

# CY 2021 PBP Data Entry System Screens

## Plan Deductible LPPD/RPPO Base 1

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

File Help

Go To: Plan Deductible LPPD/RPPO Base 1

Previous Next Exit (Validate) Exit (No Validate)

Do you offer a Deductible?  
 Yes  
 No

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

Indicate Deductible Amount:

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

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

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

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

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

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

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

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

# CY 2021 PBP Data Entry System Screens

## Plan Deductible LPPO/RPPO Base 2

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

File Help

Go To: Plan Deductible LPPO/RPPO Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

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

Yes  
 No

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

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

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

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

Yes  
 No

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

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

# CY 2021 PBP Data Entry System Screens

## Plan Deductible LPPO/RPPO Base 3

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

File Help

Go To: Plan Deductible LPPO/RPPO Base 3

Previous Next Exit (Validate) Exit (No Validate)

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

Yes  
 No

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

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

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

# CY 2021 PBP Data Entry System Screens

## Plan Deductible LPPO/RPPO Base 4

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

File Help

Go To: Plan Deductible LPPO/RPPO Base 4

Previous Next Exit (Validate) Exit (No Validate)

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

# CY 2021 PBP Data Entry System Screens

## Plan Deductible LPPO/PPPO Base 5

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

File Help

◀ Previous
Next ▶
✔ Exit (Validate)
✘ Exit (No Validate)
Go To:

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

# CY 2021 PBP Data Entry System Screens

## Plan Deductible LPPO/RPPO Base 6

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

File Help

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

Indicate Differential Deductible Amount for Other 1: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Kidney Disease Education Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Other Medicare-covered Preventive Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Hearing Exams: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Other 2: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Medicare-covered Glaucoma Screening Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Medicare Part B Rx Drugs: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Hearing Aids: <input style="width: 100%;" type="text"/>
Indicate Differential Deductible Amount for Other 3: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Medicare-covered Diabetes Self-management Training: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Preventive Dental: <input style="width: 100%;" type="text"/>	
Indicate Differential Deductible Amount for Dual Eligible SNPs with Highly Integrated Services: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Medicare-covered Barium Enemas: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Comprehensive Dental: <input style="width: 100%;" type="text"/>	
Indicate Differential Deductible Amount for the Annual Physical Exam: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Medicare-covered Digital Rectal Exams: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Eye Exams: <input style="width: 100%;" type="text"/>	
Indicate Differential Deductible Amount for Other Defined Supplemental Benefit: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Medicare-covered EKG following Welcome Visit: <input style="width: 100%;" type="text"/>	Indicate Differential Deductible Amount for Eyewear: <input style="width: 100%;" type="text"/>	

# CY 2021 PBP Data Entry System Screens

## Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 1

The screenshot shows a web-based data entry application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a navigation bar with "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons. A "Go To:" dropdown menu is set to "Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 1".

The main content area is divided into two sections:

- Do you offer a mandatory enhanced benefit enrollee deductible amount?**  
 Yes  
 No
- Select the mandatory enhanced benefits that have an enrollee deductible:**  
A list box contains the following items:
  - 1a: Inpatient Hospital-Acute
  - 1b: Inpatient Hospital Psychiatric
  - 2: Skilled Nursing Facility (SNF)
  - 3: Cardiac and Pulmonary Rehabilitation Services
  - 4c: Worldwide Emergency/Urgent Coverage
  - 7b: Chiropractic Services
  - 7f: Podiatry Services
  - 9d: Outpatient Blood Services
  - 10b: Transportation Services
  - 13a: Acupuncture
  - 13b: Over-the-Counter (OTC) Items
  - 13c: Meal Benefit
  - 13d: Other 1
  - 13e: Other 2

**Indicate deductible for one or more of the following services**

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

# CY 2021 PBP Data Entry System Screens

## Deductible for LPPO/RPPO Mandatory Supplemental Benefits – Base 2

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

The main content area contains the instruction: "Indicate deductible for one or more of the following services". Below this is a table with two columns: a list of services and a "Deductible Amount" column with input fields.

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



# CY 2021 PBP Data Entry System Screens

## Plan Deductible (In-Network)

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

File Help

Go To: Plan Deductible (In-Network)

Previous Next Exit (Validate) Exit (No Validate)

Is there an In-Network Plan Deductible?  
 Yes  
 No

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

Indicate In-Network Plan Deductible Amount:

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

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

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

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

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

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

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

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

# CY 2021 PBP Data Entry System Screens

## Plan Deductible (Combined) – Base 1

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

File Help

Go To: Plan Deductible (Combined) - Base 1

Previous Next Exit (Validate) Exit (No Validate)

Is there a Combined (In-Network and Out-of-Network) Deductible?

Yes  
 No

Do you charge the Medicare-defined Part B Deductible amount?

Yes  
 No

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

Select the benefits that apply to the Combined Deductible:

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

Does the Combined Deductible apply to all In-Network Medicare-covered plan services?

Yes  
 No

Does the Combined Deductible apply to all In-Network Non-Medicare-covered plan services?

Yes  
 No

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

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

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

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

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

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

# CY 2021 PBP Data Entry System Screens

## Plan Deductible (Combined) – Base 2

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

File Help

Go To: Plan Deductible (Combined) - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

Yes  
 No

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

Yes  
 No

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

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

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e: Mental Health Specialty Services
- 7f: Podiatry Services
- 7g: Other Health Care Professional
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 7k: Opioid Treatment Program Services
- 8a: Diagnostic Procedures/Tests/Lab Services
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services

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

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

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

# CY 2021 PBP Data Entry System Screens

## Plan Deductible (Out-of-Network)

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

File Help

Go To: Plan Deductible (Out-of-Network)

Previous Next Exit (Validate) Exit (No Validate)

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

Yes  
 No

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

Indicate Out-of-Network Plan Deductible Amount:

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

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

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

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

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

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

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

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

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

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

# CY 2021 PBP Data Entry System Screens

## Plan Deductible (Non-Network)

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

File Help

Go To: Plan Deductible (Non-Network)

Previous Next Exit (Validate) Exit (No Validate)

Is there a Plan Deductible?  
 Yes  
 No

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

Indicate Plan Deductible Amount:

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

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

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

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

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

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

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

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

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

# CY 2021 PBP Data Entry System Screens

## Max Enrollee Cost Limit (In-Network)

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# CY 2021 PBP Data Entry System Screens

## Max Enrollee Cost Limit (Combined) – Base 1

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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

Yes  
 No

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

Voluntary  
 Mandatory

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

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

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

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

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

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

Yes  
 No

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

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

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

Yes  
 No

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

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

# CY 2021 PBP Data Entry System Screens

## Max Enrollee Cost Limit (Combined) – Base 2

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

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

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

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

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

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

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

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

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c: Worldwide Emergency/Urgent Coverage
- 7b: Chiropractic Services
- 7f: Podiatry Services
- 9d: Outpatient Blood Services
- 10b: Transportation Services
- 13a: Acupuncture



# CY 2021 PBP Data Entry System Screens

## Max Enrollee Cost Limit (Out-of-Network)

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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

Yes  
 No

Is your Out-of-Network Maximum Enrollee Out-of-Pocket Cost Lower, Intermediate or Mandatory?

Lower  
 Intermediate  
 Mandatory

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

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

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

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

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

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

Yes  
 No

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

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

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

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

Yes  
 No

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

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

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

# CY 2021 PBP Data Entry System Screens

## Max Enrollee Cost Limit (Non-Network)

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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

Voluntary  
 Mandatory

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

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

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

Medicare-covered benefits  
 Non-Medicare-covered benefits

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

Yes  
 No

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

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

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

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

Yes  
 No

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

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

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

# CY 2021 PBP Data Entry System Screens

## Max Plan Benefit Coverage

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

File Help

Go To: Max Plan Benefit Coverage

Previous Next Exit (Validate) Exit (No Validate)

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

Is there a Maximum Plan Benefit Coverage Amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

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

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

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

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

Yes  
 No

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

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

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

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

Yes  
 No

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

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

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

# CY 2021 PBP Data Entry System Screens

## Max Plan Benefit Coverage (Non-Network)

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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

Is there a Maximum Plan Benefit Coverage Amount?

Yes  
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity

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

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

Yes  
 No

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

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

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

# CY 2021 PBP Data Entry System Screens

## Plan Premium/Rebate Reduction

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

File Help

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

Indicate Plan Premium Amount (Part A/B):

Indicate Plan Premium Amount (B Only):

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

Indicate the Part B Premium reduction amount:

# CY 2021 PBP Data Entry System Screens

## MMP – Medicaid/plan covered cost sharing

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

File Help

Go To: MMP - Medicaid/plan covered cost sharing

Previous Next Exit (Validate) Exit (No Validate)

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

Yes  
 No

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

Select all of the benefits that are covered under Medicaid:

- 1a1: Additional Days for Inpatient Hospital-Acute
- 1a2: Non-Medicare-covered Stay for Inpatient Hospital-Acute
- 1a3: Upgrades for Inpatient Hospital-Acute
- 1b1: Additional Days for Inpatient Hospital Psychiatric
- 1b2: Non-Medicare-covered Stay for Inpatient Hospital Psychiatric
- 2-1: Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)
- 2-2: Non-Medicare-covered Stay for Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c1: Worldwide Emergency Coverage
- 4c2: Worldwide Urgent Coverage
- 4c3: Worldwide Emergency Transportation
- 6-1: Additional Hours of Care
- 6-2: Personal Care Services
- 6-3: Other 1 for Home Health Services
- 6-4: Other 2 for Home Health Services
- 7b1: Routine Chiropractic Care
- 7b2: Other Chiropractic Services
- 7c: Occupational Therapy Services
- 7f: Podiatry Services
- 7i1: Other 1 for PT and SP Services
- 7i2: Other 2 for PT and SP Services
- 9d: Outpatient Blood Services

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

- 1a1: Additional Days for Inpatient Hospital-Acute
- 1a2: Non-Medicare-covered Stay for Inpatient Hospital-Acute
- 1a3: Upgrades for Inpatient Hospital-Acute
- 1b1: Additional Days for Inpatient Hospital Psychiatric
- 1b2: Non-Medicare-covered Stay for Inpatient Hospital Psychiatric
- 2-1: Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)
- 2-2: Non-Medicare-covered Stay for Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4c1: Worldwide Emergency Coverage
- 4c2: Worldwide Urgent Coverage
- 4c3: Worldwide Emergency Transportation
- 6-1: Additional Hours of Care
- 6-2: Personal Care Services
- 6-3: Other 1 for Home Health Services
- 6-4: Other 2 for Home Health Services
- 7b1: Routine Chiropractic Care
- 7b2: Other Chiropractic Services
- 7c: Occupational Therapy Services
- 7f: Podiatry Services
- 7i1: Other 1 for PT and SP Services
- 7i2: Other 2 for PT and SP Services

# CY 2021 PBP Data Entry System Screens

## PFFS Balance Billing

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

File Help

Go To: PFFS Balance Billing

Previous Next Exit (Validate) Exit (No Validate)

Do you permit balance billing?  Yes  No

Balance Billing is a percentage of plan payment rate provider may collect.

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

Enter Minimum percentage for balance billing:

Enter Maximum percentage for balance billing:

What category of providers do you permit to balance bill?

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

# CY 2021 PBP Data Entry System Screens

## MSA Annual Deductible/Deposit

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



# CY 2021 PBP Data Entry System Screens

## Reductions in Cost Sharing #1 – Base 1

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

File Help

◀ Previous
Next ▶
Exit (Validate) ✓
Exit (No Validate) ✗
Go To:

Do you offer Reductions in Cost Sharing?

Yes

No

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

How many groups of Reductions in Cost Sharing are you offering?

1

2

3

Select which Medicare-Covered Services your Reductions in Cost Sharing apply to:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4a: Emergency/Post-Stabilization Services
- 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 Program Services
- 8a1: Diagnostic Procedures/Tests
- 8a2: Lab Services
- 8b1: Diagnostic Radiological Services

Select which Non-Medicare Covered Services you

- 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
- 4c1: Worldwide Emergency Coverage
- 4c2: Worldwide Urgent Coverage
- 4c3: Worldwide Emergency Transportation
- 7b1: Routine Chiropractic Care
- 7b2: Other Chiropractic Services
- 7f: Podiatry Services
- 10b1: Transportation Services - Plan Approved He
- 10b2: Transportation Services - Any Health-relate
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 14b: Annual Physical Exam
- 14c1: Health Education
- 14c2: Nutritional/Dietary Benefit
- 14c3: Additional Sessions of Smoking and Tobacco
- 14c4: Fitness Benefit

Select the benefits that apply to the Reductions in Cost Sharing benefit:

Medicare-covered benefits

Non-Medicare covered benefits

# CY 2021 PBP Data Entry System Screens

## Reductions in Cost Sharing #1 – Base 2

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons. A "Go To:" dropdown menu is set to "Reductions in Cost Sharing #1 - Base 2".

The main content area is titled "Reductions in Cost Sharing 1" and contains the following fields and options:

- Indicate Max Plan Benefit amount:** A text input field.
- Select Reductions in Cost Sharing periodicity:** Radio button options for "Every three months", "Every six months", and "Every year".
- Can the reduction in cost sharing be applied to a deductible?:** Radio button options for "Yes" and "No".
- What is your Reductions in Cost Sharing mode of delivery?:** Check box options for "Debit Card", "Reimbursement", and "Other (describe)".
- Notes:** A large text area for additional information, with a note that it should not repeat data already entered.

# CY 2021 PBP Data Entry System Screens

## Reductions in Cost Sharing #2 – Base 1

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

File Help

Go To: **Reductions in Cost Sharing #2 - Base 1**

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

**Reductions in Cost Sharing 2**

Select the benefits that apply to the Reductions in Cost Sharing benefit:

- Medicare-covered benefits
- Non-Medicare covered benefits

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

Select which Medicare-Covered Services your Reductions in Cost Sharing apply to:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4a: Emergency/Post-Stabilization Services
- 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 Program Services
- 8a1: Diagnostic Procedures/Tests
- 8a2: Lab Services
- 8b1: Diagnostic Radiological Services

Select which Non-Medicare Covered Services your Reductions in Cost Sharing apply to:

- 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
- 4c1: Worldwide Emergency Coverage
- 4c2: Worldwide Urgent Coverage
- 4c3: Worldwide Emergency Transportation
- 7b1: Routine Chiropractic Care
- 7b2: Other Chiropractic Services
- 7f: Podiatry Services
- 10b1: Transportation Services - Plan Approved Health-related Location
- 10b2: Transportation Services - Any Health-related Location
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 14b: Annual Physical Exam
- 14c1: Health Education
- 14c2: Nutritional/Dietary Benefit
- 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling
- 14c4: Fitness Benefit

# CY 2021 PBP Data Entry System Screens

## Reductions in Cost Sharing #2 – Base 2

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

File Help

Go To: Reductions in Cost Sharing #2 - Base 2

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

Reductions in Cost Sharing 2

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

Indicate Max Plan Benefit amount:

Select Reductions in Cost Sharing periodicity:

Every three months  
 Every six months  
 Every year

Can the reduction in cost sharing be applied to a deductible?

Yes  
 No

What is your Reductions in Cost Sharing mode of delivery?

Debit Card  
 Reimbursement  
 Other (describe)

Notes:

# CY 2021 PBP Data Entry System Screens

## Reductions in Cost Sharing #3 – Base 1

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

File Help

Go To: Reductions in Cost Sharing #3 - Base 1

Previous Next Exit (Validate) Exit (No Validate)

Reductions in Cost Sharing 3

Select the benefits that apply to the Reductions in Cost Sharing benefit:

Medicare-covered benefits

Non-Medicare covered benefits

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

Select which Medicare-Covered Services your Reductions in Cost Sharing apply to:

- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 4a: Emergency/Post-Stabilization Services
- 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 Program Services
- 8a1: Diagnostic Procedures/Tests
- 8a2: Lab Services
- 8b1: Diagnostic Radiological Services

Select which Non-Medicare Covered Services your Reductions in Cost Sharing apply to:

- 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
- 4c1: Worldwide Emergency Coverage
- 4c2: Worldwide Urgent Coverage
- 4c3: Worldwide Emergency Transportation
- 7b1: Routine Chiropractic Care
- 7b2: Other Chiropractic Services
- 7f: Podiatry Services
- 10b1: Transportation Services - Plan Approved Health-related Location
- 10b2: Transportation Services - Any Health-related Location
- 13a: Acupuncture
- 13b: Over-the-Counter (OTC) Items
- 13c: Meal Benefit
- 13d: Other 1
- 13e: Other 2
- 13f: Other 3
- 14b: Annual Physical Exam
- 14c1: Health Education
- 14c2: Nutritional/Dietary Benefit
- 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling
- 14c4: Fitness Benefit

# CY 2021 PBP Data Entry System Screens

## Reductions in Cost Sharing #3 – Base 2

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

File Help

Go To:

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

Reductions in Cost Sharing 3

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

Indicate Max Plan Benefit amount:

Select Reductions in Cost Sharing periodicity:

Every three months  
 Every six months  
 Every year

Can the reduction in cost sharing be applied to a deductible?

Yes  
 No

What is your Reductions in Cost Sharing mode of delivery?

Debit Card  
 Reimbursement  
 Other (describe)

Notes:

# CY 2021 PBP Data Entry System Screens

## Combined Benefits #1

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

File Help

Go To: Combined Benefits #1

Previous Next Exit (Validate) Exit (No Validate)

Do you offer Combined Supplemental Benefits with uniform cost sharing?

Yes  
 No

Select the number of Combined Supplemental Benefit packages you are offering?

1  
 2  
 3

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:

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  
4c1: Worldwide Emergency Coverage  
4c2: Worldwide Urgent Coverage  
4c3: Worldwide Emergency Transportation  
7b1: Routine Chiropractic Care  
7b2: Other Chiropractic Services  
7f: Podiatry Services  
10b1: Transportation Services - Plan Approved Health-related Location  
10b2: Transportation Services - Any Health-related Location  
13a: Acupuncture

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes  
 No

Max Plan Benefit Amount:

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?

Yes  
 No

# CY 2021 PBP Data Entry System Screens

## Combined Benefits #2

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

File Help

Go To: Combined Benefits #2

Previous Next Exit (Validate) Exit (No Validate)

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:

- 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
- 4c1: Worldwide Emergency Coverage
- 4c2: Worldwide Urgent Coverage
- 4c3: Worldwide Emergency Transportation
- 7b1: Routine Chiropractic Care
- 7b2: Other Chiropractic Services
- 7f: Podiatry Services
- 10b1: Transportation Services - Plan Approved Health-related Location
- 10b2: Transportation Services - Any Health-related Location
- 13a: Acupuncture

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

No

Max Plan Benefit Amount:

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?

Yes

No



# CY 2021 PBP Data Entry System Screens

## Combined Benefits #3

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

File Help

Go To: Combined Benefits #3

Previous Next Exit (Validate) Exit (No Validate)

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:

- 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
- 4c1: Worldwide Emergency Coverage
- 4c2: Worldwide Urgent Coverage
- 4c3: Worldwide Emergency Transportation
- 7b1: Routine Chiropractic Care
- 7b2: Other Chiropractic Services
- 7f: Podiatry Services
- 10b1: Transportation Services - Plan Approved Health-related Location
- 10b2: Transportation Services - Any Health-related Location
- 13a: Acupuncture

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

No

Max Plan Benefit Amount:

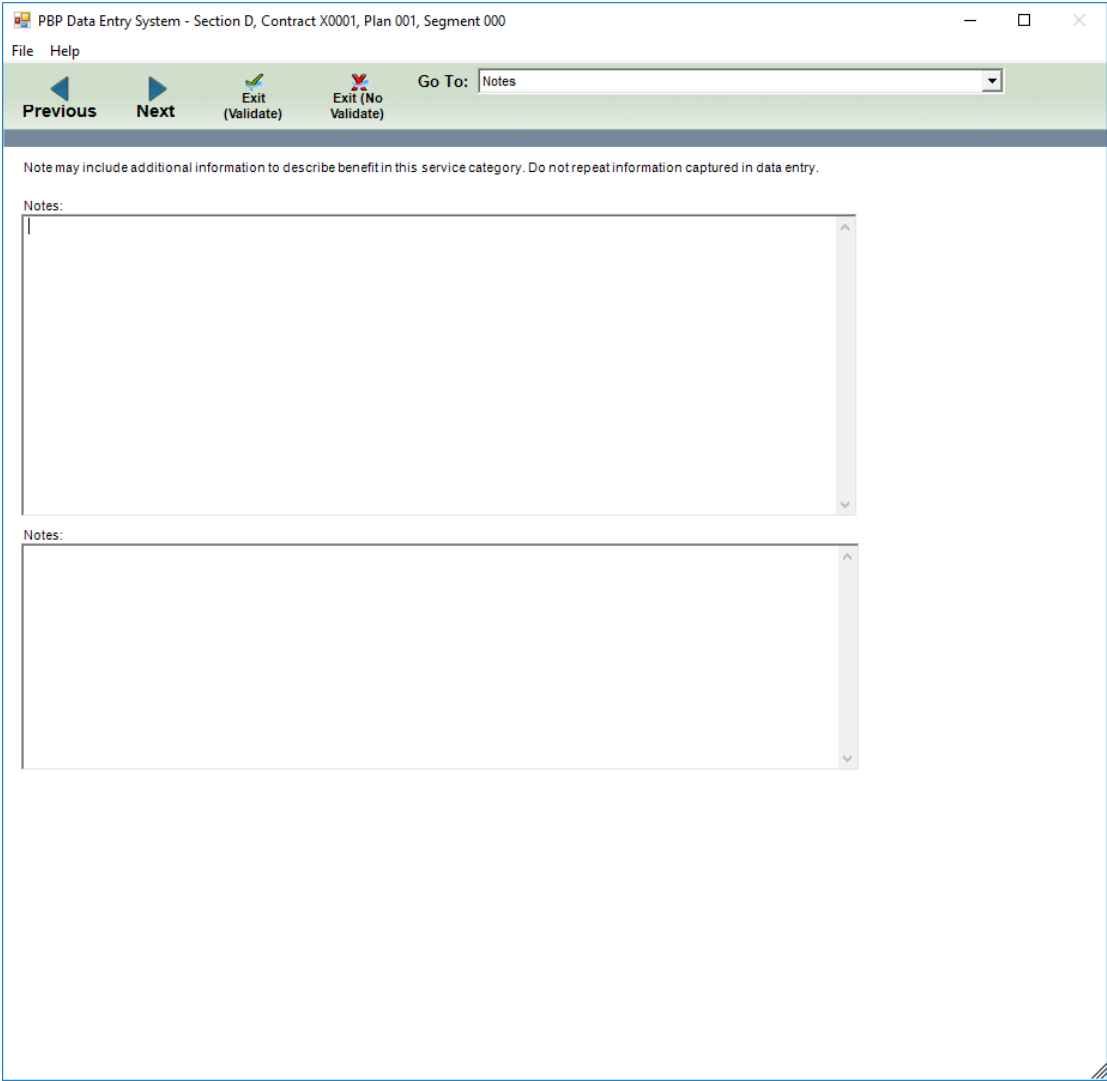
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?

Yes

No

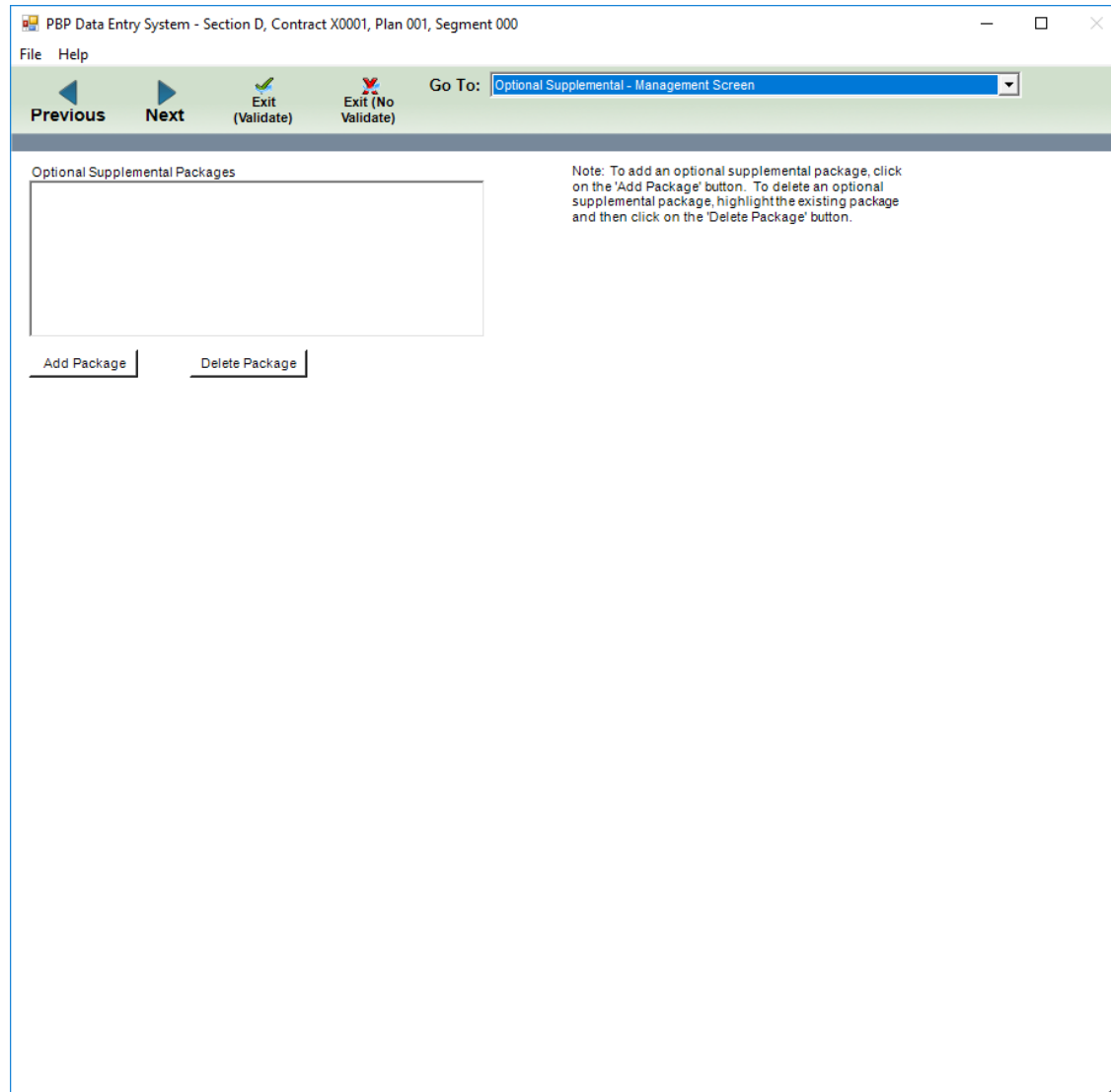
# CY 2021 PBP Data Entry System Screens

## Notes



# CY 2021 PBP Data Entry System Screens

## Optional Supplemental – Management Screen



# CY 2021 PBP Data Entry System Screens

## Optional Supplemental – Label and Premium

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

File Help

Go To: **Optional Supplemental - Label and Premium**

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

Optional Supplemental Benefits ID:

Optional Supplemental Package Description:

Indicate Optional Supplemental Premium Amount:

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

Indicate Maximum Plan Benefit Coverage Amount for this package:

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

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

Is there an enrollee Deductible for this package?  
 Yes  
 No

Indicate Deductible Amount:

Select the benefits to which the deductible applies:

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

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

Notes:

# CY 2021 PBP Data Entry System Screens

## Optional Supplemental – Service Categories

# CY 2021 PBP Data Entry System Screens

## Optional Supplemental – OON Step-up

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

File Help

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

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

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

Is there an OON Copayment?  
 Yes  
 No

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

Enter Minimum Copayment Amount:

Enter Maximum Copayment Amount:

Is there an OON Coinsurance?  
 Yes  
 No

Enter Minimum Coinsurance Percentage:

Enter Maximum Coinsurance Percentage:

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

Notes:

# CY 2021 PBP Data Entry System Screens

## Optional Supplemental – OON Optional

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

The main content area contains the following fields and questions:

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

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

# CY 2021 PBP Data Entry System Screens

## Step-up #10b Transportation Services – Base 1

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

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

Yes  
 No

Select enhanced benefit:

Plan Approved Health-related Location  
 Any Health-related Location

Select type of benefit for Plan Approved Health-related Location:

Mandatory  
 Optional

Is this benefit unlimited for number of trips for Plan Approved Health-related Location?

Yes  
 No

Indicate number of trips for Plan Approved Health-related Location:

Select Plan Approved 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 Plan Approved Health-related Location:

One-way  
 Round Trip  
 Days  
 Other, Describe

Indicate number of days for Plan Approved Health-related Location:

Select Mode of Transportation for Plan Approved Health-related 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 2021 PBP Data Entry System Screens

## Step-up #10b Transportation Services – Base 2

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Indicate Maximum Plan Benefit Coverage amount: <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>
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# CY 2021 PBP Data Entry System Screens

## Step-up #10b Transportation Services – Base 3

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?

Yes  
 No

Indicate Minimum Copayment amount per trip:

Indicate Maximum Copayment amount per trip:

Is authorization required?

Yes  
 No

Is a referral required for Transportation Services?

Yes  
 No

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

Notes:

# CY 2021 PBP Data Entry System Screens

## Step-up #16a Preventive Dental – Base 1

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

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

Yes  
 No

Select enhanced benefits:

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

Select type of benefit for Oral Exams:

Mandatory  
 Optional

Is this benefit unlimited for Oral Exams?

Yes  
 No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

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

Select type of benefit for Prophylaxis (Cleaning):

Mandatory  
 Optional

Is this benefit unlimited for Prophylaxis (Cleaning)?

Yes  
 No, indicate number

Indicate number of visits for Prophylaxis (Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

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

Select type of benefit for Fluoride Treatment:

Mandatory  
 Optional

Is this benefit unlimited for Fluoride Treatment?

Yes  
 No, indicate number

Indicate number of visits for Fluoride Treatment:

Select the Fluoride Treatment periodicity:

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

# CY 2021 PBP Data Entry System Screens

## Step-up #16a Preventive Dental – Base 2

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

Select type of benefit for Dental X-Rays:

Mandatory

Optional

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

Yes

No

Is this benefit unlimited for Dental X-Rays?

Yes

No, indicate number

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

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 2021 PBP Data Entry System Screens

## Step-up #16a Preventive Dental – Base 3

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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 2021 PBP Data Entry System Screens

## Step-up #16a Preventive Dental – Base 4

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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

Is there an enrollee Copayment?  
 Yes  
 No

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

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

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

Indicate 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 2021 PBP Data Entry System Screens

## Step-up #16a Preventive Dental – Base 5

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

File Help

Go To: Step-up #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 2021 PBP Data Entry System Screens

## Step-up #16b Comprehensive Dental – Base 1

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

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

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

Yes  
 No

Select enhanced benefits:

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

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



# CY 2021 PBP Data Entry System Screens

## Step-up #16b Comprehensive Dental – Base 2

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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

# CY 2021 PBP Data Entry System Screens

## Step-up #16b Comprehensive Dental – Base 3

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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

Yes  
 No

Select the Maximum Plan Benefit Coverage 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 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

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

Covered under Preventive Dental Category 16a  
 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 2021 PBP Data Entry System Screens

## Step-up #16b Comprehensive Dental – Base 4

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

File Help

◀ Previous
Next ▶
✔ Exit (Validate)
✘ Exit (No Validate)
Go To:

Is there an enrollee Coinsurance?

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

	Minimum Coinsurance	Maximum Coinsurance
Medicare-covered Benefits	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Non-routine Services	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Diagnostic Services	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Restorative Services	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Endodontics	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Periodontics	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Extractions	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>

Is there an enrollee Deductible?

Yes

No

Indicate Deductible Amount:

# CY 2021 PBP Data Entry System Screens

## Step-up #16b Comprehensive Dental – Base 5

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

File Help

Go To: Step-up #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 2021 PBP Data Entry System Screens

## Step-up #16b Comprehensive Dental – Base 6

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

The main content area contains two radio button questions:

Is authorization required?  
 Yes  
 No

Is a referral required for Comprehensive Dental Services?  
 Yes  
 No

Below these questions is a section for "Comprehensive Dental Services Notes" with a text area for entering notes. The text area is currently empty.

# CY 2021 PBP Data Entry System Screens

## Step-Up #17a Eye Exams – Base 1

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

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

Yes  
 No

Select enhanced benefit:

Routine Eye Exams  
 Other

Select type of benefit for Routine Eye Exams:

Mandatory  
 Optional

Is this benefit unlimited for Routine Eye Exams?

Yes  
 No, indicate number

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

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

Enter name of Other Service:

Select type of benefit for Other Service:

Mandatory  
 Optional

Is this benefit unlimited for Other Service?

Yes  
 No, indicate number

Indicate quantity for Other Service:

Select the Other Service periodicity:

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

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

Yes  
 No

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

In-network services only  
 Both In-network and Out-of-network services

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

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

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

Yes  
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

# CY 2021 PBP Data Entry System Screens

## Step-Up #17a Eye Exams – Base 2

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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 2021 PBP Data Entry System Screens

## Step-Up #17a Eye Exams – Base 3

The screenshot shows a web application window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a navigation bar with "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons. A "Go To:" dropdown menu is set to "Step-up #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 2021 PBP Data Entry System Screens

## Step-up #17b Eyewear – Base 1

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**  
Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.

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

Select enhanced benefits:  
 Contact lenses  
 Eyeglasses (lenses and frames)  
 Eyeglass lenses  
 Eyeglass frames  
 Upgrades

Select type of benefit for Contact lenses:  
 Mandatory  
 Optional

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

Indicate quantity (number of pairs) for Contact lenses:

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

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

Is this benefit unlimited for Eyeglasses (lenses and frames)?  
 Yes  
 No, indicate number

Indicate quantity for Eyeglasses (lenses and frames):

Select Eyeglasses (lenses and frames) periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

# CY 2021 PBP Data Entry System Screens

## Step-up #17b Eyewear – Base 2

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

Select type of benefit for Eyeglass lenses:  
 Mandatory  
 Optional

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

Indicate quantity (number of pairs) for Eyeglass lenses:

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

Select type of benefit for Eyeglass frames:  
 Mandatory  
 Optional

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

Indicate quantity for Eyeglass frames:

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 2021 PBP Data Entry System Screens

## Step-up #17b Eyewear – Base 3

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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

# CY 2021 PBP Data Entry System Screens

## Step-up #17b Eyewear – Base 4

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

File Help

◀ Previous
▶ Next
✔ Exit (Validate)
✘ Exit (No Validate)
Go To: Step-up #17b Eyewear - Base 4

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

# CY 2021 PBP Data Entry System Screens

## Step-up #17b Eyewear – Base 5

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?  
 Yes  
 No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Contact lenses:

Indicate Maximum Copayment amount for Contact lenses:

Indicate Minimum Copayment amount for Eyeglass frames:

Indicate Maximum Copayment amount for Eyeglass frames:

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

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

Indicate Minimum Copayment amount for Upgrades:

Indicate Maximum Copayment amount for Upgrades:

Indicate Minimum Copayment amount for Eyeglass lenses:

Indicate Maximum Copayment amount for Eyeglass lenses:

# CY 2021 PBP Data Entry System Screens

## Step-up #17b Eyewear – Base 6

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: Step-up #17b Eyewear - Base 6

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 2021 PBP Data Entry System Screens

## Step-up #18a Hearing Exams – Base 1

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

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

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

Yes  
 No

Select enhanced benefits:

Routine Hearing Exams  
 Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Exams:

Mandatory  
 Optional

Is this benefit unlimited for Routine Hearing Exams?

Yes  
 No, indicate number

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

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

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

Mandatory  
 Optional

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

Yes  
 No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

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

# CY 2021 PBP Data Entry System Screens

## Step-up #18a Hearing Exams – Base 2

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

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



# CY 2021 PBP Data Entry System Screens

## Step-up #18a Hearing Exams – Base 3

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: Step-up #18a Hearing Exams - Base 3

Is there an enrollee Copayment?

Yes  
 No

Is authorization required?

Yes  
 No

Select which Hearing Exam Benefits have a Copayment (Select all that apply):

Medicare-covered Benefits  
 Routine Hearing Exams  
 Fitting/Evaluation for Hearing Aid

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

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

Indicate Minimum Copayment amount for Routine Hearing Exams:  
[ ]

Indicate Maximum Copayment amount for Routine Hearing Exams:  
[ ]

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

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

Is a referral required for Hearing Exams?

Yes  
 No

# CY 2021 PBP Data Entry System Screens

## Step-up #18a Hearing Exams – Base 4

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The window has a menu bar with "File" and "Help". Below the menu bar is a navigation bar with four buttons: "Previous" (left arrow), "Next" (right arrow), "Exit (Validate)" (checkmark), and "Exit (No Validate)" (X). To the right of these buttons is a "Go To:" dropdown menu currently set to "Step-up #18a Hearing Exams - Base 4".

The main content area is titled "Hearing Exams 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 text input field labeled "Notes:" which is currently empty and has a vertical scrollbar on the right side.

# CY 2021 PBP Data Entry System Screens

## Step-up #18b Hearing Aids -Base 1

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

**CLICK FOR DESCRIPTION OF BENEFIT**

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

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

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

# CY 2021 PBP Data Entry System Screens

## Step-up #18b Hearing Aids -Base 2

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: Step-up #18b Hearing Aids - Base 2

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

Mandatory  
 Optional

Is this benefit unlimited for Hearing Aids - Over the Ear?

Yes  
 No, indicate number

Indicate quantity for Hearing Aids - Over the Ear:

Select Hearing Aids - Over the Ear 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 per ear or for both ears combined?

Per ear  
 One single ear  
 Both ears combined

Select the Maximum Plan Benefit Coverage type:

Covered under Hearing Exams Category - 18a  
 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 Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage periodicity:

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

# CY 2021 PBP Data Entry System Screens

## Step-up #18b Hearing Aids -Base 3

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

File Help

Previous Next Exit (Validate) Exit (No Validate) Go To: Step-up #18b Hearing Aids - Base 3

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 2021 PBP Data Entry System Screens

## Step-up #18b Hearing Aids -Base 4

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment?  
 Yes  
 No

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):

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

Indicate Minimum Copayment amount per Hearing Aid - Inner Ear:

Indicate Maximum Copayment amount per Hearing Aid - Inner Ear:

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

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

Indicate Minimum Copayment amount per Hearing Aid - Outer Ear:

Indicate Maximum Copayment amount per Hearing Aid - Outer Ear:

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

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

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

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

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

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

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

# CY 2021 PBP Data Entry System Screens

## Step-up #18b Hearing Aids -Base 5

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

File Help

Go To: Step-up #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 2021 PBP Data Entry System Screens

## Step-up #7b Chiropractic Services – Base 1

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

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

Yes  
 No

Select enhanced benefit:

Routine Care  
 Other

Select type of benefit for Routine Care:

Mandatory  
 Optional

Is this benefit unlimited for Routine Care?

Yes  
 No, indicate number

Indicate number of visits for Routine Care:

Select Routine Care periodicity:

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

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

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



# CY 2021 PBP Data Entry System Screens

## Step-up #7b Chiropractic Services – Base 2

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>Select which Chiropractic Services have a Coinsurance (Select all that apply):</p> <p><input type="checkbox"/> Medicare-covered Chiropractic Services <input type="checkbox"/> Routine Care <input type="checkbox"/> Other</p> <p>Indicate Minimum Coinsurance percentage per visit for Medicare-covered Benefits:</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>
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# CY 2021 PBP Data Entry System Screens

## Step-up #7b Chiropractic Services – Base 3

The screenshot shows a software window titled "PBP Data Entry System - Section D, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help". Below the menu bar is a navigation toolbar with four buttons: "Previous" (left arrow), "Next" (right arrow), "Exit (Validate)" (green checkmark), and "Exit (No Validate)" (red X). To the right of these buttons is a "Go To:" dropdown menu currently displaying "Step-up #7b Chiropractic Services - Base 3".

The main content area is titled "Chiropractic Services Notes" and contains the following text: "Note may include additional information to describe benefit in this service category. Do not repeat information captured in data entry." Below this text is a large, empty text input field with a vertical scrollbar on the right side, labeled "Notes:".

# CY 2021 PBP Data Entry System Screens

## Step-up #7f Podiatry Services – Base 1

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

File Help

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

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

CLICK FOR DESCRIPTION OF BENEFIT

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

Select enhanced benefits:  
 Routine Foot Care

Select type of benefit for Routine Foot Care:  
 Mandatory  
 Optional

Is this benefit unlimited for Routine Foot Care?  
 Yes  
 No

Indicate number of Routine Foot Care visits:

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

# CY 2021 PBP Data Entry System Screens

## Step-up #7f Podiatry Services – Base 2

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

File Help

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

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Coinsurance?  
 Yes  
 No

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

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Foot Care:

Indicate Maximum Coinsurance percentage for Routine Foot Care:

Is there an enrollee Copayment?  
 Yes  
 No

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

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

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

Indicate Minimum Copayment amount per visit for Routine Foot Care:

Indicate Maximum Copayment amount per visit for Routine Foot Care:

Is there an enrollee Deductible?  
 Yes  
 No

Indicate Deductible Amount:

# CY 2021 PBP Data Entry System Screens

## Step-up #7f Podiatry Services – Base 3

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

File Help

Go To: Step-up #7f Podiatry Services - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is authorization required?

Yes

No

Is a referral required for Podiatrist Services?

Yes

No

Podiatry Services Notes

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

Notes: