Outpatient Hospital Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Outpatient Hospital Services 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 scroll bar]

# CY 2020 PBP Data Entry System Screens

## #9b ASC Services – Base 1

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

File Help

Go To: #9b ASC Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

# CY 2020 PBP Data Entry System Screens

## #9b ASC Services – Base 2

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

File Help

Go To: #9b ASC Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

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

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

Is authorization required?  
 Yes  
 No

Is a referral required for Ambulatory Surgical Center Services?  
 Yes  
 No

# CY 2020 PBP Data Entry System Screens

## #9b ASC Services – Base 3

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

File Help

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

ASC Services Notes

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

Notes:

[Large empty text area for notes]

# CY 2020 PBP Data Entry System Screens

## #9c Outpatient Substance Abuse – Base 1

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

File Help

Go To: #9c Outpatient Substance Abuse - Base 1

Previous Next Exit (Validate) Exit (No Validate)

[CLICK FOR DESCRIPTION OF BENEFIT](#)

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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



# CY 2020 PBP Data Entry System Screens

## #9c Outpatient Substance Abuse – Base 2

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

File Help

Go To: #9c Outpatient Substance Abuse - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
\_\_\_\_\_

Is there an enrollee Copayment?  
 Yes  
 No

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

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

Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions:  
\_\_\_\_\_

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:  
\_\_\_\_\_

Indicate Maximum Coinsurance percentage for Medicare-covered Individual Sessions:  
\_\_\_\_\_

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:  
\_\_\_\_\_

Indicate Minimum Coinsurance percentage for Medicare-covered Group Sessions:  
\_\_\_\_\_

Indicate Minimum Copayment amount for Medicare-covered Group Sessions:  
\_\_\_\_\_

Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions:  
\_\_\_\_\_

Indicate Maximum Copayment amount for Medicare-covered Group Sessions:  
\_\_\_\_\_

# CY 2020 PBP Data Entry System Screens

## #9c Outpatient Substance Abuse – Base 3

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

File Help

Go To: #9c Outpatient Substance Abuse - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?

Yes

No

Is a referral required for Outpatient Substance Abuse?

Yes

No

Outpatient Substance Abuse Notes

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

Notes:

# CY 2020 PBP Data Entry System Screens

## #9d Outpatient Blood Services – Base 1

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

File Help

Go To: #9d Outpatient Blood Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

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

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

Yes  
 No

Select enhanced benefit:  
 Three (3) Pint Deductible Waived

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

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

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

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

# CY 2020 PBP Data Entry System Screens

## #9d Outpatient Blood Services – Base 2

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

File Help

Go To: #9d Outpatient Blood Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

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

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

Is authorization required?  
 Yes  
 No

Is a referral required for Outpatient Blood Services?  
 Yes  
 No

Outpatient Blood 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

## #10a Ambulance Services – Base 1

**PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000**

File Help

Go To: #10a Ambulance Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Select which Services have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply):

Medicare-covered Ground Ambulance Services  
 Medicare-covered Air Ambulance Services

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Ground Ambulance Services:

\_\_\_\_\_

Select Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Ground Ambulance Services:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Air Ambulance Services:

\_\_\_\_\_

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Air Ambulance Services:

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

Is there an enrollee Coinsurance?

Yes  
 No

Is this Coinsurance waived if admitted to hospital?

Yes  
 No

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

Medicare-covered Ground Ambulance Services  
 Medicare-covered Air Ambulance Services

Indicate the Minimum Coinsurance percentage for Medicare-covered Ground Ambulance Services:

\_\_\_\_\_

Indicate the Maximum Coinsurance percentage for Medicare-covered Ground Ambulance Services:

\_\_\_\_\_

Indicate Minimum Coinsurance percentage for Medicare-covered Air Ambulance Services:

\_\_\_\_\_

Indicate Maximum Coinsurance percentage for Medicare-covered Air Ambulance Services:

\_\_\_\_\_

# CY 2020 PBP Data Entry System Screens

## #10a Ambulance Services – Base 2

**PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000**

File Help

Go To: #10a Ambulance Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?  
 Yes  
 No

Is there an enrollee Copayment?  
 Yes  
 No

Is this Copayment waived if admitted to hospital?  
 Yes  
 No

Select which Services have a Deductible (Select all that apply):  
 Medicare-covered Ground Ambulance Services  
 Medicare-covered Air Ambulance Services

Select which Services have a Copayment (Select all that apply):  
 Medicare-covered Ground Ambulance Services  
 Medicare-covered Air Ambulance Services

Indicate Deductible Amount for Medicare-covered Ground Ambulance Services:

Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:

Indicate Deductible Amount for Medicare-covered Air Ambulance Services:

Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:

Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:

Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:

# CY 2020 PBP Data Entry System Screens

## #10a Ambulance Services – Base 3

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

Go To: #10a Ambulance Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required for non-emergency Medicare services?

Yes

No

Referral is not applicable for this Service Category.

Ambulance 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

## #10b Transportation Services – Base 1

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

Go To: #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

## #10b Transportation Services – Base 2

**PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000**

File Help

Go To: #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: <input type="text"/></p> <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>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: <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>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Minimum Coinsurance percentage: <input type="text"/></p> <p>Indicate Maximum Coinsurance percentage: <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>
--	---	--

# CY 2020 PBP Data Entry System Screens

## #10b Transportation Services – Base 3

PBP Data Entry System - Section B-10, Contract X0001, Plan 001, Segment 000

File Help

Go To: #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:  
[Text Box]

Indicate Maximum Copayment amount per trip:  
[Text Box]

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:  
[Text Area]

# CY 2020 PBP Data Entry System Screens

#11a DME – Base 1

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

File Help

Go To: #11a DME - Base 1

Previous Next Exit (Validate) Exit (No Validate)

[CLICK FOR DESCRIPTION OF BENEFIT](#)

Enhanced Benefits are not applicable for this Service Category, except for MMPs.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

# CY 2020 PBP Data Entry System Screens

#11a DME – Base 2

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

File Help

Go To: #11a DME - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

Yes  
 No

Is authorization required?

Yes  
 No

Referral is not applicable for this Service Category.

Durable Medical Equipment 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

#11a DME – MMP – Base 1

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

File Help

Go To: #11a DME - MMP - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare-covered Durable Medical Equipment?

Yes  
 No

Select Non-Medicare-covered Durable Medical Equipment:

Durable Medical Equipment for use outside the home  
 Other 1  
 Other 2

Enter name of Other 1 Service:  
[Text Field]

Enter name of Other 2 Service:  
[Text Field]

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:  
[Text Field]

Select Maximum Plan Benefit Coverage periodicity:

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

Is there an enrollee Coinsurance?

Yes  
 No

Select which Non-Medicare-covered Durable Medical Equipment(s) (select all that apply):

Durable Medical Equipment for use outside the home  
 Other 1  
 Other 2

Indicate coinsurance percentage for one or more of the following services:

	Minimum Coinsurance	Maximum Coinsurance
Durable Medical Equipment for use outside the home:	[Text Field]	[Text Field]
Other 1:	[Text Field]	[Text Field]
Other 2:	[Text Field]	[Text Field]

# CY 2020 PBP Data Entry System Screens

## #11a DME – MMP – Base 2

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

File Help

Go To: #11a DME - MMP - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?  
 Yes  
 No

Is authorization required?  
 Yes  
 No

Select which Non-Medicare-covered Durable Medical Equipment(s) have a Copayment (select all that apply):  
 Durable Medical Equipment for use outside the home  
 Other 1  
 Other 2

Is a referral required for Services?  
 Yes  
 No

Indicate copayment amount for one or more of the following services:

	Minimum Copayment	Maximum Copayment
Durable Medical Equipment for use outside the home:		
Other 1:		
Other 2:		

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

Notes:

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #11b Prosthetics/Medical Supplies - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category, except for MMPs.

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

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

Yes  
 No

Select Maximum Enrollee Out-of-Pocket Cost type:

Covered under DME Category 11a  
 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 Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):

Medicare-covered Prosthetic Devices  
 Medicare-covered Medical Supplies

Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:

# CY 2020 PBP Data Entry System Screens

## #11b Prosthetics/Medical Supplies – Base 2

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

File Help

Go To: #11b Prosthetics/Medical Supplies - Base 2

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 Prosthetics/Medical Supplies have a Copayment (Select all that apply):  
 Medicare-covered Prosthetic Devices  
 Medicare-covered Medical Supplies

Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:

Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:

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

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



# CY 2020 PBP Data Entry System Screens

## #11b Prosthetics/Medical Supplies – Base 3

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: #11b Prosthetics/Medical Supplies - Base 3

Is authorization required?

Yes

No

Referral is not applicable for this Service Category.

Prosthetics/Medical Supplies Notes

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

Notes:

[Large empty text area for notes]

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #11b Prosthetics/Medical Supplies - MMP - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare-covered Prosthetics/Medical Supplies?  
 Yes  
 No

Enter name of Non-Medicare-covered Service:  
[Text Field]

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

Indicate Maximum Plan Benefit Coverage amount:  
[Text Field]

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

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Copayment Amount:  
[Text Field]

Is authorization required?  
 Yes  
 No

Is a referral required for Services?  
 Yes  
 No

Prosthetics/Medical Supplies MMP Notes  
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.

Notes:  
[Text Area]

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Coinsurance Percentage:  
[Text Field]

# CY 2020 PBP Data Entry System Screens

## #11c Diabetic Supplies and Services – Base 1

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

File Help

Go To: #11c Diabetic Supplies and Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Select Maximum Enrollee Out-of-Pocket Cost type:

Covered under DME Category 11a  
 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  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Select which Diabetic Supplies and Services have a Coinsurance (Select all that apply):

Medicare-covered Diabetic Supplies  
 Medicare-covered Diabetic Therapeutic Shoes or Inserts

Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Supplies:

Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Supplies:

Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

# CY 2020 PBP Data Entry System Screens

## #11c Diabetic Supplies and Services – Base 2

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

File Help

Go To: #11c Diabetic Supplies and Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?  
 Yes  
 No

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

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

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

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

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

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

Is authorization required?  
 Yes  
 No

Referral is not applicable for this Service Category.

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

Notes:

# CY 2020 PBP Data Entry System Screens

## #12 Dialysis Services – Base 1

PBP Data Entry System - Section B-12, Contract X0001, Plan 001, Segment 000

File Help

Go To: #12 Dialysis Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes  
 No

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

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

Reminder: Dialysis received from an Out-of-Network provider will be covered at the In-Network cost.

# CY 2020 PBP Data Entry System Screens

## #12 Dialysis Services – Base 2

PBP Data Entry System - Section B-12, Contract X0001, Plan 001, Segment 000

File Help

Go To: #12 Dialysis Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?

Yes

No

Is a referral required for Dialysis Services?

Yes

No

Dialysis 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

## #13a Acupuncture – Base 1

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

File Help

Go To: #13a Acupuncture - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Acupuncture as a supplemental benefit under Part C? <input type="radio"/> Yes <input type="radio"/> No	Is there a service-specific Maximum Plan Benefit Coverage amount? <input type="radio"/> Yes <input type="radio"/> No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? <input type="radio"/> Yes <input type="radio"/> No
Select enhanced benefit: <input type="checkbox"/> Number of Treatments	Indicate Maximum Plan Benefit Coverage amount: _____	Indicate Maximum Enrollee Out-of-Pocket Cost amount: _____
Select type of benefit for Number of Treatments: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select Maximum Plan Benefit Coverage 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 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"/> Every three months <input type="radio"/> Other, Describe
Is this benefit unlimited for Number of Treatments? <input type="radio"/> Yes <input type="radio"/> No	Indicate limit for Number of Treatments: _____	Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both? <input type="radio"/> Yes <input type="radio"/> No
Indicate Number of Treatments 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

## #13a Acupuncture – Base 2

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

File Help

Go To: #13a Acupuncture - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?  
 Yes  
 No  
Indicate Minimum Coinsurance percentage:  
\_\_\_\_\_  
Indicate Maximum Coinsurance percentage:  
\_\_\_\_\_

Is there an enrollee Copayment?  
 Yes  
 No  
Indicate Minimum Copayment amount per treatment:  
\_\_\_\_\_  
Indicate Maximum Copayment amount per treatment:  
\_\_\_\_\_

Is there an enrollee Deductible?  
 Yes  
 No  
Indicate Deductible Amount:  
\_\_\_\_\_

Is authorization required?  
 Yes  
 No

Is a referral required for Acupuncture?  
 Yes  
 No



# CY 2020 PBP Data Entry System Screens

## #13a Acupuncture – Base 3

The screenshot shows a web-based application window titled "PBP Data Entry System - Section B-13, 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 "#13a Acupuncture - Base 3". The main content area is titled "Acupuncture 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 input field labeled "Notes:".

# CY 2020 PBP Data Entry System Screens

## #13b OTC Items – Base 1

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

File Help

Go To: #13b OTC Items - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

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

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

Yes  
 No

Select type of benefit for OTC Items:

Mandatory  
 Optional

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every month

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?

Yes  
 No

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Every month

Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?

Yes  
 No

Nicotine Replacement Therapy (NRT) Attestation:

The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

# CY 2020 PBP Data Entry System Screens

## #13b OTC Items – Base 2

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

File Help

Go To: #13b OTC Items - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?  
 Yes  
 No  
Indicate Minimum Coinsurance percentage:  
  
Indicate Maximum Coinsurance percentage:

Is there an enrollee Copayment?  
 Yes  
 No  
Indicate Minimum Copayment amount:  
  
Indicate Maximum Copayment amount:

Is there an enrollee Deductible?  
 Yes  
 No  
Indicate Deductible Amount:

Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?  
 Yes  
 No

Authorization is not applicable for this service category.  
Referral is not applicable for this service category.

# CY 2020 PBP Data Entry System Screens

## #13b OTC Items – Base 3

The screenshot shows a web-based application window titled "PBP Data Entry System - Section B-13, 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 "#13b OTC Items - Base 3". The main content area is titled "OTC Items 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:" for data entry.

# CY 2020 PBP Data Entry System Screens

## #13c Meal Benefit – Base 1

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

File Help

Go To: #13c Meal Benefit - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Select type of benefit for Meals:  
 Mandatory  
 Optional

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

How many days does your Meal Benefit last?

What is the maximum number of meals the benefit provides?

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

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

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

# CY 2020 PBP Data Entry System Screens

## #13c Meal Benefit – Base 2

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

File Help

Go To: #13c Meal Benefit - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?  
 Yes  
 No  
Indicate Minimum Coinsurance percentage:   
Indicate Maximum Coinsurance percentage:

Is there an enrollee Copayment?  
 Yes  
 No  
Indicate Minimum Copayment amount:   
Indicate Maximum Copayment amount:

Is there an enrollee Deductible?  
 Yes  
 No  
Indicate Deductible Amount:

Is authorization required?  
 Yes  
 No

Is a referral required for the Meal Benefit?  
 Yes  
 No

# CY 2020 PBP Data Entry System Screens

## #13c Meal Benefit – Base 3

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

File Help

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

Meal Benefit Notes

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

Notes:

[Empty text area for notes]

# CY 2020 PBP Data Entry System Screens

## #13d Other 1 – Base 1

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

File Help

Go To: #13d Other 1 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

Note: After completing your data entry in this category, if you delete ALL text in the "Enter name of Service(Optional):" field you will lose all previously entered data.

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

Do not put Medicare-covered benefits in this service category (e.g., do not include homehealth, nutritional support, transportation, medical devices etc).

Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13B.

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

Enter name of Service (Optional):

Select type of benefit for Other 1:

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

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

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

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

Mandatory  
 Optional

Yes  
 No

Yes  
 No

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



# CY 2020 PBP Data Entry System Screens

## #13d Other 1 – Base 2

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

File Help

Go To: #13d Other 1 - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?  
 Yes  
 No  
Indicate Minimum Coinsurance percentage:   
Indicate Maximum Coinsurance percentage:

Is there an enrollee Copayment?  
 Yes  
 No  
Indicate Minimum Copayment amount:   
Indicate Maximum Copayment amount:

Is there an enrollee Deductible?  
 Yes  
 No  
Indicate Deductible Amount:

Is authorization required?  
 Yes  
 No

Is a referral required for Other Services?  
 Yes  
 No

# CY 2020 PBP Data Entry System Screens

## #13d Other 1 – Base 3

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

File Help

Go To: #13d Other 1 - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Other 1 Notes

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

Notes:

[Empty text box for notes]

# CY 2020 PBP Data Entry System Screens

## #13e Other 2 – Base 1

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

File Help

Go To: #13e Other 2 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional):' field you will lose all previously entered data.

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

Do not put Medicare-covered benefits in this service category (e.g., do not include homehealth, nutritional support, transportation, medical devices etc).

Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13B.

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

Enter name of Service (Optional):

Select type of benefit for Other 2:

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

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

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

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

Yes  
 No

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

Mandatory  
 Optional

Yes  
 No

# CY 2020 PBP Data Entry System Screens

#13e Other 2 – Base 2

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

File Help

Go To: #13e Other 2 - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No Indicate Minimum Coinsurance percentage: <input type="text"/> Indicate Maximum Coinsurance percentage: <input type="text"/>	Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No Indicate Minimum Copayment amount: <input type="text"/> Indicate Maximum Copayment amount: <input type="text"/>
Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No Indicate Deductible Amount: <input type="text"/>	Is authorization required? <input type="radio"/> Yes <input type="radio"/> No Is a referral required for Other Services? <input type="radio"/> Yes <input type="radio"/> No

# CY 2020 PBP Data Entry System Screens

#13e Other 2 – Base 3

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

File Help

Go To: #13e Other 2 - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Other 2 Notes

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

Notes:

[Empty text box for notes]

# CY 2020 PBP Data Entry System Screens

#13f Other 3 – Base 1

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

File Help

Go To: #13f Other 3 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

Note: After completing your data entry in this category, if you delete ALL text in the "Enter name of Service (Optional):" field you will lose all previously entered data.

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

Do not put Medicare-covered benefits in this service category (e.g., do not include homehealth, nutritional support, transportation, medical devices etc).

Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13B.

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

Enter name of Service (Optional):

Select type of benefit for Other 3:

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

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

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

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

Yes  
 No

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

Mandatory  
 Optional

Yes  
 No

# CY 2020 PBP Data Entry System Screens

#13f Other 3 – Base 2

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

File Help

Go To: #13f Other 3 - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?  
 Yes  
 No  
Indicate Minimum Coinsurance percentage:   
Indicate Maximum Coinsurance percentage:

Is there an enrollee Copayment?  
 Yes  
 No  
Indicate Minimum Copayment amount:   
Indicate Maximum Copayment amount:

Is there an enrollee Deductible?  
 Yes  
 No  
Indicate Deductible Amount:

Is authorization required?  
 Yes  
 No

Is a referral required for Other Services?  
 Yes  
 No

# CY 2020 PBP Data Entry System Screens

#13f Other 3 – Base 3

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

File Help

Go To: #13f Other 3 - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Other 3 Notes

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

Notes:

[Empty text box for notes]



# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

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

Dual Eligible SNPs with Highly Integrated Services Benefit Attestation

I attest that I have received written notification from CMS that this individual SNP plan qualifies for the new supplemental benefit flexibility for certain Dual Eligible SNPs with Highly Integrated Services for CY 2019. I further attest that the additional supplemental benefit(s) that the SNP describes in this section of the PBP do not inappropriately duplicate an existing service(s) that enrollees are eligible to receive under a waiver, the State Medicaid plan, Medicare Part A or B, or through the local jurisdiction in which they reside.

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

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

Enter name of Service (Optional):

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

Mandatory  
 Optional

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

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 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

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

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

File Help

Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Minimum Coinsurance percentage:  
[ ]

Indicate Maximum Coinsurance percentage:  
[ ]

Is there an enrollee Copayment?  
 Yes  
 No

Indicate Minimum Copayment amount:  
[ ]

Indicate Maximum Copayment amount:  
[ ]

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[ ]

Is authorization required?  
 Yes  
 No

Is a referral required for Other Services?  
 Yes  
 No

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Dual Eligible SNPs with Highly Integrated 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

## #13h Additional Services – Base 1

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

File Help

Go To: #13h Additional Services - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Additional Services?

Yes  
 No

Select Additional Services (select all that apply):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18
- Other 19
- Other 20
- Other 21
- Other 22
- Other 23

Enter name of Other 1 Service:

Enter name of Other 2 Service:

Enter name of Other 3 Service:

Enter name of Other 4 Service:

Enter name of Other 5 Service:

Enter name of Other 6 Service:

Enter name of Other 7 Service:

Enter name of Other 8 Service:

Enter name of Other 9 Service:

Enter name of Other 10 Service:

Enter name of Other 11 Service:

Enter name of Other 12 Service:

Enter name of Other 13 Service:

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 2

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: #13h Additional Services - Base 2

Enter name of Other 14 Service: <input type="text"/>	Enter name of Other 27 Service: <input type="text"/>
Enter name of Other 15 Service: <input type="text"/>	Enter name of Other 28 Service: <input type="text"/>
Enter name of Other 16 Service: <input type="text"/>	Enter name of Other 29 Service: <input type="text"/>
Enter name of Other 17 Service: <input type="text"/>	Enter name of Other 30 Service: <input type="text"/>
Enter name of Other 18 Service: <input type="text"/>	Enter name of Other 31 Service: <input type="text"/>
Enter name of Other 19 Service: <input type="text"/>	Enter name of Other 32 Service: <input type="text"/>
Enter name of Other 20 Service: <input type="text"/>	Enter name of Other 33 Service: <input type="text"/>
Enter name of Other 21 Service: <input type="text"/>	Enter name of Other 34 Service: <input type="text"/>
Enter name of Other 22 Service: <input type="text"/>	Enter name of Other 35 Service: <input type="text"/>
Enter name of Other 23 Service: <input type="text"/>	Enter name of Other 36 Service: <input type="text"/>
Enter name of Other 24 Service: <input type="text"/>	Enter name of Other 37 Service: <input type="text"/>
Enter name of Other 25 Service: <input type="text"/>	Enter name of Other 38 Service: <input type="text"/>
Enter name of Other 26 Service: <input type="text"/>	

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 3

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

File Help

Go To: #13h Additional Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there a limit on the Additional Services provided?  
 Yes  
 No

Select Additional Services where a limit applies:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18
- Other 19
- Other 20
- Other 21
- Other 22
- Other 23

Indicate units a limit will be provided in for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:

Sessions  
 Visits  
 Hours  
 Points  
 Meals  
 Items/Other, Describe

Indicate numerical limit on the services provided for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:

\_\_\_\_\_

Select limit on services periodicity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:

Every day  
 Every week  
 Every month  
 Every year  
 Every Session/Visit  
 Every Pregnancy  
 Every Lifetime  
 Other, Describe

Indicate units a limit will be provided in for Tobacco Cessation Counseling for Pregnant Women:

Sessions  
 Visits  
 Hours  
 Points  
 Meals  
 Items/Other, Describe

Indicate numerical limit on the services provided for Tobacco Cessation Counseling for Pregnant Women:

\_\_\_\_\_

Select limit on services periodicity for Tobacco Cessation Counseling for Pregnant Women:

Every day  
 Every week  
 Every month  
 Every year  
 Every Session/Visit  
 Every Pregnancy  
 Every Lifetime  
 Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 4

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

File Help

Go To: #13h Additional Services - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Freestanding Birth Center Services:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Freestanding Birth Center Services:

Select limit on services periodicity for Freestanding Birth Center Services:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Family Planning Services:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Family Planning Services:

Select limit on services periodicity for Family Planning Services:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Respiratory Care Services:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Respiratory Care Services:

Select limit on services periodicity for Respiratory Care Services:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Nursing Home Services:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Nursing Home Services:

Select limit on services periodicity for Nursing Home Services:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 5

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

File Help

Go To: #13h Additional Services - Base 5

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Home and Community Based Services:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Home and Community Based Services:

Select limit on services periodicity for Home and Community Based Services:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Personal Care Services:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Personal Care Services:

Select limit on services periodicity for Personal Care Services:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Self-Directed Personal Assistance Services:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Self-Directed Personal Assistance Services:

Select limit on services periodicity for Self-Directed Personal Assistance Services:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Private Duty Nursing Services:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Private Duty Nursing Services:

Select limit on services periodicity for Private Duty Nursing Services:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe



# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 6

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

File Help

Go To: #13h Additional Services - Base 6

Previous Next Exit (Validate) Exit (No Validate)

<p>Indicate units a limit will be provided in for Case Management (Long Term Care):</p> <ul style="list-style-type: none"><li><input type="radio"/> Sessions</li><li><input type="radio"/> Visits</li><li><input type="radio"/> Hours</li><li><input type="radio"/> Points</li><li><input type="radio"/> Meals</li><li><input type="radio"/> Items/Other, Describe</li></ul>	<p>Indicate units a limit will be provided in for Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities:</p> <ul style="list-style-type: none"><li><input type="radio"/> Sessions</li><li><input type="radio"/> Visits</li><li><input type="radio"/> Hours</li><li><input type="radio"/> Points</li><li><input type="radio"/> Meals</li><li><input type="radio"/> Items/Other, Describe</li></ul>
<p>Indicate numerical limit on the services provided for Case Management (Long Term Care):</p> <input type="text"/>	<p>Indicate numerical limit on the services provided for Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities:</p> <input type="text"/>
<p>Select limit on services periodicity for Case Management (Long Term Care):</p> <ul style="list-style-type: none"><li><input type="radio"/> Every day</li><li><input type="radio"/> Every week</li><li><input type="radio"/> Every month</li><li><input type="radio"/> Every year</li><li><input type="radio"/> Every Session/Visit</li><li><input type="radio"/> Every Pregnancy</li><li><input type="radio"/> Every Lifetime</li><li><input type="radio"/> Other, Describe</li></ul>	<p>Select limit on services periodicity for Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities:</p> <ul style="list-style-type: none"><li><input type="radio"/> Every day</li><li><input type="radio"/> Every week</li><li><input type="radio"/> Every month</li><li><input type="radio"/> Every year</li><li><input type="radio"/> Every Session/Visit</li><li><input type="radio"/> Every Pregnancy</li><li><input type="radio"/> Every Lifetime</li><li><input type="radio"/> Other, Describe</li></ul>
<p>Indicate units a limit will be provided in for Institution for Mental Disease Services for Individuals 65 or Older:</p> <ul style="list-style-type: none"><li><input type="radio"/> Sessions</li><li><input type="radio"/> Visits</li><li><input type="radio"/> Hours</li><li><input type="radio"/> Points</li><li><input type="radio"/> Meals</li><li><input type="radio"/> Items/Other, Describe</li></ul>	<p>Indicate units a limit will be provided in for Case Management:</p> <ul style="list-style-type: none"><li><input type="radio"/> Sessions</li><li><input type="radio"/> Visits</li><li><input type="radio"/> Hours</li><li><input type="radio"/> Points</li><li><input type="radio"/> Meals</li><li><input type="radio"/> Items/Other, Describe</li></ul>
<p>Indicate numerical limit on the services provided for Institution for Mental Disease Services for Individuals 65 or Older:</p> <input type="text"/>	<p>Indicate numerical limit on the services provided for Case Management:</p> <input type="text"/>
<p>Select limit on services periodicity for Institution for Mental Disease Services for Individuals 65 or Older:</p> <ul style="list-style-type: none"><li><input type="radio"/> Every day</li><li><input type="radio"/> Every week</li><li><input type="radio"/> Every month</li><li><input type="radio"/> Every year</li><li><input type="radio"/> Every Session/Visit</li><li><input type="radio"/> Every Pregnancy</li><li><input type="radio"/> Every Lifetime</li><li><input type="radio"/> Other, Describe</li></ul>	<p>Select limit on services periodicity for Case Management:</p> <ul style="list-style-type: none"><li><input type="radio"/> Every day</li><li><input type="radio"/> Every week</li><li><input type="radio"/> Every month</li><li><input type="radio"/> Every year</li><li><input type="radio"/> Every Session/Visit</li><li><input type="radio"/> Every Pregnancy</li><li><input type="radio"/> Every Lifetime</li><li><input type="radio"/> Other, Describe</li></ul>

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 7

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

File Help

Go To: #13h Additional Services - Base 7

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 1:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 1:

Select limit on services periodicity for Other 1:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 2:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 2:

Select limit on services periodicity for Other 2:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 3:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 3:

Select limit on services periodicity for Other 3:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 4:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 4:

Select limit on services periodicity for Other 4:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 8

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

File Help

Go To: #13h Additional Services - Base 8

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 5:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 5:

Select limit on services periodicity for Other 5:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 6:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 6:

Select limit on services periodicity for Other 6:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 7:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 7:

Select limit on services periodicity for Other 7:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 8:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 8:

Select limit on services periodicity for Other 8:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 9

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

File Help

Go To: #13h Additional Services - Base 9

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 9:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 9:

Select limit on services periodicity for Other 9:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 11:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 11:

Select limit on services periodicity for Other 11:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 10:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 10:

Select limit on services periodicity for Other 10:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 12:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 12:

Select limit on services periodicity for Other 12:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 10

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

File Help

Go To: #13h Additional Services - Base 10

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 13:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 13:

Select limit on services periodicity for Other 13:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 14:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 14:

Select limit on services periodicity for Other 14:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 15:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 15:

Select limit on services periodicity for Other 15:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 16:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 16:

Select limit on services periodicity for Other 16:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 11

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

File Help

Go To: #13h Additional Services - Base 11

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 17:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 17:

Select limit on services periodicity for Other 17:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 18:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 18:

Select limit on services periodicity for Other 18:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 19:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 19:

Select limit on services periodicity for Other 19:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 20:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 20:

Select limit on services periodicity for Other 20:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 12

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

File Help

Go To: #13h Additional Services - Base 12

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 21:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 21:

Select limit on services periodicity for Other 21:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 23:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 23:

Select limit on services periodicity for Other 23:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 22:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 22:

Select limit on services periodicity for Other 22:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 24:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 24:

Select limit on services periodicity for Other 24:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 13

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

File Help

Go To: #13h Additional Services - Base 13

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 25:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 25:

Select limit on services periodicity for Other 25:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 27:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 27:

Select limit on services periodicity for Other 27:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 26:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 26:

Select limit on services periodicity for Other 26:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 28:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 28:

Select limit on services periodicity for Other 28:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe



# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 14

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

File Help

Go To: #13h Additional Services - Base 14

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 29:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 29:

Select limit on services periodicity for Other 29:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 31:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 31:

Select limit on services periodicity for Other 31:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 30:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 30:

Select limit on services periodicity for Other 30:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 32:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 32:

Select limit on services periodicity for Other 32:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 15

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

File Help

Go To: #13h Additional Services - Base 15

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 33:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 33:

Select limit on services periodicity for Other 33:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 34:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 34:

Select limit on services periodicity for Other 34:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 35:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 35:

Select limit on services periodicity for Other 35:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 36:

- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

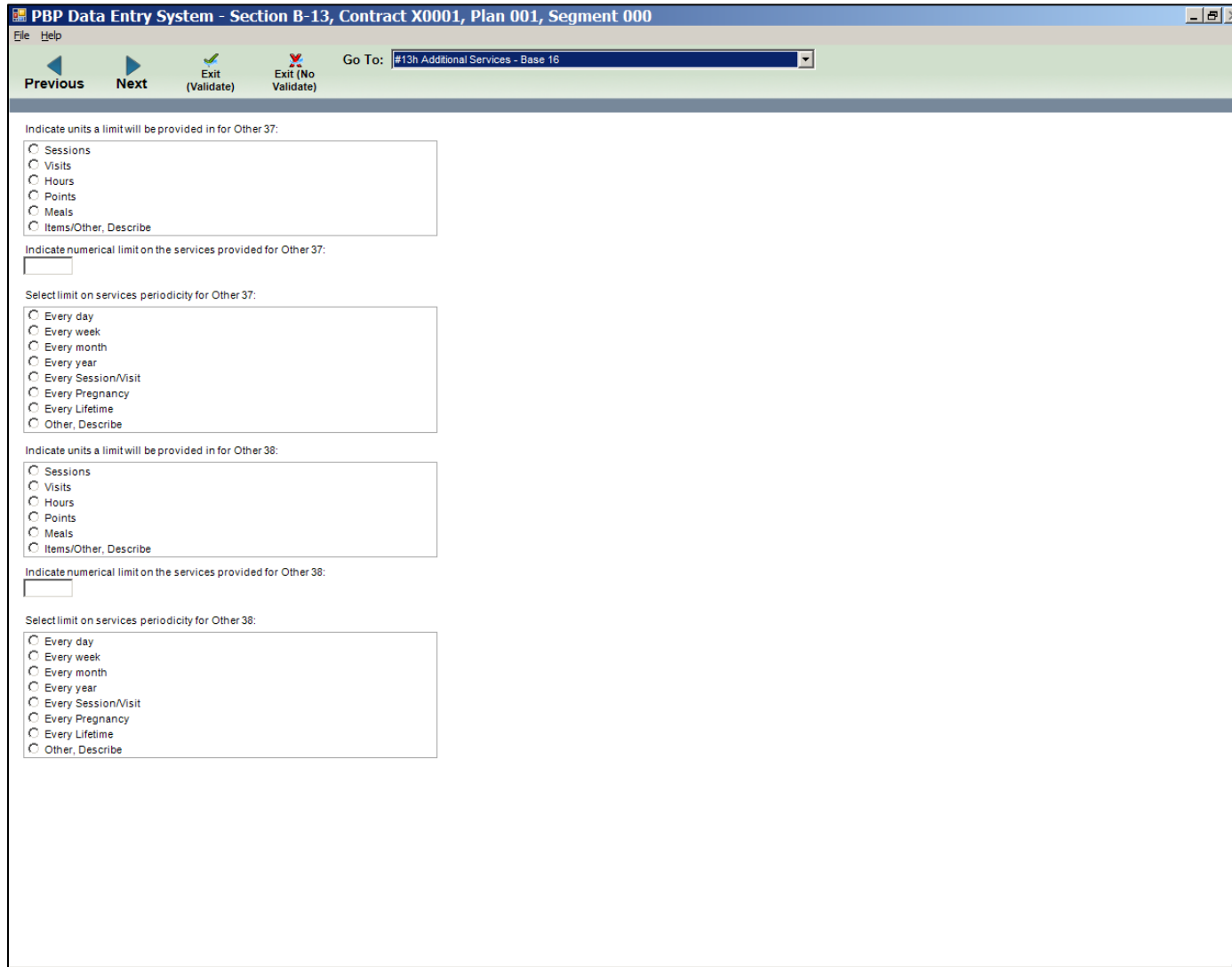
Indicate numerical limit on the services provided for Other 36:

Select limit on services periodicity for Other 36:

- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 16



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

File Help

Go To: #13h Additional Services - Base 16

Previous Next Exit (Validate) Exit (No Validate)

Indicate units a limit will be provided in for Other 37:

Sessions  
 Visits  
 Hours  
 Points  
 Meals  
 Items/Other, Describe

Indicate numerical limit on the services provided for Other 37:

\_\_\_\_\_

Select limit on services periodicity for Other 37:

Every day  
 Every week  
 Every month  
 Every year  
 Every Session/Visit  
 Every Pregnancy  
 Every Lifetime  
 Other, Describe

Indicate units a limit will be provided in for Other 38:

Sessions  
 Visits  
 Hours  
 Points  
 Meals  
 Items/Other, Describe

Indicate numerical limit on the services provided for Other 38:

\_\_\_\_\_

Select limit on services periodicity for Other 38:

Every day  
 Every week  
 Every month  
 Every year  
 Every Session/Visit  
 Every Pregnancy  
 Every Lifetime  
 Other, Describe

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 17

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

File Help

Go To: #13h Additional Services - Base 17

---

Is there a Maximum Plan Benefit Amount for Additional Services?

Yes  
 No

Select which Additional Services have a Maximum Plan Benefit Coverage Amount (Select all that apply):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18
- Other 19
- Other 20
- Other 21
- Other 22
- Other 23

Indicate Maximum Plan Benefit Amount for EPSDT:

Select Maximum Plan Benefit Coverage Periodicity EPSDT:

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

Indicate Maximum Plan Benefit Amount for TCCPW:

Select Maximum Plan Benefit Coverage Periodicity TCCPW:

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

Indicate Maximum Plan Benefit Amount for FBCS:

Select Maximum Plan Benefit Coverage Periodicity FBCS:

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

Indicate Maximum Plan Benefit Amount for RCS:

Select Maximum Plan Benefit Coverage Periodicity RCS:

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

Indicate Maximum Plan Benefit Amount for FPS:

Select Maximum Plan Benefit Coverage Periodicity FPS:

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

Indicate Maximum Plan Benefit Amount for NHS:

Select Maximum Plan Benefit Coverage Periodicity NHS:

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

Softrams

CY2020 PBP – Section B  
12/12/2018

Page 172 of 260

**CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING**

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 18

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

File Help

Go To: #13h Additional Services - Base 18

Previous Next Exit (Validate) Exit (No Validate)

Indicate Maximum Plan Benefit Amount for HCBS: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity HCBS: <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	Indicate Maximum Plan Benefit Amount for PDNS: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity PDNS: <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	Indicate Maximum Plan Benefit Amount for SICFID: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity SICFID: <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	Indicate Maximum Plan Benefit Amount for OTHER2: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER2: <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
Indicate Maximum Plan Benefit Amount for PCS: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity PCS: <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	Indicate Maximum Plan Benefit Amount for CM_LTC: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity CM_LTC: <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	Indicate Maximum Plan Benefit Amount for CM: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity CM: <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	Indicate Maximum Plan Benefit Amount for OTHER3: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER3: <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
Indicate Maximum Plan Benefit Amount for SDPAS: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity SDPAS: <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	Indicate Maximum Plan Benefit Amount for IMDS: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity IMDS: <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	Indicate Maximum Plan Benefit Amount for OTHER1: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER1: <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	Indicate Maximum Plan Benefit Amount for OTHER4: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER4: <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

## #13h Additional Services – Base 19

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

File Help

Go To: #13h Additional Services - Base 19

Previous Next Exit (Validate) Exit (No Validate)

Indicate Maximum Plan Benefit Amount for OTHER5: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER5: <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	Indicate Maximum Plan Benefit Amount for OTHER8: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER8: <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	Indicate Maximum Plan Benefit Amount for OTHER11: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER11: <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	Indicate Maximum Plan Benefit Amount for OTHER14: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER14: <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
Indicate Maximum Plan Benefit Amount for OTHER6: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER6: <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	Indicate Maximum Plan Benefit Amount for OTHER9: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER9: <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	Indicate Maximum Plan Benefit Amount for OTHER12: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER12: <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	Indicate Maximum Plan Benefit Amount for OTHER15: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER15: <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
Indicate Maximum Plan Benefit Amount for OTHER7: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER7: <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	Indicate Maximum Plan Benefit Amount for OTHER10: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER10: <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	Indicate Maximum Plan Benefit Amount for OTHER13: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER13: <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	Indicate Maximum Plan Benefit Amount for OTHER16: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER16: <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

## #13h Additional Services – Base 20

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

File Help

Go To: #13h Additional Services - Base 20

Previous Next Exit (Validate) Exit (No Validate)

Indicate Maximum Plan Benefit Amount for OTHER17: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER17: <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	Indicate Maximum Plan Benefit Amount for OTHER20: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER20: <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	Indicate Maximum Plan Benefit Amount for OTHER23: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER23: <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	Indicate Maximum Plan Benefit Amount for OTHER26: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER26: <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
Indicate Maximum Plan Benefit Amount for OTHER18: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER18: <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	Indicate Maximum Plan Benefit Amount for OTHER21: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER21: <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	Indicate Maximum Plan Benefit Amount for OTHER24: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER24: <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	Indicate Maximum Plan Benefit Amount for OTHER27: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER27: <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
Indicate Maximum Plan Benefit Amount for OTHER19: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER19: <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	Indicate Maximum Plan Benefit Amount for OTHER22: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER22: <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	Indicate Maximum Plan Benefit Amount for OTHER25: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER25: <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	Indicate Maximum Plan Benefit Amount for OTHER28: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER28: <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

## #13h Additional Services – Base 21

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

File Help

Go To: #13h Additional Services - Base 21

Previous Next Exit (Validate) Exit (No Validate)

Indicate Maximum Plan Benefit Amount for OTHER29: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER29: <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	Indicate Maximum Plan Benefit Amount for OTHER32: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER32: <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	Indicate Maximum Plan Benefit Amount for OTHER35: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER35: <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	Indicate Maximum Plan Benefit Amount for OTHER38: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER38: <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
Indicate Maximum Plan Benefit Amount for OTHER30: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER30: <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	Indicate Maximum Plan Benefit Amount for OTHER33: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER33: <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	Indicate Maximum Plan Benefit Amount for OTHER36: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER36: <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	
Indicate Maximum Plan Benefit Amount for OTHER31: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER31: <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	Indicate Maximum Plan Benefit Amount for OTHER34: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER34: <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	Indicate Maximum Plan Benefit Amount for OTHER37: <input type="text"/> Select Maximum Plan Benefit Coverage Periodicity OTHER37: <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

## #13h Additional Services – Base 22

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

File Help

Go To: #13h Additional Services - Base 22

Previous Next Exit (Validate) Exit (No Validate)

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

Is a beneficiary receiving any benefit subject to a state-required monthly payment amount that is based on his or her financial resources (for example: a "patient pay amount")?  
 Yes  
 No

Select services that require qualification for and enrollment in a state-operated waiver program:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18
- Other 19
- Other 20
- Other 21
- Other 22
- Other 23

Select benefits subject to a state-required monthly payment amount that is based on his or her financial resources (for example: a "patient pay amount"):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18
- Other 19
- Other 20
- Other 21
- Other 22
- Other 23

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 23

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

File Help

◀ Previous
Next ▶
✔ Exit (Validate)
✘ Exit (No Validate)
Go To: #13h Additional Services - Base 23

Enter minimum and maximum values only if instructed to do so by the State. If your state did not provide guidance on what values to enter, leave the minimum and maximum fields blank.

	Minimum Patient Pay Amount	Maximum Patient Pay Amount		Minimum Patient Pay Amount	Maximum Patient Pay Amount
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	<input type="text"/>	<input type="text"/>	Case Management	<input type="text"/>	<input type="text"/>
Tobacco Cessation Counseling for Pregnant Women	<input type="text"/>	<input type="text"/>	Other 1	<input type="text"/>	<input type="text"/>
Freestanding Birth Center Services	<input type="text"/>	<input type="text"/>	Other 2	<input type="text"/>	<input type="text"/>
Respiratory Care Services	<input type="text"/>	<input type="text"/>	Other 3	<input type="text"/>	<input type="text"/>
Family Planning Services	<input type="text"/>	<input type="text"/>	Other 4	<input type="text"/>	<input type="text"/>
Nursing Home Services	<input type="text"/>	<input type="text"/>	Other 6	<input type="text"/>	<input type="text"/>
Home and Community Based Services	<input type="text"/>	<input type="text"/>	Other 6	<input type="text"/>	<input type="text"/>
Personal Care Services	<input type="text"/>	<input type="text"/>	Other 7	<input type="text"/>	<input type="text"/>
Self-Directed Personal Assistance Services	<input type="text"/>	<input type="text"/>	Other 8	<input type="text"/>	<input type="text"/>
Private Duty Nursing Services	<input type="text"/>	<input type="text"/>	Other 9	<input type="text"/>	<input type="text"/>
Case Management (Long Term Care)	<input type="text"/>	<input type="text"/>	Other 10	<input type="text"/>	<input type="text"/>
Institution for Mental Disease Services for Individuals 65 or Older	<input type="text"/>	<input type="text"/>	Other 11	<input type="text"/>	<input type="text"/>
Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities	<input type="text"/>	<input type="text"/>	Other 12	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 24

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

File Help

◀ Previous
Next ▶
✔ Exit (Validate)
✘ Exit (No Validate)
Go To: #13h Additional Services - Base 24

Enter minimum and maximum values only if instructed to do so by the State. If your state did not provide guidance on what values to enter, leave the minimum and maximum fields blank.

	Minimum Patient Pay Amount	Maximum Patient Pay Amount		Minimum Patient Pay Amount	Maximum Patient Pay Amount
Other 13	<input type="text"/>	<input type="text"/>	Other 26	<input type="text"/>	<input type="text"/>
Other 14	<input type="text"/>	<input type="text"/>	Other 27	<input type="text"/>	<input type="text"/>
Other 15	<input type="text"/>	<input type="text"/>	Other 28	<input type="text"/>	<input type="text"/>
Other 16	<input type="text"/>	<input type="text"/>	Other 29	<input type="text"/>	<input type="text"/>
Other 17	<input type="text"/>	<input type="text"/>	Other 30	<input type="text"/>	<input type="text"/>
Other 18	<input type="text"/>	<input type="text"/>	Other 31	<input type="text"/>	<input type="text"/>
Other 19	<input type="text"/>	<input type="text"/>	Other 32	<input type="text"/>	<input type="text"/>
Other 20	<input type="text"/>	<input type="text"/>	Other 33	<input type="text"/>	<input type="text"/>
Other 21	<input type="text"/>	<input type="text"/>	Other 34	<input type="text"/>	<input type="text"/>
Other 22	<input type="text"/>	<input type="text"/>	Other 35	<input type="text"/>	<input type="text"/>
Other 23	<input type="text"/>	<input type="text"/>	Other 36	<input type="text"/>	<input type="text"/>
Other 24	<input type="text"/>	<input type="text"/>	Other 37	<input type="text"/>	<input type="text"/>
Other 25	<input type="text"/>	<input type="text"/>	Other 38	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 25

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

File Help

Go To: #13h Additional Services - Base 25

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

Is there an enrollee Coinsurance?

Yes  
 No

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

Service	Minimum Coinsurance	Maximum Coinsurance
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	<input type="text"/>	<input type="text"/>
Tobacco Cessation Counseling for Pregnant Women	<input type="text"/>	<input type="text"/>
Freestanding Birth Center Services	<input type="text"/>	<input type="text"/>
Respiratory Care Services	<input type="text"/>	<input type="text"/>
Family Planning Services	<input type="text"/>	<input type="text"/>
Nursing Home Services	<input type="text"/>	<input type="text"/>
Home and Community Based Services	<input type="text"/>	<input type="text"/>
Personal Care Services	<input type="text"/>	<input type="text"/>
Self-Directed Personal Assistance Services	<input type="text"/>	<input type="text"/>
Private Duty Nursing Services	<input type="text"/>	<input type="text"/>
Case Management (Long Term Care)	<input type="text"/>	<input type="text"/>
Institution for Mental Disease Services for Individuals 65 or Older	<input type="text"/>	<input type="text"/>
Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities	<input type="text"/>	<input type="text"/>
Other 1		
Other 2		
Other 3		
Other 4		
Other 5		
Other 6		
Other 7		
Other 8		
Other 9		
Other 10		
Other 11		
Other 12		
Other 13		
Other 14		
Other 15		
Other 16		
Other 17		
Other 18		
Other 19		
Other 20		
Other 21		
Other 22		
Other 23		

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 26

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

File Help

◀ Previous
Next ▶
✓ Exit (Validate)
✗ Exit (No Validate)
Go To: #13h Additional Services - Base 26

Indicate Coinsurance for one or more of the following services.

	Minimum Coinsurance	Maximum Coinsurance		Minimum Coinsurance	Maximum Coinsurance
Case Management	<input type="text"/>	<input type="text"/>	Other 13	<input type="text"/>	<input type="text"/>
Other 1	<input type="text"/>	<input type="text"/>	Other 14	<input type="text"/>	<input type="text"/>
Other 2	<input type="text"/>	<input type="text"/>	Other 15	<input type="text"/>	<input type="text"/>
Other 3	<input type="text"/>	<input type="text"/>	Other 16	<input type="text"/>	<input type="text"/>
Other 4	<input type="text"/>	<input type="text"/>	Other 17	<input type="text"/>	<input type="text"/>
Other 5	<input type="text"/>	<input type="text"/>	Other 18	<input type="text"/>	<input type="text"/>
Other 6	<input type="text"/>	<input type="text"/>	Other 19	<input type="text"/>	<input type="text"/>
Other 7	<input type="text"/>	<input type="text"/>	Other 20	<input type="text"/>	<input type="text"/>
Other 8	<input type="text"/>	<input type="text"/>	Other 21	<input type="text"/>	<input type="text"/>
Other 9	<input type="text"/>	<input type="text"/>	Other 22	<input type="text"/>	<input type="text"/>
Other 10	<input type="text"/>	<input type="text"/>	Other 23	<input type="text"/>	<input type="text"/>
Other 11	<input type="text"/>	<input type="text"/>	Other 24	<input type="text"/>	<input type="text"/>
Other 12	<input type="text"/>	<input type="text"/>	Other 25	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 27

Indicate Coinsurance for one or more of the following services.

	Minimum Coinsurance	Maximum Coinsurance
Other 26	<input type="text"/>	<input type="text"/>
Other 27	<input type="text"/>	<input type="text"/>
Other 28	<input type="text"/>	<input type="text"/>
Other 29	<input type="text"/>	<input type="text"/>
Other 30	<input type="text"/>	<input type="text"/>
Other 31	<input type="text"/>	<input type="text"/>
Other 32	<input type="text"/>	<input type="text"/>
Other 33	<input type="text"/>	<input type="text"/>
Other 34	<input type="text"/>	<input type="text"/>
Other 35	<input type="text"/>	<input type="text"/>
Other 36	<input type="text"/>	<input type="text"/>
Other 37	<input type="text"/>	<input type="text"/>
Other 38	<input type="text"/>	<input type="text"/>

Is there an enrollee Copayment?

Yes  
 No

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

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18
- Other 19
- Other 20
- Other 21
- Other 22
- Other 23

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 28

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

File Help

Go To: #13h Additional Services - Base 28

Previous Next Exit (Validate) Exit (No Validate)

Indicate Copayment for one or more of the following services.

	Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	<input type="text"/>	<input type="text"/>	Case Management	<input type="text"/>	<input type="text"/>
Tobacco Cessation Counseling for Pregnant Women	<input type="text"/>	<input type="text"/>	Other 1	<input type="text"/>	<input type="text"/>
Freestanding Birth Center Services	<input type="text"/>	<input type="text"/>	Other 2	<input type="text"/>	<input type="text"/>
Respiratory Care Services	<input type="text"/>	<input type="text"/>	Other 3	<input type="text"/>	<input type="text"/>
Family Planning Services	<input type="text"/>	<input type="text"/>	Other 4	<input type="text"/>	<input type="text"/>
Nursing Home Services	<input type="text"/>	<input type="text"/>	Other 5	<input type="text"/>	<input type="text"/>
Home and Community Based Services	<input type="text"/>	<input type="text"/>	Other 6	<input type="text"/>	<input type="text"/>
Personal Care Services	<input type="text"/>	<input type="text"/>	Other 7	<input type="text"/>	<input type="text"/>
Self-Directed Personal Assistance Services	<input type="text"/>	<input type="text"/>	Other 8	<input type="text"/>	<input type="text"/>
Private Duty Nursing Services	<input type="text"/>	<input type="text"/>	Other 9	<input type="text"/>	<input type="text"/>
Case Management (Long Term Care)	<input type="text"/>	<input type="text"/>	Other 10	<input type="text"/>	<input type="text"/>
Institution for Mental Disease Services for Individuals 65 or Older	<input type="text"/>	<input type="text"/>	Other 11	<input type="text"/>	<input type="text"/>
Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities	<input type="text"/>	<input type="text"/>	Other 12	<input type="text"/>	<input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 29

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

File Help

Go To: #13h Additional Services - Base 29

Previous Next Exit (Validate) Exit (No Validate)

Indicate Copayment for one or more of the following services.

	Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment
Other 13	<input type="text"/>	<input type="text"/>	Other 26	<input type="text"/>	<input type="text"/>
Other 14	<input type="text"/>	<input type="text"/>	Other 27	<input type="text"/>	<input type="text"/>
Other 15	<input type="text"/>	<input type="text"/>	Other 28	<input type="text"/>	<input type="text"/>
Other 16	<input type="text"/>	<input type="text"/>	Other 29	<input type="text"/>	<input type="text"/>
Other 17	<input type="text"/>	<input type="text"/>	Other 30	<input type="text"/>	<input type="text"/>
Other 18	<input type="text"/>	<input type="text"/>	Other 31	<input type="text"/>	<input type="text"/>
Other 19	<input type="text"/>	<input type="text"/>	Other 32	<input type="text"/>	<input type="text"/>
Other 20	<input type="text"/>	<input type="text"/>	Other 33	<input type="text"/>	<input type="text"/>
Other 21	<input type="text"/>	<input type="text"/>	Other 34	<input type="text"/>	<input type="text"/>
Other 22	<input type="text"/>	<input type="text"/>	Other 35	<input type="text"/>	<input type="text"/>
Other 23	<input type="text"/>	<input type="text"/>	Other 36	<input type="text"/>	<input type="text"/>
Other 24	<input type="text"/>	<input type="text"/>	Other 37	<input type="text"/>	<input type="text"/>
Other 25	<input type="text"/>	<input type="text"/>	Other 38	<input type="text"/>	<input type="text"/>



# CY 2020 PBP Data Entry System Screens

## #13h Additional Services – Base 30

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

File Help

Go To: #13h Additional Services - Base 30

Previous Next Exit (Validate) Exit (No Validate)

Is Authorization required for one or more Additional Services?  
 Yes  
 No

Select which Additional Services need an Authorization (Select all that apply):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18
- Other 19

Is a referral required for one or more Additional Services?  
 Yes  
 No

Select which Additional Services need a Referral (Select all that apply):

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Tobacco Cessation Counseling for Pregnant Women
- Freestanding Birth Center Services
- Respiratory Care Services
- Family Planning Services
- Nursing Home Services
- Home and Community Based Services
- Personal Care Services
- Self-Directed Personal Assistance Services
- Private Duty Nursing Services
- Case Management (Long Term Care)
- Institution for Mental Disease Services for Individuals 65 or Older
- Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities
- Case Management
- Other 1
- Other 2
- Other 3
- Other 4
- Other 5
- Other 6
- Other 7
- Other 8
- Other 9
- Other 10
- Other 11
- Other 12
- Other 13
- Other 14
- Other 15
- Other 16
- Other 17
- Other 18
- Other 19

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

Notes:

Additional Notes:

# CY 2020 PBP Data Entry System Screens

## #14a Medicare-covered Zero Dollar Preventive Services

The screenshot shows a web-based data entry application. The title bar reads "PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000". The navigation bar includes "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons, along with a "Go To:" dropdown menu set to "#14a Medicare-covered Zero Dollar Preventive Services".

The main content area is divided into two columns. The left column contains the following elements:

- A link: "CLICK FOR DESCRIPTION OF BENEFIT"
- Section: "Medicare-covered Zero Dollar Preventive Services Attestation"
- Text: "I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing."
- Note: "Note: Plan may not require an authorization or referral for certain \$0 cost sharing preventive services, for example, screening mammograms."
- Form: "Is authorization required?" with radio buttons for "Yes" and "No".
- Form: "Is a referral required?" with radio buttons for "Yes" and "No".

The right column contains:

- Section: "Medicare-covered Zero Dollar Preventive Services Notes"
- Text: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry."
- Form: A large text area labeled "Notes:" for entering additional information.

# CY 2020 PBP Data Entry System Screens

## #14b Annual Physical Exam – Base 1

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

File Help

Go To: #14b Annual Physical Exam - Base 1

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

You should only use these supplemental benefits for Annual Physical Exams not covered by Original Medicare. You may charge copays for these Annual Physical Exams. NOTE: Medicare-covered preventive services are always plan covered, and consequently they are not appropriate as a supplemental benefit.

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

Yes  
 No

Select type of benefit for the Annual Physical Exam:

Mandatory  
 Optional

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

Yes  
 No

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage amount:

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

# CY 2020 PBP Data Entry System Screens

## #14b Annual Physical Exam – Base 2

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

File Help

Go To: #14b Annual Physical Exam - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?

Yes  
 No

Indicate Minimum Coinsurance percentage for each Annual Physical Exam:  
[ ]

Indicate Maximum Coinsurance percentage for each Annual Physical Exam:  
[ ]

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount for each Annual Physical Exam:  
[ ]

Indicate Maximum Copayment amount for each Annual Physical Exam:  
[ ]

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:  
[ ]

# CY 2020 PBP Data Entry System Screens

## #14b Annual Physical Exam – Base 3

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

File Help

Go To: #14b Annual Physical Exam - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?

Yes

No

Is a referral required for the Annual Physical Exam?

Yes

No

Annual Physical Exam 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

## #14c Other Defined Supplemental Benefits – Base 1

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 1

---

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?

Yes  
 No

Select enhanced benefit (Select all that apply):

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

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

Select type of benefit for Health Education:

Mandatory  
 Optional

Select type of benefit for Nutritional/Dietary Benefit:

Mandatory  
 Optional

Is this benefit unlimited for Nutritional/Dietary Benefit?

Yes  
 No, indicate number

Indicate number of visits for Nutritional/Dietary Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Individual Sessions  
 Group Sessions  
 Both Sessions (Individual and Group)

Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Mandatory  
 Optional

Indicate number of visits offered in addition to Medicare:

Select type of benefit for Fitness Benefit:

Mandatory  
 Optional

Select type of benefit for Enhanced Disease Management:

Mandatory  
 Optional

Select type of benefit for Telemonitoring Services:

Mandatory  
 Optional

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

Mandatory  
 Optional

Select the type of Remote Access Technologies offered (Select all that apply):

Web/Phone-based technologies  
 Nursing Hotline

Select type of benefit for Bathroom Safety Devices:

Mandatory  
 Optional

Select type of benefit for Counseling Services:

Mandatory  
 Optional

Is this benefit unlimited for Counseling Services?

Yes  
 No, indicate number

Indicate number of visits for Counseling Services:

Indicate setting for Counseling Services:

Individual Sessions  
 Group Sessions  
 Both Sessions (Individual and Group)

Indicate duration of sessions (in minutes):

Select type of benefit for In-Home Safety Assessment:

Mandatory  
 Optional

# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 2

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Select type of benefit for Personal Emergency Response System (PERS):  
 Mandatory  
 Optional

Select type of benefit for Medical Nutrition Therapy (MNT):  
 Mandatory  
 Optional

Do you offer Additional Sessions for Medicare-covered diseases?  
 Yes  
 No

Indicate the limit for Additional Sessions:  
 Visits  
 Hours

Indicate numerical limit on the services provided for Additional Sessions:

Do you offer Coverage for Non-Medicare-covered diseases? (Specify the diseases and describe the coverage in the notes field)  
 Yes  
 No

Indicate units a limit will be provided in for Coverage for Non-Medicare covered diseases:  
 Visits  
 Hours

Indicate numerical limit on the services provided for Coverage for Non-Medicare covered diseases:

Select type of benefit for Post discharge In-Home Medication Reconciliation:  
 Mandatory  
 Optional

Select type of benefit for Re-admission Prevention:  
 Mandatory  
 Optional

What does your Re-admission Prevention benefit include (check all that apply):  
 Meals  
 Medication Reconciliation  
 In-Home Safety Assessment  
 Other, Describe

Enter name of Service:

Please describe the Meal benefit included in Re-admission Prevention:

How many days does your Meal Benefit last?

What is the maximum number of meals the benefit provides?

Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:  
 Mandatory  
 Optional

Select type of benefit for Weight Management Programs:  
 Mandatory  
 Optional

Select type of benefit for Alternative Therapies:  
 Mandatory  
 Optional

Is this benefit unlimited for Alternative Therapies?  
 Yes  
 No, indicate number

Indicate number of visits offered for Alternative Therapies:

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

Select type of benefit for Therapeutic Massage:  
 Mandatory  
 Optional

Select type of benefit for Adult Day Health Services:  
 Mandatory  
 Optional

Select type of benefit for Home-Based Palliative Care:  
 Mandatory  
 Optional

Select type of benefit for In-Home Support Services:  
 Mandatory  
 Optional

Select type of benefit for Support for Caregivers of Enrollees:  
 Mandatory  
 Optional

# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 3

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?

Yes  
 No

Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):

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

Indicate Maximum Plan Benefit Coverage amount for Health Education:

\_\_\_\_\_

Select Maximum Plan Benefit Coverage periodicity for Health Education:

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

Indicate Maximum Plan Benefit Coverage amount for Nutritional/Dietary Benefit:

\_\_\_\_\_

Select Maximum Plan Benefit Coverage periodicity for Nutritional/Dietary Benefit:

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

Indicate Maximum Plan Benefit Coverage amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:

\_\_\_\_\_

Select Maximum Plan Benefit Coverage periodicity for Additional Sessions of Smoking and Tobacco Cessation Counseling:

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

Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:

\_\_\_\_\_

Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:

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

Indicate Maximum Plan Benefit Coverage amount for Enhanced Disease Management:

\_\_\_\_\_

Select Maximum Plan Benefit Coverage periodicity for Enhanced Disease Management:

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

Indicate Maximum Plan Benefit Coverage amount for Telemonitoring Services:

\_\_\_\_\_

Select Maximum Plan Benefit Coverage periodicity for Telemonitoring Services:

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



# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 4

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 4

Previous Next Exit (Validate) Exit (No Validate)

<p>Indicate Maximum Plan Benefit Coverage amount for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Coverage amount for In-Home Safety Assessment:</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Coverage amount for Post discharge In-Home Medication Reconciliation:</p> <input type="text"/>
<p>Select Maximum Plan Benefit Coverage periodicity for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):</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 Plan Benefit Coverage periodicity for In-Home Safety Assessment:</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 Plan Benefit Coverage periodicity for Post discharge In-Home Medication Reconciliation:</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 Plan Benefit Coverage amount for Bathroom Safety Devices:</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Coverage amount for Personal Emergency Response System (PERS):</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Coverage amount for Re-admission Prevention:</p> <input type="text"/>
<p>Select Maximum Plan Benefit Coverage periodicity for Bathroom Safety Devices:</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 Plan Benefit Coverage periodicity for Personal Emergency Response System (PERS):</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 Plan Benefit Coverage periodicity for Re-admission Prevention:</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 Plan Benefit Coverage amount for Counseling Services:</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Coverage amount for Medical Nutrition Therapy (MNT):</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Coverage amount for Wigs for Hair Loss Related to Chemotherapy:</p> <input type="text"/>
<p>Select Maximum Plan Benefit Coverage periodicity for Counseling Services:</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 Plan Benefit Coverage periodicity for Medical Nutrition Therapy (MNT):</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 Plan Benefit Coverage periodicity for Wigs for Hair Loss Related to Chemotherapy:</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

## #14c Other Defined Supplemental Benefits – Base 5

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 5

Previous Next Exit (Validate) Exit (No Validate)

<p>Indicate Maximum Plan Benefit Coverage amount for Weight Management Programs:</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Coverage amount for Adult Day Health Services:</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Coverage amount for Support for Caregivers of Enrollees:</p> <input type="text"/>
<p>Select Maximum Plan Benefit Coverage periodicity for Weight Management Programs:</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 Plan Benefit Coverage periodicity for Adult Day Health Services:</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 Plan Benefit Coverage periodicity for Support for Caregivers of Enrollees:</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 Plan Benefit Coverage amount for Alternative Therapies:</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Coverage amount for Home-Based Palliative Care:</p> <input type="text"/>	
<p>Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:</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 Plan Benefit Coverage periodicity for Home-Based Palliative Care:</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 Plan Benefit Coverage amount for Therapeutic Massage:</p> <input type="text"/>	<p>Indicate Maximum Plan Benefit Coverage amount for In-Home Support Services:</p> <input type="text"/>	
<p>Select Maximum Plan Benefit Coverage periodicity for Therapeutic Massage:</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 Plan Benefit Coverage periodicity for In-Home Support Services:</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

## #14c Other Defined Supplemental Benefits – Base 6

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 6

---

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?

Yes  
 No

Select which Other Defined Supplemental Benefits have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply):

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Health Education:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Health Education:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Nutritional/Dietary Benefit:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Nutritional/Dietary Benefit:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Additional Sessions of Smoking and Tobacco Cessation Counseling:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Fitness Benefit:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Fitness Benefit:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Enhanced Disease Management:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Enhanced Disease Management:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Telemonitoring Services:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Telemonitoring Services:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Bathroom Safety Devices:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Bathroom Safety Devices:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Counseling Services:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Counseling Services:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for In-Home Safety Assessment:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for In-Home Safety Assessment:

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

# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 7

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 7

Previous Next Exit (Validate) Exit (No Validate)

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Personal Emergency Response System (PERS): <input type="text"/>	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Re-admission Prevention: <input type="text"/>	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Alternative Therapies: <input type="text"/>
Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Personal Emergency Response System (PERS): <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 Maximum Enrollee Out-of-Pocket Cost periodicity for Re-admission Prevention: <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 Maximum Enrollee Out-of-Pocket Cost periodicity for Alternative Therapies: <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
Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medical Nutrition Therapy (MNT): <input type="text"/>	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Wigs for Hair Loss Related to Chemotherapy: <input type="text"/>	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Therapeutic Massage: <input type="text"/>
Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medical Nutrition Therapy (MNT): <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 Maximum Enrollee Out-of-Pocket Cost periodicity for Wigs for Hair Loss Related to Chemotherapy: <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 Maximum Enrollee Out-of-Pocket Cost periodicity for Therapeutic Massage: <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
Indicate Maximum Enrollee Out-of-Pocket Cost amount for Post discharge In-Home Medication Reconciliation: <input type="text"/>	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Weight Management Programs: <input type="text"/>	Indicate Maximum Enrollee Out-of-Pocket Cost amount for Adult Day Health Services: <input type="text"/>
Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Post discharge In-Home Medication Reconciliation: <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 Maximum Enrollee Out-of-Pocket Cost periodicity for Weight Management Programs: <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 Maximum Enrollee Out-of-Pocket Cost periodicity for Adult Day Health Services: <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

## #14c Other Defined Supplemental Benefits – Base 8

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 8

Previous Next Exit (Validate) Exit (No Validate)

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Home-Based Palliative Care:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Home-Based Palliative Care:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for In-Home Support Services:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for In-Home Support Services:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Support for Caregivers of Enrollees:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Support for Caregivers of Enrollees:

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

# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 9

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 9

Is there an enrollee Coinsurance?

Yes  
 No

Select which Other Defined Supplemental Benefits have a Coinsurance (Select all that apply):

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

Indicate Minimum Coinsurance percentage for Health Education: <input type="text"/>	Indicate Minimum Coinsurance percentage for Fitness Benefit: <input type="text"/>	Indicate Minimum Coinsurance percentage for Counseling Services: <input type="text"/>	Indicate Minimum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy: <input type="text"/>
Indicate Maximum Coinsurance percentage for Health Education: <input type="text"/>	Indicate Maximum Coinsurance percentage for Fitness Benefit: <input type="text"/>	Indicate Maximum Coinsurance percentage for Counseling Services: <input type="text"/>	Indicate Maximum Coinsurance percentage for Wigs for Hair Loss Related to Chemotherapy: <input type="text"/>
Indicate Minimum Coinsurance percentage for Nutritional/Dietary Benefit: <input type="text"/>	Indicate Minimum Coinsurance percentage for Enhanced Disease Management: <input type="text"/>	Indicate Minimum Coinsurance percentage for In-Home Safety Assessment: <input type="text"/>	Indicate Minimum Coinsurance percentage for Weight Management Programs: <input type="text"/>
Indicate Maximum Coinsurance percentage for Nutritional/Dietary Benefit: <input type="text"/>	Indicate Maximum Coinsurance percentage for Enhanced Disease Management: <input type="text"/>	Indicate Maximum Coinsurance percentage for In-Home Safety Assessment: <input type="text"/>	Indicate Maximum Coinsurance percentage for Weight Management Programs: <input type="text"/>
Indicate Minimum Coinsurance percentage for Additional Sessions of Smoking and Tobacco Cessation Counseling: <input type="text"/>	Indicate Minimum Coinsurance percentage for Telemonitoring Services: <input type="text"/>	Indicate Minimum Coinsurance percentage for Personal Emergency Response System (PERS): <input type="text"/>	Indicate Minimum Coinsurance percentage for Alternative Therapies: <input type="text"/>
Indicate Maximum Coinsurance percentage for Additional Sessions of Smoking and Tobacco Cessation Counseling: <input type="text"/>	Indicate Maximum Coinsurance percentage for Telemonitoring Services: <input type="text"/>	Indicate Maximum Coinsurance percentage for Personal Emergency Response System (PERS): <input type="text"/>	Indicate Maximum Coinsurance percentage for Alternative Therapies: <input type="text"/>
	Indicate Minimum Coinsurance percentage for Remote Access Technologies (Web/Phone-based technologies): <input type="text"/>	Indicate Minimum Coinsurance percentage for Medical Nutrition Therapy (MNT): <input type="text"/>	Indicate Minimum Coinsurance percentage for Therapeutic Massage: <input type="text"/>
	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Web/Phone-based technologies): <input type="text"/>	Indicate Maximum Coinsurance percentage for Medical Nutrition Therapy (MNT): <input type="text"/>	Indicate Maximum Coinsurance percentage for Therapeutic Massage: <input type="text"/>
	Indicate Minimum Coinsurance percentage for Remote Access Technologies (Nursing Hotline): <input type="text"/>	Indicate Minimum Coinsurance percentage for Post discharge In-Home Medication Reconciliation: <input type="text"/>	Indicate Minimum Coinsurance percentage for Adult Day Health Services: <input type="text"/>
	Indicate Maximum Coinsurance percentage for Remote Access Technologies (Nursing Hotline): <input type="text"/>	Indicate Maximum Coinsurance percentage for Post discharge In-Home Medication Reconciliation: <input type="text"/>	Indicate Maximum Coinsurance percentage for Adult Day Health Services: <input type="text"/>
	Indicate Minimum Coinsurance percentage for Bathroom Safety Devices: <input type="text"/>	Indicate Minimum Coinsurance percentage for Re-admission Prevention: <input type="text"/>	
	Indicate Maximum Coinsurance percentage for Bathroom Safety Devices: <input type="text"/>	Indicate Maximum Coinsurance percentage for Re-admission Prevention: <input type="text"/>	

# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 10

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 10

Previous Next Exit (Validate) Exit (No Validate)

Indicate Minimum Coinsurance percentage for Home-Based Palliative Care:

Indicate Maximum Coinsurance percentage for Home-Based Palliative Care:

Indicate Minimum Coinsurance percentage for In-Home Support Services:

Indicate Maximum Coinsurance percentage for In-Home Support Services:

Indicate Minimum Coinsurance percentage for Support for Caregivers of Enrollees:

Indicate Maximum Coinsurance percentage for Support for Caregivers of Enrollees:

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

# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 11

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 11

<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 there an enrollee Copayment?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which Other Defined Supplemental Benefits have a Copayment (Select all that apply):</p> <div style="border: 1px solid gray; padding: 2px; min-height: 150px;"> <ul style="list-style-type: none"> <li>Health Education</li> <li>Nutritional/Dietary Benefit</li> <li>Additional Sessions of Smoking and Tobacco Cessation Counsel</li> <li>Fitness Benefit</li> <li>Telemonitoring Services</li> <li>Remote Access Technologies (including Web/Phone-based techn</li> <li>Bathroom Safety Devices</li> <li>Counseling Services</li> <li>In-Home Safety Assessment</li> <li>Personal Emergency Response System (PERS)</li> <li>Medical Nutrition Therapy (MNT)</li> <li>Post discharge In-Home Medication Reconciliation</li> <li>Re-admission Prevention</li> <li>Wigs for Hair Loss Related to Chemotherapy</li> <li>Weight Management Programs</li> <li>Alternative Therapies</li> </ul> </div> <p>Indicate Minimum Copayment amount for Health Education: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Health Education: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Nutritional/Dietary Benef <input type="text"/></p> <p>Indicate Maximum Copayment amount for Nutritional/Dietary Bene <input type="text"/></p>	<p>Indicate Minimum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Additional Sessions of Smoking and Tobacco Cessation Counseling: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Fitness Benefit: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Fitness Benefit: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Enhanced Disease Management: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Enhanced Disease Management: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Telemonitoring Services: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Telemonitoring Services: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Remote Access Technologies (Web/Phone-based technologies): <input type="text"/></p> <p>Indicate Maximum Copayment amount for Remote Access Technologies (Web/Phone-based technologies): <input type="text"/></p> <p>Indicate Minimum Copayment amount for Remote Access Technologies (Nursing Hotline): <input type="text"/></p> <p>Indicate Maximum Copayment amount for Remote Access Technologies (Nursing Hotline): <input type="text"/></p>	<p>Indicate Minimum Copayment amount for Bathroom Safety Devices: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Bathroom Safety Devices: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Counseling Services: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Counseling Services: <input type="text"/></p> <p>Indicate Minimum Copayment amount for In-Home Safety Assessment: <input type="text"/></p> <p>Indicate Maximum Copayment amount for In-Home Safety Assessment: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Personal Emergency Response System (PERS): <input type="text"/></p> <p>Indicate Maximum Copayment amount for Personal Emergency Response System (PERS): <input type="text"/></p> <p>Indicate Minimum Copayment amount for Medical Nutrition Therapy (MNT): <input type="text"/></p> <p>Indicate Maximum Copayment amount for Medical Nutrition Therapy (MNT): <input type="text"/></p> <p>Indicate Minimum Copayment amount for Post discharge In-Home Medication Reconciliation: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Post discharge In-Home Medication Reconciliation: <input type="text"/></p>	<p>Indicate Minimum Copayment amount for Re-admission Prevention: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Re-admission Prevention: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Wigs for Hair Loss Related to Chemotherapy: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Wigs for Hair Loss Related to Chemotherapy: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Weight Management Programs: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Weight Management Programs: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Alternative Therapies: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Alternative Therapies: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Therapeutic Massage: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Therapeutic Massage: <input type="text"/></p> <p>Indicate Minimum Copayment amount for Adult Day Health Services: <input type="text"/></p> <p>Indicate Maximum Copayment amount for Adult Day Health Services: <input type="text"/></p>
---	---	---	---



# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 12

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 12

Previous Next Exit (Validate) Exit (No Validate)

Indicate Minimum Copayment amount for Home-Based Palliative Care:

Indicate Maximum Copayment amount for Home-Based Palliative Care:

Indicate Minimum Copayment amount for In-Home Support Services:

Indicate Maximum Copayment amount for In-Home Support Services:

Indicate Minimum Copayment amount for Support for Caregivers of Enrollees:

Indicate Maximum Copayment amount for Support for Caregivers of Enrollees:

# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 13

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 13

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?  
 Yes  
 No

Is a referral required for Other Defined Supplemental Benefits?  
 Yes  
 No

Other Defined Supplemental Benefits Notes:  
Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry.  
\* = This notes field is required when the corresponding benefit is offered.

Health Education Notes:

Nutritional/Dietary Benefit Notes:

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

Fitness Benefit Notes.\*

Enhanced Disease Management Notes:

Telemonitoring Services Notes.\*

# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 14

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 14

Previous Next Exit (Validate) Exit (No Validate)

Remote Access Technology (Web/Phone-based technologies) Notes\*

In-Home Safety Assessment Notes:

Remote Access Technologies (Nursing Hotline) Notes:

Personal Emergency Response System (PERS) Notes:

Bathroom Safety Devices Notes:\*

Medical Nutrition Therapy (MNT) Notes:

Counseling Services Notes:

Post discharge In-Home Medication Reconciliation Notes:

# CY 2020 PBP Data Entry System Screens

## #14c Other Defined Supplemental Benefits – Base 15

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

File Help

Go To: #14c Other Defined Supplemental Benefits - Base 15

Previous Next Exit (Validate) EXIT (No Validate)

Re-admission Prevention Notes:

Therapeutic Massage Notes:\*

Support for Caregivers of Enrollees Notes:\*

Wigs for Hair Loss Related to Chemotherapy Notes:

Adult Day Health Services Notes:\*

Weight Management Notes:\*

Home-Based Palliative Care Notes:\*

Alternative Therapies Notes:\*

In-Home Support Services Notes:\*

# CY 2020 PBP Data Entry System Screens

## #14d Kidney Disease Education Services – Base 1

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

File Help

Go To: #14d - Kidney Disease Education Services Base 1

Previous Next Exit (Validate) Exit (No Validate)

[CLICK FOR DESCRIPTION OF BENEFIT](#)

Enhanced Benefits are not applicable for this Service Category.

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

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

Yes  
 No

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

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

Is there an enrollee Coinsurance?

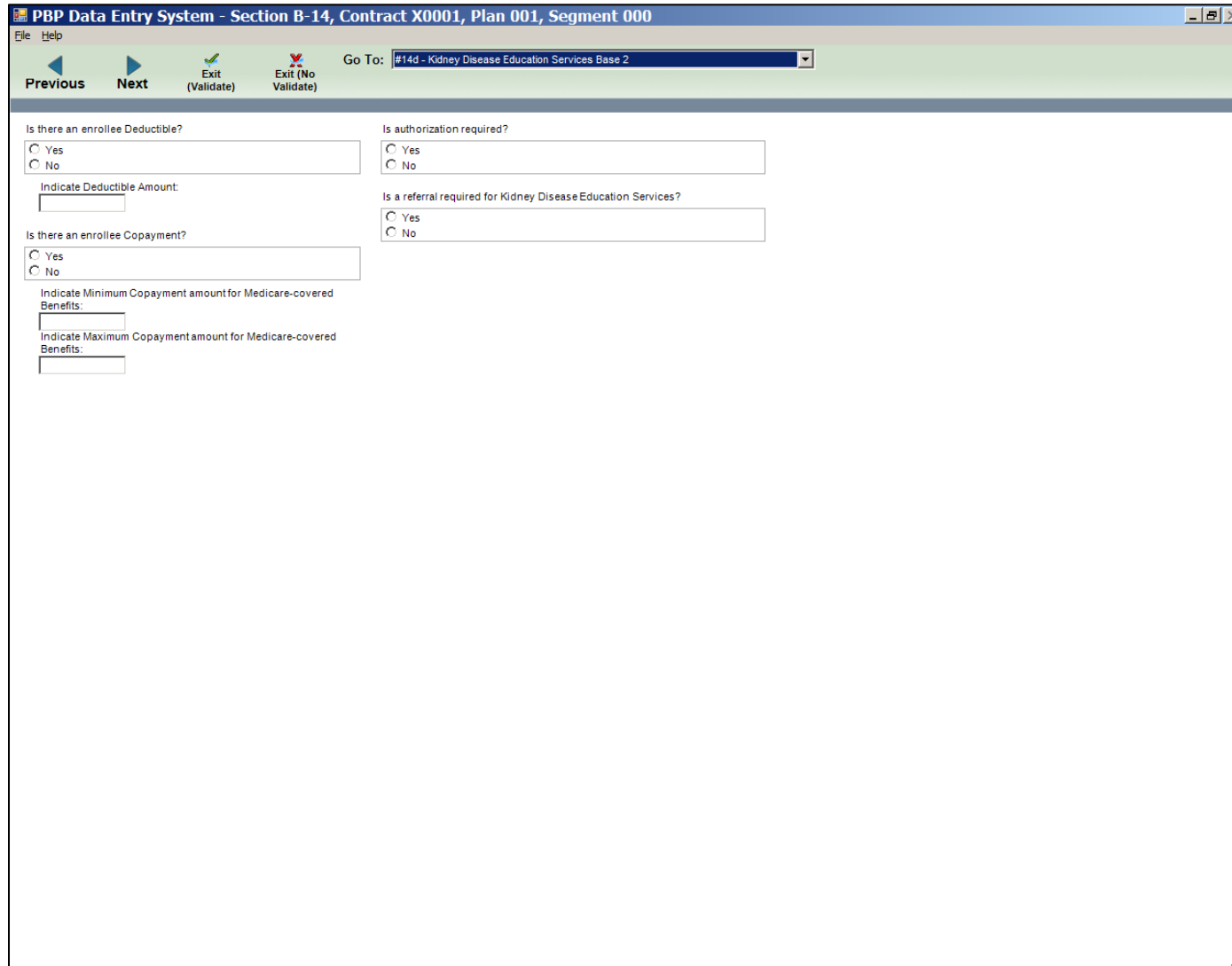
Yes  
 No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

# CY 2020 PBP Data Entry System Screens

## #14d Kidney Disease Education Services – Base 2



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

File Help

Go To: #14d - Kidney Disease Education Services Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[Text Field]

Is there an enrollee Copayment?  
 Yes  
 No

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

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

Is authorization required?  
 Yes  
 No

Is a referral required for Kidney Disease Education Services?  
 Yes  
 No

# CY 2020 PBP Data Entry System Screens

## #14d Kidney Disease Education Services – Base 3

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

File Help

Go To: #14d - Kidney Disease Education Services Base 3

Previous Next Exit (Validate) Exit (No Validate)

Kidney Disease Education Services Notes

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

Notes:

[Empty text box with vertical scrollbar]

# CY 2020 PBP Data Entry System Screens

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

File Help
- [ ] X

Go To: #14e Other Medicare-covered Preventive Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

Glaucoma screening, diabetes self-management training, barium enemas, digital rectal exams, EKG following welcome visit, and Other Medicare-covered preventive services are Medicare-covered preventive services for which data entry must be completed in this section. See the Benefit Description for more guidance.

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?

Yes  
 No

Select which Services have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply):

- Medicare-covered Glaucoma Screening
- Medicare-covered Diabetes Self-Management Training
- Medicare-covered Barium Enemas
- Medicare-covered Digital Rectal Exams
- Medicare-covered EKG following Welcome Visit
- Other Medicare-covered Preventive Services

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

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Glaucoma Screening:

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

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

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Diabetes Self-Management Training:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Barium Enemas:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Barium Enemas:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Digital Rectal Exams:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Digital Rectal Exams:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered EKG following Welcome Visit:

Select the Enrollee Out-of-Pocket Cost periodicity for Medicare-covered EKG following Welcome Visit:

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

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

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Other Medicare-covered Preventive Services:

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



# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #14e Other Medicare-covered Preventive Services - Base 2

---

Is there an enrollee Coinsurance?

Yes  
 No

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

Medicare-covered Glaucoma Screening

Medicare-covered Diabetes Self-Management Training

Medicare-covered Barium Enemas

Medicare-covered Digital Rectal Exams

Medicare-covered EKG following Welcome Visit

Other Medicare-covered Preventive Services

	Minimum Coinsurance	Maximum Coinsurance
Medicare-covered Glaucoma Screening	<input type="text"/>	<input type="text"/>
Medicare-covered Diabetes Self-Management Training	<input type="text"/>	<input type="text"/>
Medicare-covered Barium Enemas	<input type="text"/>	<input type="text"/>
Medicare-covered Digital Rectal Exams	<input type="text"/>	<input type="text"/>
Medicare-covered EKG following Welcome Visit	<input type="text"/>	<input type="text"/>
Other Medicare-covered Preventive Services	<input type="text"/>	<input type="text"/>

Is there an enrollee Deductible?

Yes  
 No

Select which Services have a Deductible (Select all that apply):

Medicare-covered Glaucoma Screening

Medicare-covered Diabetes Self-Management Training

Medicare-covered Barium Enemas

Medicare-covered Digital Rectal Exams

Medicare-covered EKG following Welcome Visit

Other Medicare-covered Preventive Services

Indicate Medicare-covered Glaucoma Screening Deductible Amount:

Indicate Medicare-covered Diabetes Self-Management Training Deductible Amount:

Indicate Medicare-covered Barium Enemas Deductible Amount:

Indicate Medicare-covered Digital Rectal Exams Deductible Amount:

Indicate Medicare-covered EKG following Welcome Visit Deductible Amount:

Indicate Other Medicare-covered Preventive Services Deductible Amount:

Softrams

CY2020 PBP – Section B  
12/12/2018

Page 209 of 260

**CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING**

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #14e Other Medicare-covered Preventive Services - Base 3

---

Is there an enrollee Copayment?

Yes  
 No

Is authorization required for Medicare-covered Glaucoma Screening?

Yes  
 No

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

Medicare-covered Glaucoma Screening  
 Medicare-covered Diabetes Self-Management Training  
 Medicare-covered Barium Enemas  
 Medicare-covered Digital Rectal Exams  
 Medicare-covered EKG following Welcome Visit  
 Other Medicare-covered Preventive Services

Is authorization required for Medicare-covered Diabetes Self-Management Training?

Yes  
 No

	Minimum Copayment	Maximum Copayment
Medicare-covered Glaucoma Screening	<input type="text"/>	<input type="text"/>
Medicare-covered Diabetes Self-Management Training	<input type="text"/>	<input type="text"/>
Medicare-covered Barium Enemas	<input type="text"/>	<input type="text"/>
Medicare-covered Digital Rectal Exams	<input type="text"/>	<input type="text"/>
Medicare-covered EKG following Welcome Visit	<input type="text"/>	<input type="text"/>
Other Medicare-covered Preventive Services	<input type="text"/>	<input type="text"/>

Is authorization required for Medicare-covered Barium Enemas?

Yes  
 No

Is authorization required for Medicare-covered Digital Rectal Exams?

Yes  
 No

Is authorization required for Medicare-covered EKG following Welcome Visit?

Yes  
 No

Is authorization required for Other Medicare-covered Preventive Services?

Yes  
 No  
 N/A

# CY 2020 PBP Data Entry System Screens

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

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

File Help

Go To: #14e Other Medicare-covered Preventive Services - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Is a referral required for any Services?

Yes  
 No

Select which Services require a Referral (Select all that apply):

- Medicare-covered Glaucoma Screening
- Medicare-covered Diabetes Self-Management Training
- Medicare-covered Barium Enemas
- Medicare-covered Digital Rectal Exams
- Medicare-covered EKG following Welcome Visit
- Other Medicare-covered Preventive Services

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

Medicare-covered Barium Enemas Notes:

Other Medicare-covered Preventive Services Notes:

Medicare-covered Glaucoma Screening Notes:

Medicare-covered Digital Rectal Exams Notes:

Medicare-covered Diabetes Self-Management Training Notes:

Medicare-covered EKG following Welcome Visit Notes:

# CY 2020 PBP Data Entry System Screens

## #15 Medicare Part B Rx Drugs – Base 1

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

File Help

Go To: #15 Medicare Part B Rx Drugs - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Is there a 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  
 Every month  
 Other, Describe

Is there an enrollee Coinsurance?

Yes  
 No

Select which Medicare Part B Rx Drugs have a Coinsurance (Select all that apply):

Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate the Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:

# CY 2020 PBP Data Entry System Screens

## #15 Medicare Part B Rx Drugs – Base 2

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

File Help

Go To: #15 Medicare Part B Rx Drugs - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?

Yes  
 No

Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):

Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Minimum Copayment Amount for other Medicare Part B Drugs:

Indicate Maximum Copayment Amount for other Medicare Part B Drugs:

Is there an enrollee Deductible?

Yes  
 No

Indicate Deductible Amount:

Is Authorization Required?

Yes  
 No

Does the plan offer step therapy?

Yes  
 No

Does the benefit step from (select all that apply):

Part B to Part B?  
 Part B to Part D?  
 Part D to Part B?

# CY 2020 PBP Data Entry System Screens

## #15 Medicare Part B Rx Drugs – Notes

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: #15 Medicare Part B Rx Drugs - Notes

Medicare Part B Rx Drugs Notes

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

Referral is not applicable for this Service Category.

Notes:

[Empty text input field]

# CY 2020 PBP Data Entry System Screens

## #15 Home Infusion Bundled Services

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: #15 Home Infusion Bundled Services

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

Yes  
 No

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

Yes  
 No

If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 7, 2019 at 11:59 am Eastern Time.

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

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

# CY 2020 PBP Data Entry System Screens

## #16a Preventive Dental – Base 1

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

File Help

Go To: #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

## #16a Preventive Dental – Base 2

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

File Help

Go To: #16a Preventive Dental - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

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

Indicate number of visits for Dental X-Rays:

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

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

# CY 2020 PBP Data Entry System Screens

## #16a Preventive Dental – Base 3

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

File Help

Go To: #16a Preventive Dental - Base 3

Previous Next Exit (Validate) Exit (No Validate)

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

Is there an enrollee Coinsurance?  
 Yes  
 No

Select which Preventive Dental Services have a Coinsurance (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 Minimum Coinsurance percentage for Office Visits:

Indicate Maximum Coinsurance percentage for Office Visits:

Indicate Minimum Coinsurance percentage for Oral Exams:

Indicate Maximum Coinsurance percentage for Oral Exams:

Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Minimum Coinsurance percentage for Fluoride Treatment:

Indicate Maximum Coinsurance percentage for Fluoride Treatment:

Indicate Minimum Coinsurance percentage for Dental X-Rays:

Indicate Maximum Coinsurance percentage for Dental X-Rays:

# CY 2020 PBP Data Entry System Screens

## #16a Preventive Dental – Base 4

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

File Help

Go To: #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 Minimum Copayment amount for Office Visit:

Indicate Maximum 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

## #16a Preventive Dental – Base 5

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

File Help

Go To: #16a Preventive Dental - Base 5

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?  
 Yes  
 No

Is a referral required for Preventive Dental Services?  
 Yes  
 No

Preventive Dental 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

## #16b Comprehensive Dental – Base 1

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

File Help

Go To: #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: [ ]	Indicate number of visits for Diagnostic Services: [ ]	Indicate number of visits for Restorative Services: [ ]
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

## #16b Comprehensive Dental – Base 2

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

File Help

Go To: #16b Comprehensive Dental - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Endodontics	Periodontics	Extractions	Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Endodontics: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select type of benefit for Periodontics: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select type of benefit for Extractions: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="radio"/> Mandatory <input type="radio"/> Optional
Is this benefit unlimited for Endodontics? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Periodontics? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Extractions? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services? <input type="radio"/> Yes <input type="radio"/> No, indicate number
Indicate number of visits for Endodontics: [ ]	Indicate number of visits for Periodontics: [ ]	Indicate number of visits for Extractions: [ ]	Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: [ ]
Select the Endodontics 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 Periodontics 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 Extractions 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 Prosthodontics/Other Oral/Maxillofacial Surgery/Other 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

## #16b Comprehensive Dental – Base 3

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

File Help

Go To: #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:  
\_\_\_\_\_

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

## #16b Comprehensive Dental – Base 4

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

File Help

Go To: #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

## #16b Comprehensive Dental – Base 5

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

File Help

Go To: #16b Comprehensive Dental - Base 5

Previous Next Exit (Validate) Exit (No Validate)

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

## #16b Comprehensive Dental – Base 6

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

File Help

Go To: #16b Comprehensive Dental - Base 6

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?  
 Yes  
 No

Is a referral required for Comprehensive Dental Services?  
 Yes  
 No

Comprehensive Dental 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

## #17a Eye Exams – Base 1

**PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000**

File Help

Go To: #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

## #17a Eye Exams – Base 2

**PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000**

File Help

Go To: #17a Eye Exams - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

# CY 2020 PBP Data Entry System Screens

## #17a Eye Exams – Base 3

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: #17a Eye Exams - Base 3

Is authorization required?  
 Yes  
 No

Is a referral required for Eye Exams?  
 Yes  
 No

Eye Exams 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

## #17b Eyewear – Base 1

**PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000**

File Help

Go To: #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

## #17b Eyewear – Base 2

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

Go To: #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

## #17b Eyewear – Base 3

**PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000**

File Help

Go To: #17b Eyewear - Base 3

Previous Next Exit (No 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

## #17b Eyewear – Base 4

**PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000**

File Help

Go To: #17b Eyewear - Base 4

Previous Next Exit (Validate) Exit (No Validate)

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

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Eyeglass frames:

Select the Maximum Enrollee Out-of-Pocket Cost type:  
 Covered under Eye Exams Category 17a  
 Plan-specified amount per period

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Eyeglass frames:

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Minimum Coinsurance percentage for Contact lenses:

Indicate Minimum Coinsurance percentage for Upgrades:

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

Indicate Maximum Coinsurance percentage for Contact lenses:

Indicate Maximum Coinsurance percentage for Upgrades:

Indicate Minimum Coinsurance percentage for Eyeglasses (lenses and frames):

Is there an enrollee Coinsurance?  
 Yes  
 No

Indicate Maximum Coinsurance percentage for Eyeglasses (lenses and frames):

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

Indicate Minimum Coinsurance percentage for Eyeglass lenses:

Indicate Maximum Coinsurance percentage for Eyeglass lenses:

# CY 2020 PBP Data Entry System Screens

## #17b Eyewear – Base 5

**PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000**

File Help

Go To: #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

## #17b Eyewear – Base 6

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File Help

Go To: #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

## #18a Hearing Exams – Base 1

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

File Help

Go To: #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

## #18a Hearing Exams – Base 2

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

File Help

Go To: #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

## #18a Hearing Exams – Base 3

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

File Help

Go To: #18a Hearing Exams - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?  
 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 authorization required?  
 Yes  
 No

Is a referral required for Hearing Exams?  
 Yes  
 No

# CY 2020 PBP Data Entry System Screens

## #18a Hearing Exams – Base 4

The screenshot displays the 'PBP Data Entry System' window. The title bar reads 'PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000'. The menu bar includes 'File' and 'Help'. The toolbar contains 'Previous', 'Next', 'Exit (Validate)', and 'Exit (No Validate)' buttons, along with a 'Go To:' dropdown menu set to '#18a Hearing Exams - Base 4'. The main content area is titled 'Hearing Exams Notes' and includes 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 'Notes:' label and a large, empty text input area with a vertical scrollbar on the right side.

# CY 2020 PBP Data Entry System Screens

## #18b Hearing Aids – Base 1

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

File Help

Go To: #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):  
 Mandatory  
 Optional

Is this benefit unlimited for Hearing Aids (all types)?  
 Yes  
 No, indicate number

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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

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

Indicate quantity for Hearing Aids - Inner Ear:

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

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

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

Indicate quantity for Hearing Aids - Outer Ear:

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



# CY 2020 PBP Data Entry System Screens

## #18b Hearing Aids – Base 2

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

File Help

Go To: #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

## #18b Hearing Aids – Base 3

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

File Help

Go To: #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

## #18b Hearing Aids – Base 4

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

File Help

Go To: #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:  
[Text Input]

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:  
[Text Input]

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 Minimum Copayment amount per Hearing Aid (all types):  
[Text Input]

Indicate Maximum Copayment amount per Hearing Aid (all types):  
[Text Input]

Indicate Minimum Copayment amount per Hearing Aid - Inner Ear:  
[Text Input]

Indicate Maximum Copayment amount per Hearing Aid - Inner Ear:  
[Text Input]

Indicate Minimum Copayment amount per two Hearing Aids - Inner Ear:  
[Text Input]

Indicate Maximum Copayment amount per two Hearing Aids - Inner Ear:  
[Text Input]

Indicate Minimum Copayment amount per Hearing Aid - Outer Ear:  
[Text Input]

Indicate Maximum Copayment amount per Hearing Aid - Outer Ear:  
[Text Input]

Indicate Minimum Copayment amount per two Hearing Aids - Outer Ear:  
[Text Input]

Indicate Maximum Copayment amount per two Hearing Aids - Over the Ear:  
[Text Input]

# CY 2020 PBP Data Entry System Screens

## #18b Hearing Aids – Base 5

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

File Help

Go To: #18b Hearing Aids - Base 5

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?  
 Yes  
 No

Is a referral required for Hearing Aids?  
 Yes  
 No

Hearing Aids 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

## #20 Outpatient Drugs – Base 1

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

File Help

Go To: #20 Outpatient Drugs - Base 1

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Outpatient Drugs as a supplemental benefit under Part C?  
 Yes  
 No

Select type of benefit:  
 Mandatory  
 Optional

Indicate the number of drug groupings that are offered:  
 1  
 2  
 3  
 4  
 5

Is there a Maximum Plan Benefit Coverage amount for drugs?  
 Yes  
 No

Indicate type of Maximum Plan Benefit Coverage:  
 All drug groups covered by plan  
 Combination of drug groups  
 Individual drug groups

Is the Maximum Plan Benefit Coverage net of the enrollee copay?  
 Yes  
 No

Indicate Maximum Plan Benefit Coverage periodicity for drugs:  
 Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Other, Describe

Indicate Max Plan Benefit Coverage amount annually for drugs: \_\_\_\_\_

Indicate Max Plan Benefit Coverage amount semi-annually for drugs: \_\_\_\_\_

Indicate Max Plan Benefit Coverage amount quarterly for drugs: \_\_\_\_\_

Indicate Max Plan Benefit Coverage amount monthly for drugs: \_\_\_\_\_

Indicate Max Plan Benefit Coverage amount for Other for drugs: \_\_\_\_\_

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Base 2

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

File Help

Go To: #20 Outpatient Drugs - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Can any unused amounts be carried forward to the next period within the contract period?

Yes  
 No

Select what combination of drug groups are included in the Maximum Plan Benefit:

Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5

Indicate Maximum Plan Benefit Coverage periodicity for combination of drug groups:

Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Other, Describe

Indicate Max Plan Benefit Coverage amount annually for combination of drug groups:

Indicate Max Plan Benefit Coverage amount semi-annually for combination of drug groups:

Indicate Max Plan Benefit Coverage amount quarterly for combination of drug groups:

Indicate Max Plan Benefit Coverage amount monthly for combination of drug groups:

Indicate Max Plan Benefit Coverage amount for Other for combination of drug groups:

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Base 3

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

File Help

Go To: #20 Outpatient Drugs - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached?  
 Yes  
 No

Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived:  
 Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5

Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available?  
 Yes  
 No

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

Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost:  
 Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5  
 Medicare Covered Benefits

Indicate Maximum Enrollee Out-of-Pocket Cost amount:  
\_\_\_\_\_

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:  
 Every year  
 Every six months  
 Every three months

Is there an enrollee Coinsurance for Medicare-covered Benefits?  
 Yes  
 No

Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply):  
 Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:  
\_\_\_\_\_

Indicate Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:  
\_\_\_\_\_

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:  
\_\_\_\_\_

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:  
\_\_\_\_\_

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Base 4

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

File Help

Go To: #20 Outpatient Drugs - Base 4

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?  
 Yes  
 No

Select what combination of drug groups applies for Deductible:  
 Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5  
 Medicare Covered Benefits

Indicate Deductible amount:

Indicate Minimum Copayment amount for Medicare Part B  
Chemotherapy Drugs:

Indicate Maximum Copayment amount for Medicare Part B  
Chemotherapy Drugs:

Indicate Minimum Copayment for other Medicare Part B Drugs:

Indicate Maximum Copayment for other Medicare Part B Drugs:

Is there an enrollee Copayment for Medicare-covered Benefits?  
 Yes  
 No

Select which Medicare-covered Outpatient Drugs have a Copayment  
(Select all that apply):  
 Medicare Part B Chemotherapy Drugs  
 Other Medicare Part B Drugs

Is authorization required?  
 Yes  
 No



# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Notes

The screenshot shows a software window titled "PBP Data Entry System - Section B-20, 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 "#20 Outpatient Drugs - Notes". The main content area is titled "Outpatient Drugs 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

## #20 Outpatient Drugs – Group 1 – Base 1

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

File Help

Go To: #20 Outpatient Drugs - Group 1 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

Select a label for Group 1:

Indicate Maximum Plan Benefit Coverage annual amount for Group 1:

Select the drug type(s) covered for Group 1:

Generic

Preferred Brand

Brand

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:

Is there a Maximum Plan Benefit Coverage amount for Group 1?

Yes

No

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:

Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:

Annually

Semi-annually

Quarterly

Monthly

Per Prescription

Other, Describe

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Group 1 – Base 2

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

File Help

Go To: #20 Outpatient Drugs - Group 1 - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Select from where Group 1 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, Describe

Is there an enrollee Coinsurance for Group 1?  
 Yes  
 No

Is there an enrollee Copayment for Group 1?  
 Yes  
 No

Indicate Coinsurance percentage for Group 1 Designated Retail Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 1 Designated Retail Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 1 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 1 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 1 HMO-Owned Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 1 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 1 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 1 Mail Order: <input type="text"/>	Up to a ____ day supply covered for Group 1 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 1 Other: <input type="text"/>	Indicate Copayment amount for Group 1 Other: <input type="text"/>	Up to a ____ day supply covered for Group 1 Other: <input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Group 2 – Base 1

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

File Help

Go To: #20 Outpatient Drugs - Group 2 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

Select a label for Group 2:

Indicate Maximum Plan Benefit Coverage annual amount for Group 2:

Select the drug type(s) covered for Group 2:

Generic

Preferred Brand

Brand

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:

Is there a Maximum Plan Benefit Coverage amount for Group 2?

Yes

No

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:

Indicate Maximum Plan Benefit Coverage for Group 2 periodically:

Annually

Semi-annually

Quarterly

Monthly

Per Prescription

Other, Describe

Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Group 2 – Base 2

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

Select from where Group 2 Drugs can be acquired

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, Describe

Is there an enrollee Coinsurance for Group 2?

Yes  No

Is there an enrollee Copayment for Group 2?

Yes  No

Indicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 2 Designated Retail Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 2 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 2 for HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 2 HMO-Owned Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 2 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 2 for Mail Order: <input type="text"/>	Indicate Copayment amount for Group 2 Mail Order: <input type="text"/>	Up to a ____ day supply covered for Group 2 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 2 for Other: <input type="text"/>	Indicate Copayment amount for Group 2 Other: <input type="text"/>	Up to a ____ day supply covered for Group 2 Other: <input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Group 3 – Base 1

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

File Help

Go To: #20 Outpatient Drugs - Group 3 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

Select a label for Group 3:

Indicate Maximum Plan Benefit Coverage annual amount for Group 3:

Select the drug type(s) covered for Group 3:

Generic

Preferred Brand

Brand

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 3:

Is there a Maximum Plan Benefit Coverage amount for Group 3?

Yes

No

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3:

Indicate Maximum Plan Benefit Coverage Group 3 periodicity:

Annually

Semi-annually

Quarterly

Monthly

Per Prescription

Other, Describe

Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 3:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 3:

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Group 3 – Base 2

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

File Help

Go To: #20 Outpatient Drugs - Group 3 - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Select from where Group 3 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, Describe

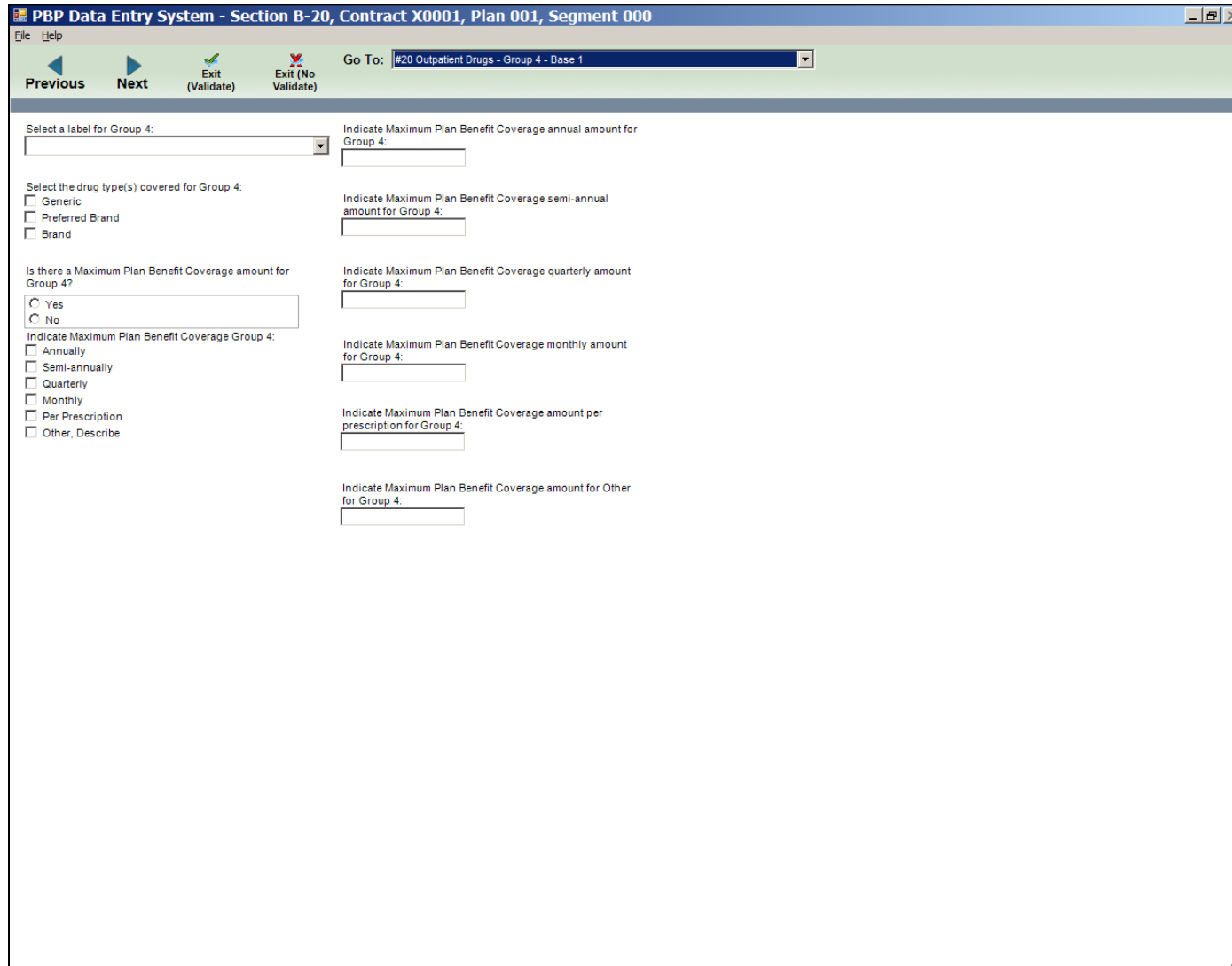
Is there an enrollee Coinsurance for Group 3?  
 Yes  No

Is there an enrollee Copayment for Group 3?  
 Yes  No

Indicate Coinsurance percentage for Group 3 Designated Retail Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 3 Designated Retail Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 3 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 3 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 3 HMO-Owned Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 3 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 3 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 3 Mail Order: <input type="text"/>	Up to a ____ day supply covered for Group 3 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 3 Other: <input type="text"/>	Indicate Copayment amount for Group 3 Other: <input type="text"/>	Up to a ____ day supply covered for Group 3 Other: <input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Group 4 – Base 1



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

File Help

Go To: #20 Outpatient Drugs - Group 4 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

Select a label for Group 4: [dropdown]

Indicate Maximum Plan Benefit Coverage annual amount for Group 4: [text box]

Select the drug type(s) covered for Group 4:

- Generic
- Preferred Brand
- Brand

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 4: [text box]

Is there a Maximum Plan Benefit Coverage amount for Group 4?

Yes

No

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4: [text box]

Indicate Maximum Plan Benefit Coverage Group 4:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, Describe

Indicate Maximum Plan Benefit Coverage monthly amount for Group 4: [text box]

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 4: [text box]

Indicate Maximum Plan Benefit Coverage amount for Other for Group 4: [text box]



# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Group 4 – Base 2

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

File Help

Go To: #20 Outpatient Drugs - Group 4 - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Select from where Group 4 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, Describe

Is there an enrollee Coinsurance for Group 4?  
 Yes  
 No

Is there an enrollee Copayment for Group 4?  
 Yes  
 No

Indicate Coinsurance percentage for Group 4 Designated Retail Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 4 Designated Retail Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 4 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 4 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 4 HMO-Owned Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 4 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 4 Mail Order: <input type="text"/>	Indicate Copayment amount for Group 4 Mail Order: <input type="text"/>	Up to a ____ day supply covered for Group 4 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 4 Other: <input type="text"/>	Indicate Copayment amount for Group 4 Other: <input type="text"/>	Up to a ____ day supply covered for Group 4 Other: <input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Group 5 – Base 1

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

File Help

Go To: #20 Outpatient Drugs - Group 5 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

Select a label for Group 5:

Indicate Maximum Plan Benefit Coverage annual amount for Group 5:

Select the drug type(s) covered for Group 5:

Generic

Preferred Brand

Brand

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

Is there a Maximum Plan Benefit Coverage amount for Group 5?

Yes

No

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:

Indicate Maximum Plan Benefit Coverage for Group 5 periodicity:

Annually

Semi-annually

Quarterly

Monthly

Per Prescription

Other, Describe

Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:

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

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

# CY 2020 PBP Data Entry System Screens

## #20 Outpatient Drugs – Group 5 – Base 2

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

Select from where Group 5 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, Describe

Is there an enrollee Coinsurance for Group 5?  Yes  No

Is there an enrollee Copayment for Group 5?  Yes  No

Indicate Coinsurance percentage for Group 5 Designated Retail Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 5 Designated Retail Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 5 Designated Retail Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 5 HMO-Owned Pharmacy: <input type="text"/>	Indicate Copayment amount for Group 5 HMO-Owned Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 5 HMO-Owned Pharmacy: <input type="text"/>
Indicate Coinsurance percentage for Group 5 Mail Ord <input type="text"/>	Indicate Copayment amount for Group 5 Mail Order: <input type="text"/>	Up to a ____ day supply covered for Group 5 Mail Order: <input type="text"/>
Indicate Coinsurance percentage for Group 5 Other: <input type="text"/>	Indicate Copayment amount for Group 5 Other: <input type="text"/>	Up to a ____ day supply covered for Group 5 Other: <input type="text"/>

# CY 2020 PBP Data Entry System Screens

## #20 Home Infusion Bundled Services

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: #20 Home Infusion Bundled Services

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

Yes  
 No

If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 7, 2019 at 11:59 am Eastern Time.

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

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