#1a Inpatient Hospital-Acute – Base 1

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

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✖ Exit (No Validate)   Go To: #1a Inpatient Hospital-Acute - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

○ Yes
○ No

Select enhanced benefits:
☐ Additional Days
☐ Non-Medicare-covered Stay
☐ Upgrades

Select type of benefit for Additional Days:
○ Mandatory
○ Optional

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

Indicate number of Additional Days per benefit period:

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

Select type of benefit for Upgrades:
○ Mandatory
○ Optional

CY 2023 PBP Data Entry System Screens

#1a Inpatient Hospital-Acute – Base 2

#1a Inpatient Hospital-Acute – Base 3

Medicare-covered Coinsurance Cost Sharing for Tier 2:	Medicare-covered Coinsurance Cost Sharing for Tier 3:
Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)	Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)
○ Yes ○ No	○ Yes ○ No

Indicate Coinsurance percentage for the Medicare-covered stay:	Indicate Coinsurance percentage for the Medicare-covered stay:
Indicate the number of day intervals for the Medicare-covered stay:	Indicate the number of day intervals for the Medicare-covered stay:
○ Zero (No Coinsurance per Day) ○ One ○ Two ○ Three	○ Zero (No Coinsurance per Day) ○ One ○ Two ○ Three
Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):	Indicate the coinsurance percentage and day interval(s) for the Medicare-covered stay (e.g., 1 to 30; 31 to 90):

Coinsurance % Interval 1	Begin Day Interval 1	End Day Interval 1:	Coinsurance % Interval 1	Begin Day Interval 1	End Day Interval 1:
Coinsurance % Interval 2	Begin Day Interval 2	End Day Interval 2:	Coinsurance % Interval 2	Begin Day Interval 2	End Day Interval 2:
Coinsurance % Interval 3	Begin Day Interval 3	End Day Interval 3:	Coinsurance % Interval 3	Begin Day Interval 3	End Day Interval 3:

#1a Inpatient Hospital-Acute – Base 4

#1a Inpatient Hospital-Acute – Base 5

#1a Inpatient Hospital-Acute – Base 6

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

File   Help

◄ Previous   ► Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #1a Inpatient Hospital-Acute - Base 6 ▼

Additional Days Coinsurance Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

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

○ Yes
○ No

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

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

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

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

○ Yes
○ No

Indicate Coinsurance percentage for Upgrades:
[   ]

#1a Inpatient Hospital-Acute – Base 7

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

File   Help

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

◄ **Previous**   ► **Next**   ✓ **Exit (Validate)**   ✗ **Exit (No Validate)**

If you do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D.

MA Organizations are not permitted to tier deductibles.

Is there an enrollee Deductible?

○ Yes
○ No

Indicate Deductible Amount for Tier 1:

Indicate Deductible Amount for Tier 2:

Indicate Deductible Amount for Tier 3:

Is there an enrollee Copayment?

○ Yes
○ No

Medicare-covered Copayment Cost Sharing for Tier 1:

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

○ Yes
○ No

Indicate Copayment amount for the Medicare-covered stay:

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

○ Zero (No Copayment per Day)
○ One
○ Two
○ Three

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

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

#1a Inpatient Hospital-Acute – Base 8

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

File   Help

◀ **Previous**   ▶ **Next**   ✓ Exit (Validate)   ✗ Exit (No Validate)   **Go To:** #1a Inpatient Hospital-Acute - Base 8 ▼

Medicare-covered Copayment Cost Sharing for Tier 2:

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

○ Yes
○ No

Indicate Copayment amount for the Medicare-covered stay:

[   ]

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

○ Zero (No Copayment per Day)
○ One
○ Two
○ Three

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

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

Medicare-covered Copayment Cost Sharing for Tier 3:

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

○ Yes
○ No

Indicate Copayment amount for the Medicare-covered stay:

[   ]

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

○ Zero (No Copayment per Day)
○ One
○ Two
○ Three

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

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

CY 2023 PBP Data Entry System Screens

#1a Inpatient Hospital-Acute – Base 9

12/27/2021
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#1a Inpatient Hospital-Acute – Base 10

CY 2023 PBP Data Entry System Screens

#1a Inpatient Hospital-Acute – Base 11

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #1a Inpatient Hospital-Acute - Base 11

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

- Zero (No Copayment per Day)
- One
- Two
- Three

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

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

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

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

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

- Yes
- No

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

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

- Zero (No Copayment per Day)
- One
- Two
- Three

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

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

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

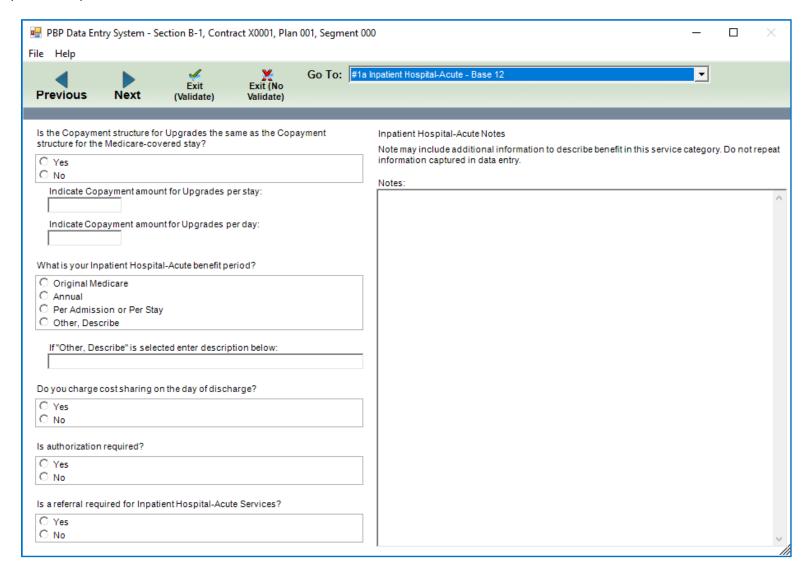Copayment Amt Interval 3   Begin Day Interval 3:   End Day Interval 3:

#1a Inpatient Hospital-Acute – Base 12

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

File   Help

◀ Previous   ▶ Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #1a Inpatient Hospital-Acute - Base 12

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

○ Yes
○ No

Indicate Copayment amount for Upgrades per stay:

Indicate Copayment amount for Upgrades per day:

What is your Inpatient Hospital-Acute benefit period?

○ Original Medicare
○ Annual
○ Per Admission or Per Stay
○ Other, Describe

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

Do you charge cost sharing on the day of discharge?

○ Yes
○ No

Is authorization required?

○ Yes
○ No

Is a referral required for Inpatient Hospital-Acute Services?

○ Yes
○ No

Inpatient Hospital-Acute Notes

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

Notes:

CY 2023 PBP Data Entry System Screens

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

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

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

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: #1a Inpatient Hospital-Acute (B Only) - Base 2 ▼

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

○ Yes
○ No

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

[   ]

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

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

Is there an enrollee Coinsurance?

○ Yes
○ No

Indicate Coinsurance percentage per stay:

[   ]

Indicate the number of day intervals for the stay:

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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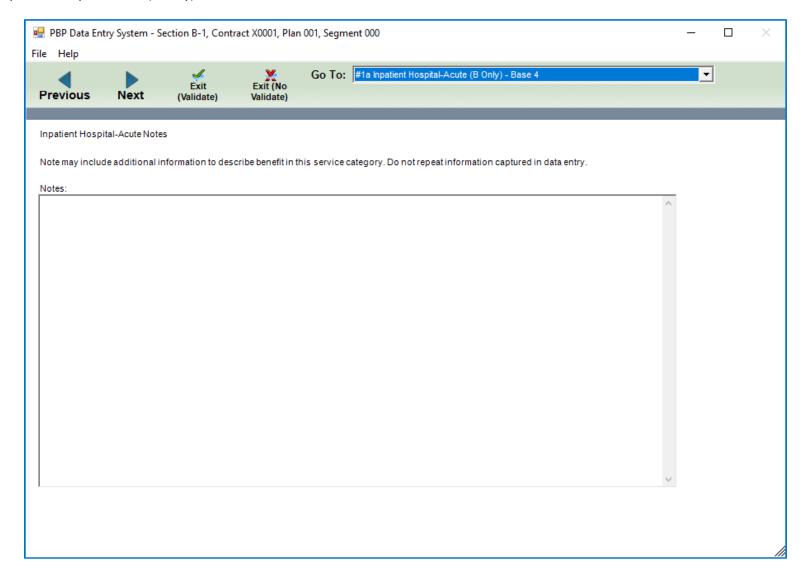[   ]   [   ]   [   ]

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

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

File   Help

Previous   **Next**   Exit (Validate)   Exit (No Validate)   Go To: #1a Inpatient Hospital-Acute (B Only) - Base 3

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:
[   ]

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Indicate Copayment amount per stay:
[   ]

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

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

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

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

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

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

Is authorization required?
- ○ Yes
- ○ No

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

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

#1b Inpatient Hospital Psychiatric – Base 1

#1b Inpatient Hospital Psychiatric – Base 2

CY 2023 PBP Data Entry System Screens

#1b Inpatient Hospital Psychiatric – Base 3

#1b Inpatient Hospital Psychiatric – Base 4

#1b Inpatient Hospital Psychiatric – Base 5

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #1b Inpatient Hospital Psychiatric - Base 5

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

○ Yes
○ No

How many cost sharing tiers do you offer?

What is your lowest cost tier?

○ Tier 1
○ Tier 2
○ Tier 3

Additional Days Coinsurance Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

Additional Days Coinsurance Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

#1b Inpatient Hospital Psychiatric – Base 6

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

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✗ Exit (No Validate)   **Go To:** #1b Inpatient Hospital Psychiatric - Base 6 ▼

Additional Days Coinsurance Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

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

○ Yes
○ No

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

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

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

#1b Inpatient Hospital Psychiatric – Base 7

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

File   Help

◄ **Previous**   ► **Next**   ✔ Exit (Validate)   ✘ Exit (No Validate)   **Go To:** #1b Inpatient Hospital Psychiatric - Base 7 ▼

If you do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D.

MA Organizations are not permitted to tier deductibles.

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount for Tier 1:
[   ]

Indicate Deductible Amount for Tier 2:
[   ]

Indicate Deductible Amount for Tier 3:
[   ]

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Medicare-covered Copayment Cost Sharing for Tier 1:

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

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

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

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

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

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

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

#1b Inpatient Hospital Psychiatric – Base 8

#1b Inpatient Hospital Psychiatric – Base 9

#1b Inpatient Hospital Psychiatric – Base 10

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

File   Help

◀ **Previous**   ▶ **Next**   ✔ **Exit (Validate)**   ✖ **Exit (No Validate)**   **Go To:** #1b Inpatient Hospital Psychiatric - Base 10 ▼

Additional Days Copayment Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:

○ Zero (No Copayment per Day)
○ One
○ Two
○ Three

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

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

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

Copayment Amt Interval 3   Begin Day Interval 3:   End Day Interval 3:
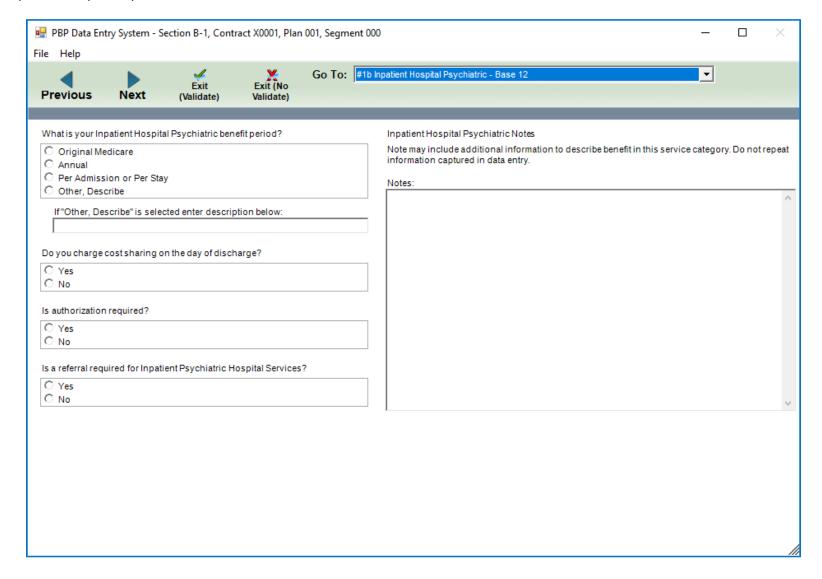
Additional Days Copayment Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:

○ Zero (No Copayment per Day)
○ One
○ Two
○ Three

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

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

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

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

#1b Inpatient Hospital Psychiatric – Base 11

CY 2023 PBP Data Entry System Screens

#1b Inpatient Hospital Psychiatric – Base 12

Softrams   *CY2023 PBP – Section B*   *Page 28 of 261*
12/27/2021
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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

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

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

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

File   Help

◄ **Previous**   ► **Next**   ✓ **Exit (Validate)**   ✗ **Exit (No Validate)**   **Go To:** #1b Inpatient Hospital Psychiatric (B Only) - Base 3 ▼

Is there an enrollee Coinsurance?

○ Yes
○ No

Indicate Coinsurance percentage per stay:

[   ]

Indicate the number of day intervals for the stay:

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

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

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)

Go To: #1b Inpatient Hospital Psychiatric (B Only) - Base 4

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Indicate Copayment amount per stay:

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

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

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

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

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

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

Is authorization required?
- ○ Yes
- ○ No

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

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

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

File   Help

◄ **Previous**   ► **Next**   ✔ **Exit (Validate)**   ✗ **Exit (No Validate)**   **Go To:** #1b Inpatient Hospital Psychiatric (B Only) - Base 5 ▼

Inpatient Hospital Psychiatric Notes

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

Notes:

#2 SNF – Base 1

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

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✗ Exit (No Validate)   Go To: #2 SNF - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?
○ Yes
○ No

Select enhanced benefits:
☐ Additional days beyond Medicare-covered
☐ Non-Medicare-covered stay (MMP Only)

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

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

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

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

Do you allow less than 3 day inpatient hospital stay prior to SNF admission?
○ Yes
○ No

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

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:
[   ]

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

CY 2023 PBP Data Entry System Screens

#2 SNF – Base 2

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?

○ Yes
○ No

How many cost sharing tiers do you offer?

[   ]

What is your lowest cost tier?

○ Tier 1
○ Tier 2
○ Tier 3

Is there an enrollee Coinsurance?

○ Yes
○ No

Medicare-covered Coinsurance Cost Sharing for Tier 1:

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

○ Yes
○ No

Indicate Coinsurance percentage for the Medicare-covered stay:

[   ]

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

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

CY 2023 PBP Data Entry System Screens

#2 SNF – Base 3

File   Help

◀ **Previous**   ▶ **Next**   ✔ Exit (Validate)   ✖ Exit (No Validate)   **Go To:** #2 SNF - Base 3

Medicare-covered Coinsurance Cost Sharing for Tier 2:

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

○ Yes
○ No

Indicate Coinsurance percentage for the Medicare-covered stay:

[   ]

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

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

Medicare-covered Coinsurance Cost Sharing for Tier 3:

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

○ Yes
○ No

Indicate Coinsurance percentage for the Medicare-covered stay:

[   ]

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

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

#2 SNF – Base 4

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

File   Help

◀ **Previous**   ▶ **Next**   ✔ Exit (Validate)   ✘ Exit (No Validate)   **Go To:** #2 SNF - Base 4

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

○ Yes
○ No

How many cost sharing tiers do you offer?

What is your lowest cost tier?

○ Tier 1
○ Tier 2
○ Tier 3

Additional Days Coinsurance Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

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

Additional Days Coinsurance Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:

○ Zero (No Coinsurance per Day)
○ One
○ Two
○ Three

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

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

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

Coinsurance % Interval 3:   Begin Day Interval 3:   End Day Interval 3:
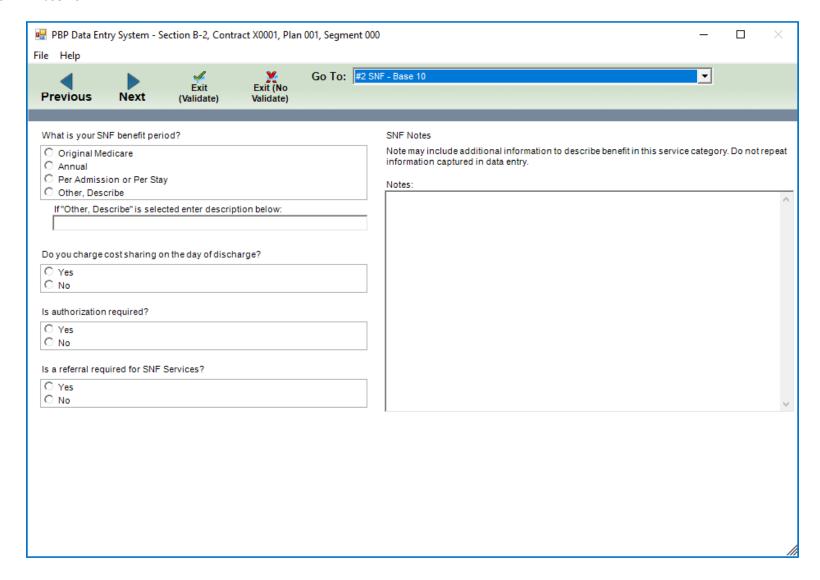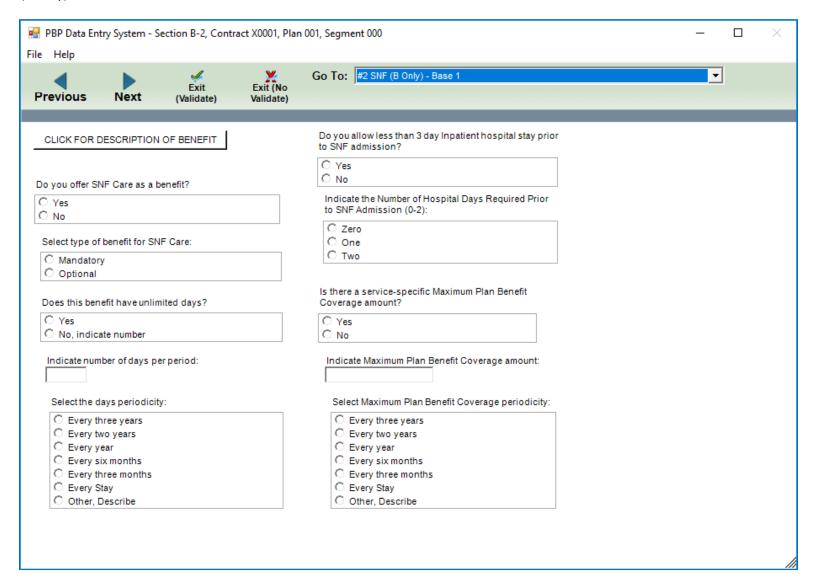
CY 2023 PBP Data Entry System Screens

#2 SNF – Base 5

#2 SNF – Base 6

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

File   Help

◀ **Previous**   ▶ **Next**   ✓ **Exit (Validate)**   ✗ **Exit (No Validate)**   **Go To:** #2 SNF - Base 6

If you do not have a service-specific deductible for this benefit but offer a plan-specific deductible, then enter the plan deductible in Section D.

MA Organizations are not permitted to tier deductibles.

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount Tier 1:
[   ]

Indicate Deductible Amount Tier 2:
[   ]

Indicate Deductible Amount Tier 3:
[   ]

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Medicare-covered Copayment Cost Sharing for Tier 1:

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

Indicate Copayment amount for Medicare-covered stay:
[   ]

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

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

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

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

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

#2 SNF – Base 7

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #2 SNF - Base 7

Medicare-covered Copayment Cost Sharing for Tier 2:

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

Indicate Copayment amount for Medicare-covered stay:

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

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

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

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

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

Medicare-covered Copayment Cost Sharing for Tier 3:

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

Indicate Copayment amount for Medicare-covered stay:

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

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

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

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

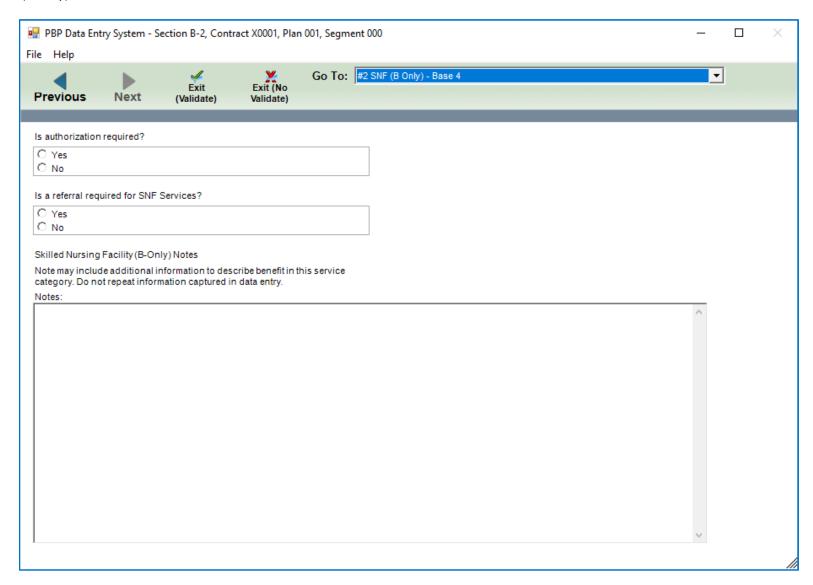Copayment Amt Interval 3:   Begin Day Interval 3:   End Day Interval 3:

CY 2023 PBP Data Entry System Screens

#2 SNF – Base 8

File   Help

◀ **Previous**   ▶ **Next**   ✔ **Exit (Validate)**   ✘ **Exit (No Validate)**   **Go To:** #2 SNF - Base 8 ▾

Additional Days Copayment Cost Sharing for Tier 1:

Indicate the number of day intervals for Additional Days:

- ○ Zero (No Copayment per Day)
- ○ One
- ○ Two
- ○ Three

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

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

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

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

Additional Days Copayment Cost Sharing for Tier 2:

Indicate the number of day intervals for Additional Days:

- ○ Zero (No Copayment per Day)
- ○ One
- ○ Two
- ○ Three

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

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

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

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

#2 SNF – Base 9

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

File   Help

◄ **Previous**   ► **Next**   ✔ Exit (Validate)   ✖ Exit (No Validate)   **Go To:** #2 SNF - Base 9 ▼

Additional Days Copayment Cost Sharing for Tier 3:

Indicate the number of day intervals for Additional Days:

○ Zero (No Copayment per Day)
○ One
○ Two
○ Three

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

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

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

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

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

○ Yes
○ No

Indicate Copayment amount for Non-Medicare-covered stay:

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

○ Zero (No Copayment per Day)
○ One
○ Two
○ Three

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

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

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

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

CY 2023 PBP Data Entry System Screens

#2 SNF – Base 10

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

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✗ Exit (No Validate)   Go To: #2 SNF - Base 10

What is your SNF benefit period?

- ○ Original Medicare
- ○ Annual
- ○ Per Admission or Per Stay
- ○ Other, Describe

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

Do you charge cost sharing on the day of discharge?

- ○ Yes
- ○ No

Is authorization required?

- ○ Yes
- ○ No

Is a referral required for SNF Services?

- ○ Yes
- ○ No

SNF Notes

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

Notes:

#2 SNF (B Only) – Base 1

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

File   Help

◀ **Previous**   ▶ **Next**   ✓ **Exit (Validate)**   ✗ **Exit (No Validate)**   **Go To:** #2 SNF (B Only) - Base 1 ▾

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer SNF Care as a benefit?
- ○ Yes
- ○ No

Select type of benefit for SNF Care:
- ○ Mandatory
- ○ Optional

Does this benefit have unlimited days?
- ○ Yes
- ○ No, indicate number

Indicate number of days per period:
[ ]

Select the days periodicity:
- ○ Every three years
- ○ Every two years
- ○ Every year
- ○ Every six months
- ○ Every three months
- ○ Every Stay
- ○ Other, Describe

Do you allow less than 3 day Inpatient hospital stay prior to SNF admission?
- ○ Yes
- ○ No

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

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

Indicate Maximum Plan Benefit Coverage amount:
[ ]

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

CY 2023 PBP Data Entry System Screens

#2 SNF (B Only) – Base 2

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

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✖ Exit (No Validate)   Go To: #2 SNF (B Only) - Base 2

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

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

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

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Indicate Coinsurance percentage:

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

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

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

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

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

#2 SNF (B Only) – Base 3

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

File   Help

◀ **Previous**   ▶ **Next**   ✔ **Exit (Validate)**   ✖ **Exit (No Validate)**   **Go To:** #2 SNF (B Only) - Base 3 ▾

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:
[ ]

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Indicate Copayment amount per Stay:
[ ]

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

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

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

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

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

#2 SNF (B Only) – Base 4

#3 Cardiac and Pulmonary Rehabilitation Services – Base 1

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#3 Cardiac and Pulmonary Rehabilitation Services – Base 2

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

File   Help

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

Previous   Next   Exit (Validate)   Exit (No Validate)

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

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

○ Yes
○ No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

[   ]

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

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

Is there an enrollee Coinsurance?

○ Yes
○ No

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

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

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

	Minimum Coinsurance	Maximum Coinsurance
Indicate Coinsurance percentage for Medicare-covered Cardiac Rehabilitation Services:	[ ]	[ ]
Indicate Coinsurance percentage for Medicare-covered Intensive Cardiac Rehabilitation Services:	[ ]	[ ]
Indicate Coinsurance percentage for Medicare-covered Pulmonary Rehabilitation Services:	[ ]	[ ]
Indicate Coinsurance percentage for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	[ ]	[ ]
Indicate Coinsurance percentage for Additional Cardiac Rehabilitation Services:	[ ]	[ ]
Indicate Coinsurance percentage for Additional Intensive Cardiac Rehabilitation Services:	[ ]	[ ]
Indicate Coinsurance percentage for Additional Pulmonary Rehabilitation Services:	[ ]	[ ]
Indicate Coinsurance percentage for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	[ ]	[ ]

#3 Cardiac and Pulmonary Rehabilitation Services – Base 3

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #3 Cardiac and Pulmonary Rehabilitation Services - Base 3

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Select which Cardiac and Pulmonary Rehabilitation Services have a Copayment (Select all that apply):
- ☐ Medicare-covered Cardiac Rehabilitation Services
- ☐ Medicare-covered Intensive Cardiac Rehabilitation Services
- ☐ Medicare-covered Pulmonary Rehabilitation Services
- ☐ Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services
- ☐ Additional Cardiac Rehabilitation Services
- ☐ Additional Intensive Cardiac Rehabilitation Services
- ☐ Additional Pulmonary Rehabilitation Services
- ☐ Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services

	Minimum Copayment	Maximum Copayment
Indicate Copayment amount for Medicare-covered Cardiac Rehabilitation Services:		
Indicate Copayment amount for Medicare-covered Intensive Cardiac Rehabilitation Services:		
Indicate Copayment amount for Medicare-covered Pulmonary Rehabilitation Services:		
Indicate Copayment amount for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:		
Indicate Copayment amount for Additional Cardiac Rehabilitation Services:		
Indicate Copayment amount for Additional Intensive Cardiac Rehabilitation Services:		
Indicate Copayment amount for Additional Pulmonary Rehabilitation Services:		
Indicate Copayment amount for Additional Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:		

#3 Cardiac and Pulmonary Rehabilitation Services – Base 4

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#4a Emergency Services – Base 1

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

#4b Urgently Needed Services – Base 1

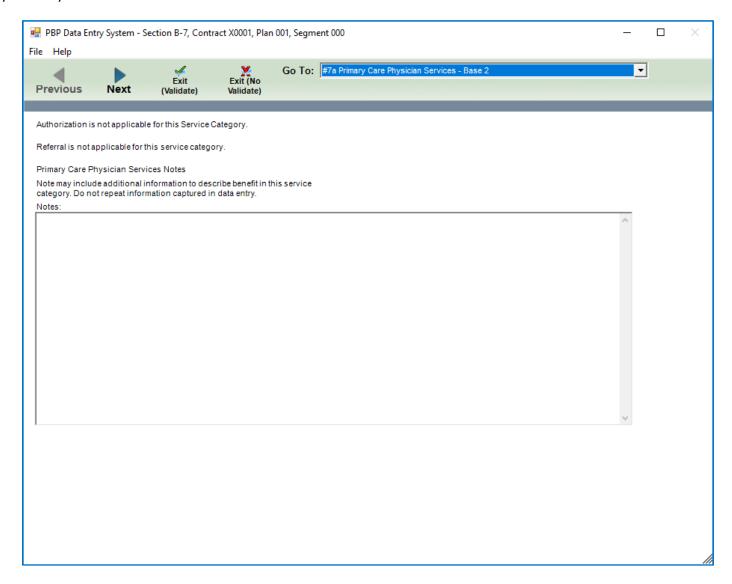4b Urgently Needed Services – Base 2

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

File   Help

◀ Previous   ▶ Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #4b Urgently Needed Services - Base 2 ▾

Is there an enrollee Copayment?
○ Yes
○ No

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

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

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

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

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

Enter number of Days or Hours:
[   ]

#4b Urgently Needed Services – Base 3

#4c Worldwide Emergency/Urgent Coverage – Base 1

CY 2023 PBP Data Entry System Screens

#4c Worldwide Emergency/Urgent Coverage – Base 2

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#4c Worldwide Emergency/Urgent Coverage – Base 3

#5 Partial Hospitalization – Base 1

CY 2023 PBP Data Entry System Screens

#5 Partial Hospitalization – Base 2

#6 Home Health Services – Base 1

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #6 Home Health Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

#6 Home Health Services – Base 2

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

File   Help

◄ Previous   ► Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #6 Home Health Services - Base 2

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
○ Yes
○ No

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

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

#6 Home Health Services – Base 3

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

File   Help

◀ **Previous**   ▶ **Next**   ✓ Exit (Validate)   ✗ Exit (No Validate)   **Go To:** #6 Home Health Services - Base 3

Is authorization required?

○ Yes
○ No

Is a referral required for Home Health Services?

○ Yes
○ No

Home Health Services Notes

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

Notes:

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#6 Home Health Services – MMP – Base 1

#6 Home Health Services – MMP – Base 2

#6 Home Health Services – MMP – Base 3

12/27/2021
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#7a Primary Care Physician Services – Base 1

#7a Primary Care Physician Services – Base 2

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #7a Primary Care Physician Services - Base 2

Authorization is not applicable for this Service Category.

Referral is not applicable for this service category.

Primary Care Physician Services Notes

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

Notes:

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

CY 2023 PBP Data Entry System Screens

#7b Chiropractic Services – Base 1

#7b Chiropractic Services – Base 2

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

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: #7b Chiropractic Services - Base 2

Is there an enrollee Coinsurance?
○ Yes
○ No

Select which Chiropractic Services have a Coinsurance (Select all that apply):
☐ Medicare-covered Chiropractic Services
☐ Routine Care
☐ Other

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

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

Indicate the Minimum Coinsurance percentage per visit for Routine Care:

Indicate the Maximum Coinsurance percentage per visit for Routine Care:

Indicate the Minimum Coinsurance percentage per visit for Other Service:

Indicate the Maximum Coinsurance percentage per visit for Other Service:

Is there an enrollee Copayment?
○ Yes
○ No

Select which Chiropractic Services have a Copayment (Select all that apply):
☐ Medicare-covered Chiropractic Services
☐ Routine Care
☐ Other

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount per visit for Routine Care:

Indicate Maximum Copayment amount per visit for Routine Care:

Indicate Minimum Copayment amount per visit for Other Service:

Indicate Maximum Copayment amount per visit for Other Service:

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount:

Is authorization required?
○ Yes
○ No

Is a referral required for Chiropractic Services?
○ Yes
○ No

#7b Chiropractic Services – Base 3
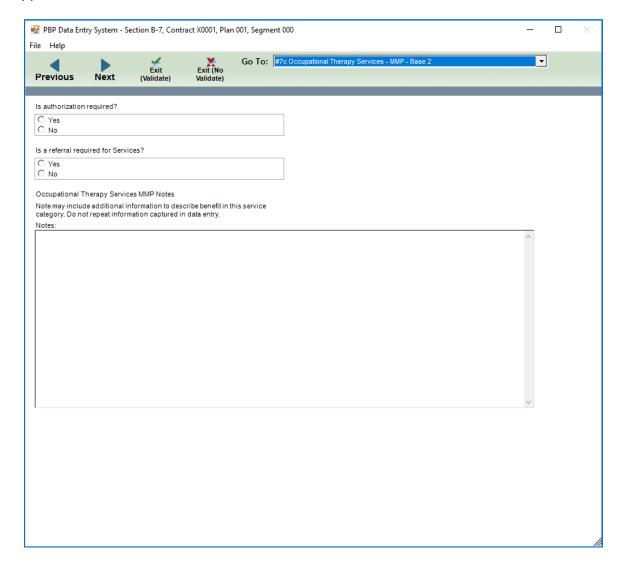
#7c Occupational Therapy Services – Base 1

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #7c Occupational Therapy Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

Is there an enrollee Coinsurance?
○ Yes
○ No

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

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

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
○ Yes
○ No

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

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

#7c Occupational Therapy Services – Base 2

#7c Occupational Therapy Services – MMP – Base 1

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#7c Occupational Therapy Services – MMP – Base 2

#7d Physician Specialist Services – Base 1

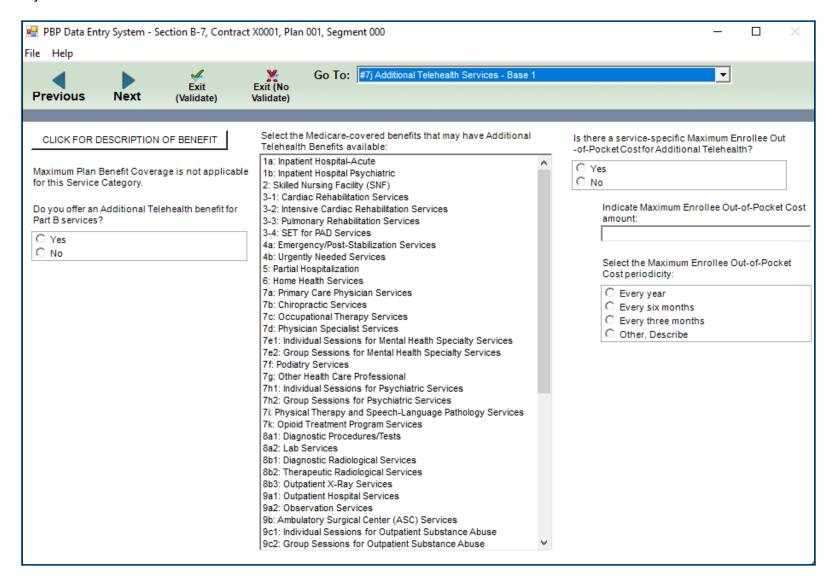PBP Data Entry System - Section B-7, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #7d Physician Specialist Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?
- ☐ Yes
- ☐ No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?
- ☐ Yes
- ☐ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- ☐ Yes
- ☐ No

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

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

#7d Physician Specialist Services – Base 2

#7e Mental Health Specialty Services – Base 1

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

File   Help

◀ **Previous**   ▶ **Next**   ✓ Exit (Validate)   ✗ Exit (No Validate)   **Go To:** #7e Mental Health Specialty Services - Base 1 ▼

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

○ Yes
○ No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

[   ]

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

#7e Mental Health Specialty Services – Base 2

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

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   **Go To:** #7e Mental Health Specialty Services - Base 2 ▼

Is there an enrollee Coinsurance?

- ○ Yes
- ○ No

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

Indicate Minimum Coinsurance percentage for Medicare-covered Individual Sessions:
[ ]

Indicate Maximum Coinsurance percentage for Medicare-covered Individual Sessions:
[ ]

Indicate Minimum Coinsurance percentage for Medicare-covered Group Sessions:
[ ]

Indicate Maximum Coinsurance percentage for Medicare-covered Group Sessions:
[ ]

Is there an enrollee Deductible?

- ○ Yes
- ○ No

Indicate Deductible Amount:
[ ]

Is there an enrollee Copayment?

- ○ Yes
- ○ No

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

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:
[ ]

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:
[ ]

Indicate Minimum Copayment amount for Medicare-covered Group Sessions:
[ ]

Indicate Maximum Copayment amount for Medicare-covered Group Sessions:
[ ]

#7e Mental Health Specialty Services – Base 3

#7f Podiatry Services – Base 1

#7f Podiatry Services – Base 2

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#7f Podiatry Services – Base 3

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #7f Podiatry Services - Base 3

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:

#7g Other Health Care Professional – Base 1

#7g Other Health Care Professional – Base 2

#7h Psychiatric Services – Base 1

#7h Psychiatric Services – Base 2

#7h Psychiatric Services – Base 3

#7i PT and SP Services – Base 1

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #7i PT and SP Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

Is there an enrollee Coinsurance?
- Yes
- No

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

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

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- Yes
- No

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

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

#7i PT and SP Services – Base 2

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #7i PT and SP Services - Base 2

Is authorization required?

- Yes
- No

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

- Yes
- No

PT and SP Services Notes

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

Notes:

#7i PT and ST – MMP – Base 1

#7i PT and ST – MMP – Base 2

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

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✖ Exit (No Validate)   Go To: #7i PT and ST - MMP - Base 2

Is there an enrollee Copayment?

○ Yes
○ No

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

☐ Other 1
☐ Other 2

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

	Minimum Copayment	Maximum Copayment
Other 1:		
Other 2:		

Is authorization required?

○ Yes
○ No

Is a referral required for Services?

○ Yes
○ No

PT and SP Services MMP Notes

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

Notes:

CY 2023 PBP Data Entry System Screens

#7j Additional Telehealth Services – Base 1

Softrams **CY2023 PBP – Section B** *Page 94 of 261*
12/27/2021
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#7j Additional Telehealth Services – Base 2

#7j Additional Telehealth Services – Base 3

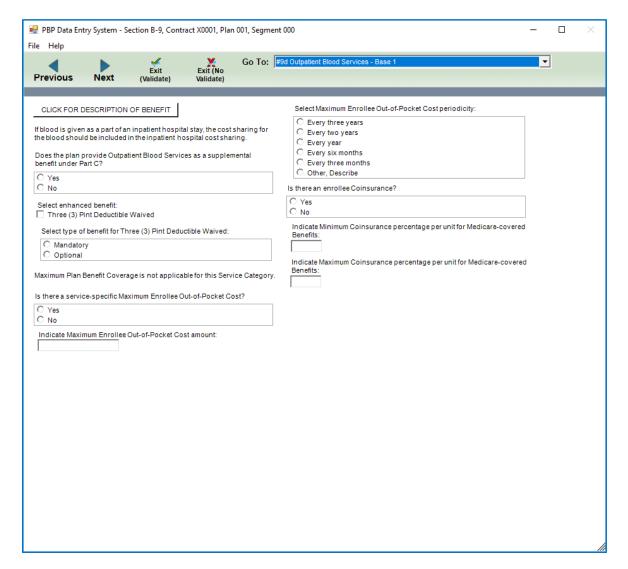#7k Opioid Treatment Program Services – Base 1

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

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✖ Exit (No Validate)   Go To: #7k Opioid Treatment Program Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:
[   ]

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

Is there an enrollee Coinsurance?
● Yes
○ No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:
[   ]

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:
[   ]

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount:
[   ]

Is there an enrollee Copayment?
○ Yes
○ No

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

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

#7k Opioid Treatment Program Services – Base 2

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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

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

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

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 2 ▾

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

Is there an enrollee Coinsurance?

☐ Yes
☐ No

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

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

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

[   ]

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

[   ]

Indicate Minimum Coinsurance percentage for Medicare-covered Lab Services:

[   ]

Indicate Maximum Coinsurance percentage for Medicare-covered Lab Services:

[   ]

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

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

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 3

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Select which Outpatient Diag Procs/Tests/Lab Services have a Copayment (Select all that apply):
- ☐ Medicare-covered Diagnostic Procedures/Tests
- ☐ Medicare-covered Lab Services

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

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

Indicate Minimum Copayment amount for Medicare-covered Lab Services:

Indicate Maximum Copayment amount for Medicare-covered Lab Services:

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

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

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

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

File   Help

◄ Previous   ► Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:
[   ]

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

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

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

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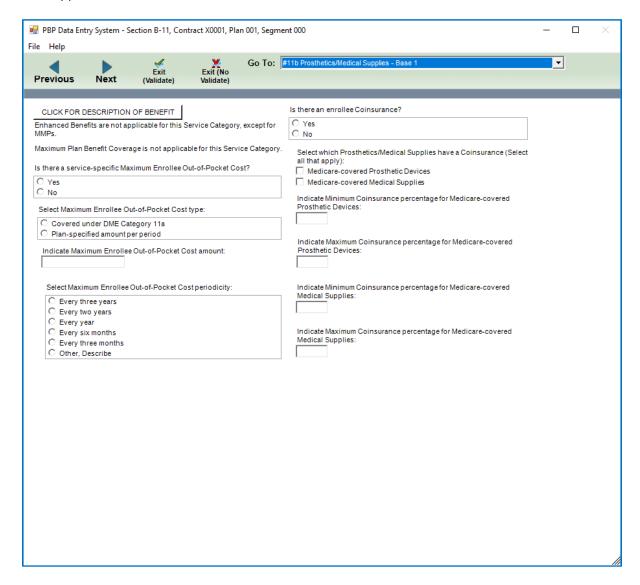- ☐ Medicare-covered Therapeutic Radiological Services
- ☐ Medicare-covered X-Ray Services

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

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

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

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

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

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

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

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

File   Help

◀ **Previous**   ▶ **Next**   ✔ **Exit (Validate)**   ✘ **Exit (No Validate)**   **Go To:** #8b Outpatient Diag/Therapeutic Rad Services - Base 2 ▾

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:
[   ]

Is there an enrollee Copayment?
- ○ Yes
- ○ No

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

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

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

Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:
[   ]

Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:
[   ]

Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:
[   ]

Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:
[   ]

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

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 3

Is authorization required?

○ Yes
○ No

Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?

○ Yes
○ No

Outpatient Diag/Therapeutic Rad Services Notes

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

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

Therapeutic Radiological Services Notes:

X-Ray Services Notes:

#9a Outpatient Hospital Services – Base 1

#9a Outpatient Hospital Services – Base 2

#9a Outpatient Hospital Services – Base 3
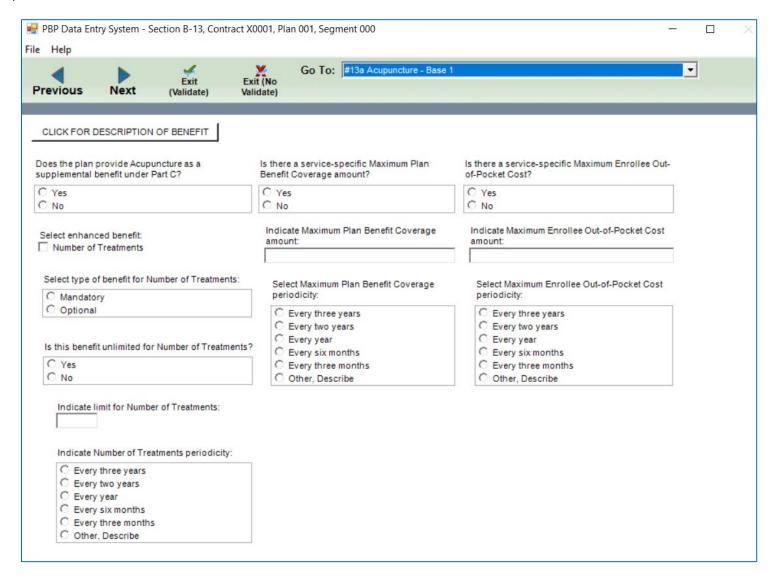
#9b ASC Services – Base 1

#9b ASC Services – Base 2

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

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✖ Exit (No Validate)   Go To: #9b ASC Services - Base 2 ▼

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount:
[   ]

Is there an enrollee Copayment?
○ Yes
○ No

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

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

Is authorization required?
○ Yes
○ No

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

#9b ASC Services – Base 3

#9c Outpatient Substance Abuse – Base 1

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

File   Help

◀ **Previous**   ▶ **Next**   ✅ Exit (Validate)   ❌ Exit (No Validate)   Go To: #9c Outpatient Substance Abuse - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Select the Maximum Enrollee Out-of-Pocket Cost type:
- ○ Covered under Outpatient Hospital Services Category 9a
- ○ Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

#9c Outpatient Substance Abuse – Base 2

#9c Outpatient Substance Abuse – Base 3

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

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✖ Exit (No Validate)   **Go To:** #9c Outpatient Substance Abuse - Base 3

Is authorization required?
- ○ Yes
- ○ No

Is a referral required for Outpatient Substance Abuse?
- ○ Yes
- ○ No

Outpatient Substance Abuse Notes

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

Notes:

#9d Outpatient Blood Services – Base 1

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #9d Outpatient Blood Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?
- Yes
- No

Select enhanced benefit:
- Three (3) Pint Deductible Waived

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

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?
- Yes
- No

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

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

#9d Outpatient Blood Services – Base 2

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #9d Outpatient Blood Services - Base 2

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- ○ Yes
- ○ No

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

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

Is authorization required?
- ○ Yes
- ○ No

Is a referral required for Outpatient Blood Services?
- ○ Yes
- ○ No

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

Notes:

#10a Ambulance Services – Base 1

#10a Ambulance Services – Base 2

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

File Help

◀ Previous   ▶ Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #10a Ambulance Services - Base 2 ▼

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Select which Services have a Deductible (Select all that apply):
- ☐ Medicare-covered Ground Ambulance Services
- ☐ Medicare-covered Air Ambulance Services

Indicate Deductible Amount for Medicare-covered Ground Ambulance Services:
[_____]

Indicate Deductible Amount for Medicare-covered Air Ambulance Services:
[_____]

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Select which Services have a Copayment (Select all that apply):
- ☐ Medicare-covered Ground Ambulance Services
- ☐ Medicare-covered Air Ambulance Services

Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:
[_____]

Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:
[_____]

Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:
[_____]

Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:
[_____]

Is this Copayment waived if admitted to hospital?
- ○ Yes
- ○ No

#10a Ambulance Services – Base 3

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

File   Help

◀ **Previous**   ▶ **Next**   ✔ **Exit (Validate)**   ✗ **Exit (No Validate)**   **Go To:** #10a Ambulance Services - Base 3

Is authorization required for non-emergency Medicare services?

○ Yes
○ No

Referral is not applicable for this Service Category.

Ambulance Services Notes

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

Notes:

#10b Transportation Services – Base 1

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

File   Help

◄ Previous   ► Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #10b Transportation Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Transportation Services as a supplemental benefit under Part C?
- ○ Yes
- ○ No

Select enhanced benefit:
- ○ Plan-approved Location
- ○ Any Health-related Location

Select type of benefit for Plan-approved Location:
- ○ Mandatory
- ○ Optional

Is this benefit unlimited for number of trips for Plan-approved Location?
- ○ Yes
- ○ No

Indicate number of trips for Plan-approved Location:
[   ]

Select Plan-approved Location Trips periodicity:
- ○ Every three years
- ○ Every two years
- ○ Every year
- ○ Every six months
- ○ Every three months
- ○ Other, Describe

Select Type of Transportation for Plan-approved Location:
- ○ One-way
- ○ Round Trip
- ○ Days
- ○ Other, Describe

Indicate number of days for Plan-approved Location:
[   ]

Select Mode of Transportation for Plan-approved Location:
- ☐ Taxi
- ☐ Rideshare Services
- ☐ Bus/Subway
- ☐ Van
- ☐ Medical Transport
- ☐ Other, Describe

Select type of benefit for Any Health-related Location:
- ○ Mandatory
- ○ Optional

Is this benefit unlimited for number of trips for Any Health-related Location?
- ○ Yes
- ○ No

Indicate number of trips for Any Health-related Location:
[   ]

Select Any Health-related Location Trips periodicity:
- ○ Every three years
- ○ Every two years
- ○ Every year
- ○ Every six months
- ○ Every three months
- ○ Other, Describe

Select Type of Transportation for Any Health-related Location:
- ○ One-way
- ○ Round Trip
- ○ Days
- ○ Other, Describe

Indicate number of days for Any Health-related Location:
[   ]

Select Mode of Transportation for Any Health-related Location:
- ☐ Taxi
- ☐ Rideshare Services
- ☐ Bus/Subway
- ☐ Van
- ☐ Medical Transport
- ☐ Other, Describe

#10b Transportation Services – Base 2

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

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #10b Transportation Services - Base 2

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Indicate Minimum Coinsurance percentage:

Indicate Maximum Coinsurance percentage:

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:

#10b Transportation Services – Base 3

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:

#11a DME – Base 1

#11a DME – Base 2

#11a DME – MMP – Base 1

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File   Help

Previous **Next** **Exit (Validate)** **Exit (No Validate)** Go To: #11a DME - MMP - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does this plan provide Non-Medicare-covered Durable Medical Equipment?
- ○ Yes
- ○ No

Select Non-Medicare-covered Durable Medical Equipment:
- ☐ Durable Medical Equipment for use outside the home
- ☐ Other 1
- ☐ Other 2

Enter name of Other 1 Service:

Enter name of Other 2 Service:

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

Indicate Maximum Plan Benefit Coverage amount:

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

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Select which Non-Medicare-covered Durable Medical Equipment(s) (select all that apply):
- ☐ Durable Medical Equipment for use outside the home
- ☐ Other 1
- ☐ Other 2

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

	Minimum Coinsurance	Maximum Coinsurance
Durable Medical Equipment for use outside the home:		
Other 1:		
Other 2:		

#11a DME – MMP – Base 2

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PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000        —   □   ✕

File   Help

  ◄          ►          ✓           ✗         Go To:  #11a DME - MMP - Base 2              ▼
Previous    Next       Exit        Exit (No
                     (Validate)    Validate)


Is there an enrollee Copayment?                        Is authorization required?
┌────────────────────────────────────────────┐       ┌────────────────────────────────────────────┐
│ ○ Yes                                        │       │ ○ Yes                                        │
│ ○ No                                         │       │ ○ No                                         │
└────────────────────────────────────────────┘       └────────────────────────────────────────────┘
 Select which Non-Medicare-covered Durable Medical Equipment(s) have a    Is a referral required for Services?
 Copayment (select all that apply):                   ┌────────────────────────────────────────────┐
  □ Durable Medical Equipment for use outside the home │ ○ Yes                                        │
  □ Other 1                                            │ ○ No                                         │
  □ Other 2                                            └────────────────────────────────────────────┘

 Indicate copayment                                    Durable Medical Equipment MMP Notes
 amount for one or      Minimum     Maximum            Note may include additional information to describe benefit in this service
 more of the following  Copayment   Copayment          category. Do not repeat information captured in data entry.
 services:
                                                       Notes:
 Durable Medical                                       ┌────────────────────────────────────────────┐
 Equipment for use      ┌────────┐  ┌────────┐         │                                          ▲   │
 outside the home:      └────────┘  └────────┘         │                                              │
 Other 1:               ┌────────┐  ┌────────┐         │                                              │
                        └────────┘  └────────┘         │                                              │
 Other 2:               ┌────────┐  ┌────────┐         │                                              │
                        └────────┘  └────────┘         │                                              │
                                                       │                                          ▼   │
                                                       └────────────────────────────────────────────┘
```

#11b Prosthetics/Medical Supplies – Base 1

#11b Prosthetics/Medical Supplies – Base 2

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #11b Prosthetics/Medical Supplies - Base 2

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
○ Yes
○ No

Select which Prosthetics/Medical Supplies have a Copayment (Select all that apply):
☐ Medicare-covered Prosthetic Devices
☐ Medicare-covered Medical Supplies

Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:

Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:

Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:

Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:

#11b Prosthetics/Medical Supplies – Base 3

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: #11b Prosthetics/Medical Supplies - Base 3

Is authorization required?

○ Yes
○ No

Referral is not applicable for this Service Category.

Prosthetics/Medical Supplies Notes

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

Notes:

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#11b Prosthetics/Medical Supplies – MMP – Base 1

#11c Diabetic Supplies and Services – Base 1

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: #11c Diabetic Supplies and Services - Base 1 ▾

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Select Maximum Enrollee Out-of-Pocket Cost type:
- ○ Covered under DME Category 11a
- ○ Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:
[   ]

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

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Select which Diabetic Supplies and Services have a Coinsurance (Select all that apply):
- ☐ Medicare-covered Diabetic Supplies
- ☐ Medicare-covered Diabetic Therapeutic Shoes or Inserts

Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Supplies:
[   ]

Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Supplies:
[   ]

Indicate Minimum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:
[   ]

Indicate Maximum Coinsurance percentage for Medicare-covered Diabetic Therapeutic Shoes or Inserts:
[   ]

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:
[   ]

#11c Diabetic Supplies and Services – Base 2

PBP Data Entry System - Section B-11, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #11c Diabetic Supplies and Services - Base 2

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Select which Diabetic Supplies and Services have a Copayment (Select all that apply):
- ☐ Medicare-covered Diabetes Supplies
- ☐ Medicare-covered Diabetic Therapeutic Shoes or Inserts

Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:

Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:

Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

Do you limit Diabetic Supplies and Services to those from specified manufacturers?
- ○ Yes
- ○ No

Is authorization required?
- ○ Yes
- ○ No

Referral is not applicable for this Service Category.

Diabetic Supplies and Services Notes

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

Notes:

#12 Dialysis Services – Base 1

PBP Data Entry System - Section B-12, Contract X0001, Plan 001, Segment 000

File   Help

◀ Previous   ▶ Next   Exit (Validate)   Exit (No Validate)   Go To: #12 Dialysis Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:
[   ]

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

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

Is there an enrollee Coinsurance?
○ Yes
○ No

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:
[   ]

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:
[   ]

Is there an enrollee Deductible?
○ Yes
○ No

Indicate Deductible Amount:
[   ]

Is there an enrollee Copayment?
○ Yes
○ No

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

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

Reminder: Dialysis received from an Out-of-Network provider will be covered at the In-Network cost.

#12 Dialysis Services – Base 2

#13a Acupuncture – Base 1

#13a Acupuncture – Base 2

#13a Acupuncture – Base 3

#13b OTC Items – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✖ Exit (No Validate)   Go To: #13b OTC Items - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Medicare-Medicaid plans may not use this section to provide benefit information about any OTC items that are submitted under the integrated formulary. Information about those benefits will be entered in the Rx section of the PBP. This section should only be used to provide benefit information about OTC items that are covered as a supplemental benefit.

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?
○ Yes
○ No

Select type of benefit for OTC Items:
○ Mandatory
○ Optional

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

Indicate Maximum Plan Benefit Coverage amount:
[   ]

Select Maximum Plan Benefit Coverage periodicity:
○ Every three years
○ Every two years
○ Every year
○ Every six months
○ Every three months
○ Every month

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?
○ Yes
○ No

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:
[   ]

Select Maximum Enrollee Out-of-Pocket Cost periodicity:
○ Every three years
○ Every two years
○ Every year
○ Every six months
○ Every three months
○ Every month

Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?
○ Yes
○ No

Nicotine Replacement Therapy (NRT) Attestation:
☐ The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

CY 2023 PBP Data Entry System Screens

#13b OTC Items – Base 2

#13b OTC Items – Base 3

#13c Meal Benefit – Base 1

CY 2023 PBP Data Entry System Screens

#13c Meal Benefit – Base 2

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13c Meal Benefit - Base 2

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Indicate Minimum Coinsurance percentage:
[   ]

Indicate Maximum Coinsurance percentage:
[   ]

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Indicate Minimum Copayment amount:
[   ]

Indicate Maximum Copayment amount:
[   ]

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:
[   ]

Is authorization required?
- ○ Yes
- ○ No

Is a referral required for the Meal Benefit?
- ○ Yes
- ○ No

#13c Meal Benefit – Base 3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13c Meal Benefit - Base 3

Meal Benefit Notes

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

Notes:

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#13d Other 1 – Base 1

#13d Other 1 – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: #13d Other 1 - Base 2

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Indicate Minimum Coinsurance percentage:
[   ]

Indicate Maximum Coinsurance percentage:
[   ]

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Indicate Minimum Copayment amount:
[   ]

Indicate Maximum Copayment amount:
[   ]

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:
[   ]

Is authorization required?
- ○ Yes
- ○ No

Is a referral required for Other Services?
- ○ Yes
- ○ No

#13d Other 1 – Base 3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help

◀ Previous   ▶ Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #13d Other 1 - Base 3

Other 1 Notes

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

Notes:

#13e Other 2 – Base 1

#13e Other 2 – Base 2

#13e Other 2 – Base 3

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✗ Exit (No Validate)   Go To: #13e Other 2 - Base 3

Other 2 Notes

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

Notes:

#13f Other 3 – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help

◄ Previous   ► Next   ✅ Exit (Validate)   ❌ Exit (No Validate)   Go To: #13f Other 3 - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional):' field you will lose all previously entered data.

You may edit the name of the service text partially without losing all previously entered data.

Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, transportation, medical devices etc).

Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13B.

If providing a supplemental benefit, enter a descriptive title. "Other" is not an acceptable title.

Enter name of Service (Optional):

Select type of benefit for Other 3:
○ Mandatory
○ Optional

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

Indicate Maximum Plan Benefit Coverage amount:

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

#13f Other 3 – Base 2

#13f Other 3 – Base 3

#13g Dual Eligible SNPs with Highly Integrated Services – Base 1

#13g Dual Eligible SNPs with Highly Integrated Services – Base 2

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13g Dual Eligible SNPs with Highly Integrated Services - Base 2

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Indicate Minimum Coinsurance percentage:
[   ]

Indicate Maximum Coinsurance percentage:
[   ]

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Indicate Minimum Copayment amount:
[   ]

Indicate Maximum Copayment amount:
[   ]

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:
[   ]

Is authorization required?
- ○ Yes
- ○ No

Is a referral required for Other Services?
- ○ Yes
- ○ No

#13g Dual Eligible SNPs with Highly Integrated Services – Base 3

#13h Additional Services – Base 1

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13h Additional Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Does the plan provide Additional Services?

- ○ Yes
- ○ No

Select Additional Services (select all that apply):

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
Tobacco Cessation Counseling for Pregnant Women
Freestanding Birth Center Services
Respiratory Care Services
Family Planning Services
Nursing Home Services
Home and Community Based Services
Personal Care Services
Self-Directed Personal Assistance Services
Private Duty Nursing Services
Case Management (Long Term Care)
Institution for Mental Disease Services for Individuals 65 or Older
Services in an Intermediate Care Facility for Individuals with Intellectual Disabilitie
Case Management
Other 1
Other 2
Other 3
Other 4
Other 5
Other 6
Other 7
Other 8
Other 9
Other 10
Other 11
Other 12
Other 13
Other 14
Other 15
Other 16
Other 17
Other 18
Other 19
Other 20
Other 21
Other 22
Other 23

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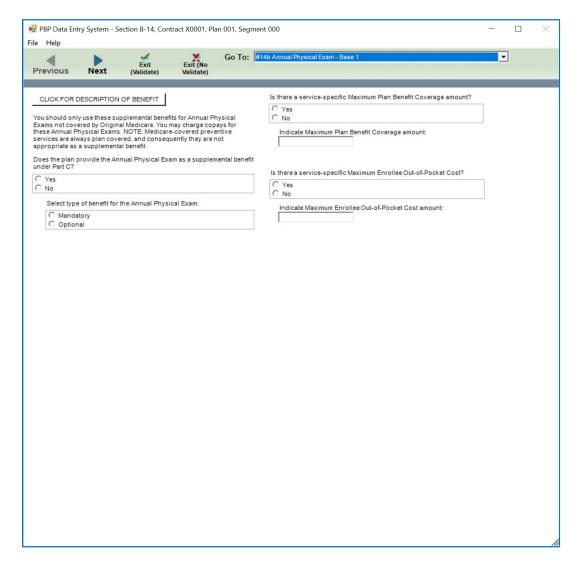
Enter name of Other 2 Service:

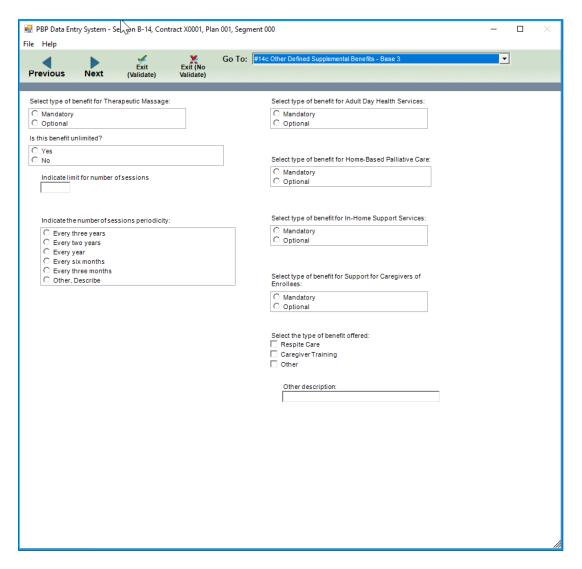Enter name of Other 3 Service:

Enter name of Other 4 Service:

Enter name of Other 5 Service:

Enter name of Other 6 Service:

Enter name of Other 7 Service:

Enter name of Other 8 Service:

Enter name of Other 9 Service:

Enter name of Other 10 Service:

Enter name of Other 11 Service:

Enter name of Other 12 Service:

Enter name of Other 13 Service:

CY 2023 PBP Data Entry System Screens

#13h Additional Services – Base 2

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✗ Exit (No Validate)   Go To: #13h Additional Services - Base 2

Enter name of Other 14 Service:

Enter name of Other 15 Service:

Enter name of Other 16 Service:

Enter name of Other 17 Service:

Enter name of Other 18 Service:

Enter name of Other 19 Service:

Enter name of Other 20 Service:

Enter name of Other 21 Service:

Enter name of Other 22 Service:

Enter name of Other 23 Service:

Enter name of Other 24 Service:

Enter name of Other 25 Service:

Enter name of Other 26 Service:

Enter name of Other 27 Service:

Enter name of Other 28 Service:

Enter name of Other 29 Service:

Enter name of Other 30 Service:

Enter name of Other 31 Service:

Enter name of Other 32 Service:

Enter name of Other 33 Service:

Enter name of Other 34 Service:

Enter name of Other 35 Service:

Enter name of Other 36 Service:

Enter name of Other 37 Service:

Enter name of Other 38 Service:

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#13h Additional Services – Base 3

#13h Additional Services – Base 4

#13h Additional Services – Base 5

#13h Additional Services – Base 6

CY 2023 PBP Data Entry System Screens

#13h Additional Services – Base 7

#13h Additional Services – Base 8

#13h Additional Services – Base 9

#13h Additional Services – Base 10

CY 2023 PBP Data Entry System Screens

#13h Additional Services – Base 11

#13h Additional Services – Base 12

CY 2023 PBP Data Entry System Screens

#13h Additional Services – Base 13

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13h Additional Services - Base 13

Indicate units a limit will be provided in for Other 25:
- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 25:

Select limit on services periodicity for Other 25:
- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 26:
- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 26:

Select limit on services periodicity for Other 26:
- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 27:
- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 27:

Select limit on services periodicity for Other 27:
- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

Indicate units a limit will be provided in for Other 28:
- Sessions
- Visits
- Hours
- Points
- Meals
- Items/Other, Describe

Indicate numerical limit on the services provided for Other 28:

Select limit on services periodicity for Other 28:
- Every day
- Every week
- Every month
- Every year
- Every Session/Visit
- Every Pregnancy
- Every Lifetime
- Other, Describe

#13h Additional Services – Base 14

#13h Additional Services – Base 15

#13h Additional Services – Base 16

#13h Additional Services – Base 17

#13h Additional Services – Base 18

CY 2023 PBP Data Entry System Screens

#13h Additional Services – Base 19

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13h Additional Services - Base 19

Indicate Maximum Plan Benefit Amount for OTHER5:

Select Maximum Plan Benefit Coverage Periodicity OTHER5:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER8:

Select Maximum Plan Benefit Coverage Periodicity OTHER8:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER11:

Select Maximum Plan Benefit Coverage Periodicity OTHER11:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER14:

Select Maximum Plan Benefit Coverage Periodicity OTHER14:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER6:

Select Maximum Plan Benefit Coverage Periodicity OTHER6:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER9:

Select Maximum Plan Benefit Coverage Periodicity OTHER9:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER12:

Select Maximum Plan Benefit Coverage Periodicity OTHER12:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER15:

Select Maximum Plan Benefit Coverage Periodicity OTHER15:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER7:

Select Maximum Plan Benefit Coverage Periodicity OTHER7:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER10:

Select Maximum Plan Benefit Coverage Periodicity OTHER10:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER13:

Select Maximum Plan Benefit Coverage Periodicity OTHER13:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

Indicate Maximum Plan Benefit Amount for OTHER16:

Select Maximum Plan Benefit Coverage Periodicity OTHER16:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, Describe

#13h Additional Services – Base 20

#13h Additional Services – Base 21

#13h Additional Services – Base 22

#13h Additional Services – Base 23

#13h Additional Services – Base 24

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13h Additional Services - Base 24

Enter minimum and maximum values only if instructed to do so by the State. If your state did not provide guidance on what values to enter, leave the minimum and maximum fields blank.

	Minimum Patient Pay Amount	Maximum Patient Pay Amount		Minimum Patient Pay Amount	Maximum Patient Pay Amount
Other 13			Other 26		
Other 14			Other 27		
Other 15			Other 28		
Other 16			Other 29		
Other 17			Other 30		
Other 18			Other 31		
Other 19			Other 32		
Other 20			Other 33		
Other 21			Other 34		
Other 22			Other 35		
Other 23			Other 36		
Other 24			Other 37		
Other 25			Other 38		

#13h Additional Services – Base 25

CY 2023 PBP Data Entry System Screens

#13h Additional Services – Base 26

#13h Additional Services – Base 27

#13h Additional Services – Base 28

PBP Data Entry System - Section B-13, Contract X0001, Plan 001, Segment 000	— □ ×

File   Help

◀ Previous   ▶ Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #13h Additional Services - Base 28 ▼

Indicate Copayment for one or more of the following services.

	Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services			Case Management		
Tobacco Cessation Counseling for Pregnant Women			Other 1		
Freestanding Birth Center Services			Other 2		
Respiratory Care Services			Other 3		
Family Planning Services			Other 4		
Nursing Home Services			Other 5		
Home and Community Based Services			Other 6		
Personal Care Services			Other 7		
Self-Directed Personal Assistance Services			Other 8		
Private Duty Nursing Services			Other 9		
Case Management (Long Term Care)			Other 10		
Institution for Mental Disease Services for Individuals 65 or Older			Other 11		
Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities			Other 12		

CY 2023 PBP Data Entry System Screens

#13h Additional Services – Base 29

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #13h Additional Services - Base 29

Indicate Copayment for one or more of the following services.

	Minimum Copayment	Maximum Copayment		Minimum Copayment	Maximum Copayment
Other 13			Other 26		
Other 14			Other 27		
Other 15			Other 28		
Other 16			Other 29		
Other 17			Other 30		
Other 18			Other 31		
Other 19			Other 32		
Other 20			Other 33		
Other 21			Other 34		
Other 22			Other 35		
Other 23			Other 36		
Other 24			Other 37		
Other 25			Other 38		

#13h Additional Services – Base 30

#14a Medicare-covered Zero Dollar Preventive Services

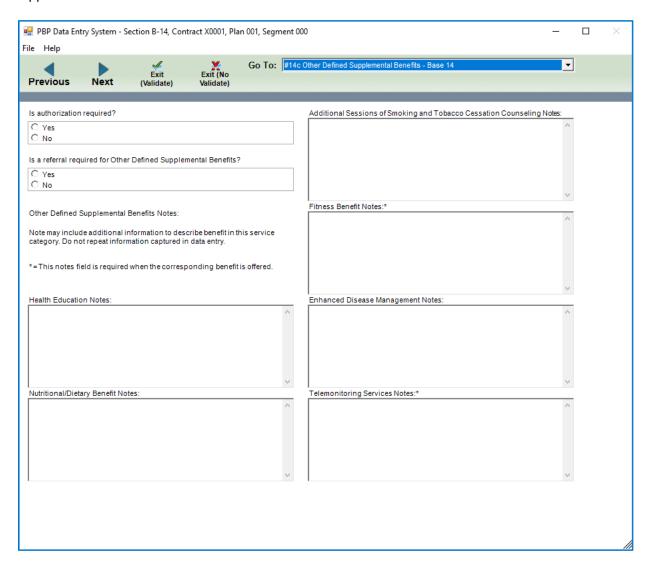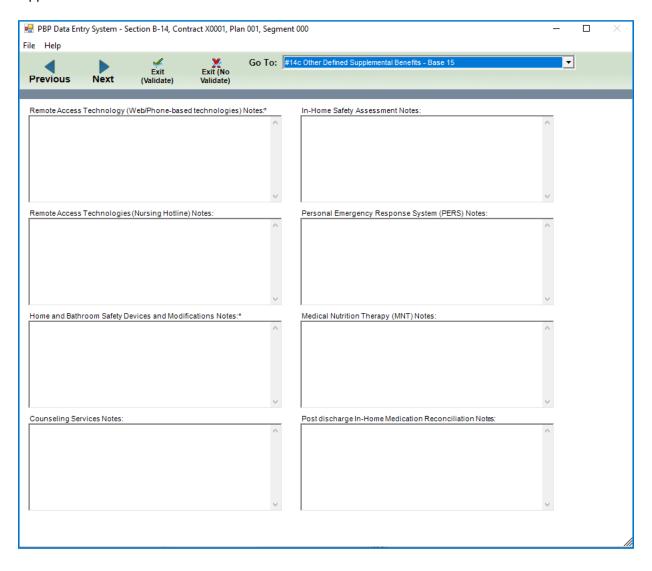#14b Annual Physical Exam – Base 1

#14b Annual Physical Exam – Base 2

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #14b Annual Physical Exam - Base 2

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Indicate Minimum Coinsurance percentage for each Annual Physical Exam:

Indicate Maximum Coinsurance percentage for each Annual Physical Exam:

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Indicate Minimum Copayment amount for each Annual Physical Exam:

Indicate Maximum Copayment amount for each Annual Physical Exam:

#14b Annual Physical Exam – Base 3

#14c Other Defined Supplemental Benefits – Base 1

#14c Other Defined Supplemental Benefits – Base 2

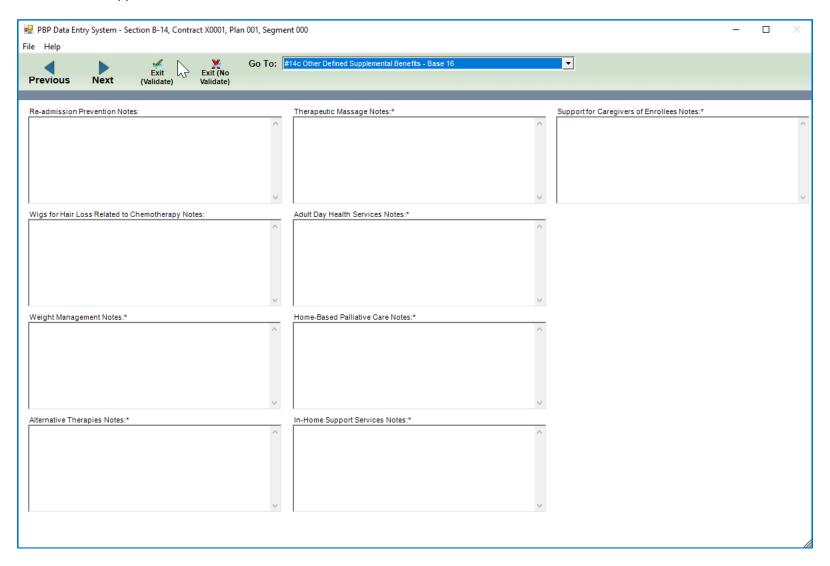PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File   Help

◀ Previous   ▶ Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #14c Other Defined Supplemental Benefits - Base 2 ▾

Select type of benefit for Personal Emergency Response System (PERS):
○ Mandatory
○ Optional

Select type of benefit for Medical Nutrition Therapy (MNT):
○ Mandatory
○ Optional

Do you offer Additional Sessions for Medicare-covered diseases?
○ Yes
○ No

Indicate the limit for Additional Sessions:
○ Visits
○ Hours

Indicate numerical limit on the services provided for Additional Sessions:
[   ]

Do you offer Coverage for Non-Medicare-covered diseases?
○ Yes
○ No

Indicate units a limit will be provided in for Coverage for Non-Medicare covered diseases:
○ Visits
○ Hours

Indicate numerical limit on the services provided for Coverage for Non-Medicare covered diseases:
[   ]

Select type of benefit for Post discharge In-Home Medication Reconciliation:
○ Mandatory
○ Optional

Select type of benefit for Re-admission Prevention:
○ Mandatory
○ Optional

What does your Re-admission Prevention benefit include (check all that apply):
☐ Meals
☐ Medication Reconciliation
☐ In-Home Safety Assessment
☐ Other, Describe

Enter name of Service:
[   ]

Select type of benefit for Wigs for Hair Loss Related to Chemotherapy:
○ Mandatory
○ Optional

Select type of benefit for Weight Management Programs:
○ Mandatory
○ Optional

Select type of benefit for Alternative Therapies:
○ Mandatory
○ Optional

Is this benefit unlimited for Alternative Therapies?
○ Yes
○ No, indicate number

Indicate number of visits offered for Alternative Therapies:
[   ]

14c Other Defined Supplemental Benefits – Base

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#14c Other Defined Supplemental Benefits – Base 4

#14c Other Defined Supplemental Benefits – Base 5

#14c Other Defined Supplemental Benefits – Base 6

#14c Other Defined Supplemental Benefits – Base 7

#14c Other Defined Supplemental Benefits – Base 8

#14c Other Defined Supplemental Benefits – Base 9

CY 2023 PBP Data Entry System Screens

#14c Other Defined Supplemental Benefits – Base 10

#14c Other Defined Supplemental Benefits – Base 11

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File   Help

◀ Previous   ▶ Next   ✓ Exit (Validate)   ✗ Exit (No Validate)   Go To: #14c Other Defined Supplemental Benefits - Base 11

Indicate Minimum Coinsurance percentage for Home-Based Palliative Care:

Indicate Maximum Coinsurance percentage for Home-Based Palliative Care:

Indicate Minimum Coinsurance percentage for In-Home Support Services:

Indicate Maximum Coinsurance percentage for In-Home Support Services:

Indicate Minimum Coinsurance percentage for Support for Caregivers of Enrollees:

Indicate Maximum Coinsurance percentage for Support for Caregivers of Enrollees:

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

#14c Other Defined Supplemental Benefits – Base 12

#14c Other Defined Supplemental Benefits – Base 13

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #14c Other Defined Supplemental Benefits - Base 13

Indicate Minimum Copayment amount for Home-Based Palliative Care:

Indicate Maximum Copayment amount for Home-Based Palliative Care:

Indicate Minimum Copayment amount for In-Home Support Services:

Indicate Maximum Copayment amount for In-Home Support Services:

Indicate Minimum Copayment amount for Support for Caregivers of Enrollees:

Indicate Maximum Copayment amount for Support for Caregivers of Enrollees:

#14c Other Defined Supplemental Benefits – Base 14

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #14c Other Defined Supplemental Benefits - Base 14

Is authorization required?
- Yes
- No

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

Is a referral required for Other Defined Supplemental Benefits?
- Yes
- No

Fitness Benefit Notes:*

Other Defined Supplemental Benefits Notes:

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

* = This notes field is required when the corresponding benefit is offered.

Health Education Notes:

Enhanced Disease Management Notes:

Nutritional/Dietary Benefit Notes:

Telemonitoring Services Notes:*

#14c Other Defined Supplemental Benefits – Base 15

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000	— ☐ ✕

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: #14c Other Defined Supplemental Benefits - Base 15 ▼

Remote Access Technology (Web/Phone-based technologies) Notes:*

In-Home Safety Assessment Notes:

Remote Access Technologies (Nursing Hotline) Notes:

Personal Emergency Response System (PERS) Notes:

Home and Bathroom Safety Devices and Modifications Notes:*

Medical Nutrition Therapy (MNT) Notes:

Counseling Services Notes:

Post discharge In-Home Medication Reconciliation Notes:

#14c Other Defined Supplemental Benefits – Base 16
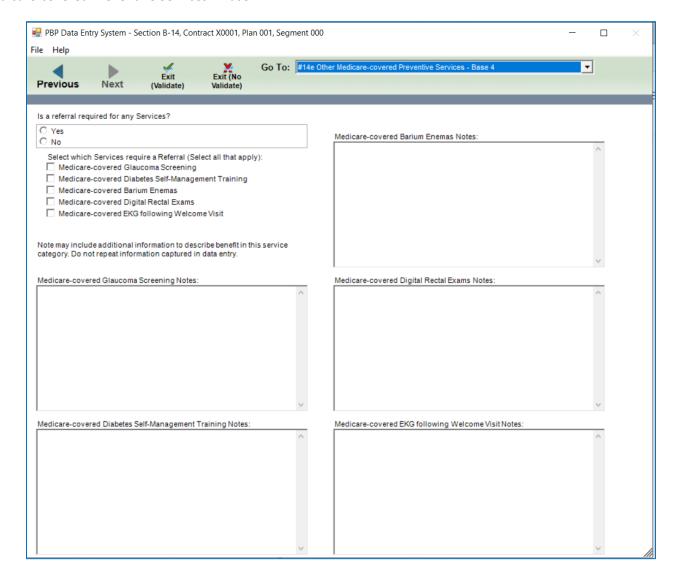
#14d Kidney Disease Education Services Base 1

#14d Kidney Disease Education Services Base 2

PBP Data Entry System - Section B-14, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #14d - Kidney Disease Education Services Base 2

Is there an enrollee Deductible?

○ Yes
○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?

○ Yes
○ No

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Is authorization required?

○ Yes
○ No

Is a referral required for Kidney Disease Education Services?

○ Yes
○ No

#14d Kidney Disease Education Services – Base 3

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#14e Other Medicare-covered Preventive Services – Base 1

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #14e Other Medicare-covered Preventive Services - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

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

Glaucoma screening, diabetes self-management training, barium enemas, digital rectal exams, EKG following welcome visit, and Other Medicare-covered preventive services are Medicare-covered preventive services for which data entry must be completed in this section. See the Benefit Description for more guidance.

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?

○ Yes
○ No

Select which Services have a Maximum Enrollee Out-of-Pocket Cost (Select all that apply):
☐ Medicare-covered Glaucoma Screening
☐ Medicare-covered Diabetes Self-Management Training
☐ Medicare-covered Barium Enemas
☐ Medicare-covered Digital Rectal Exams
☐ Medicare-covered EKG following Welcome Visit

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Glaucoma Screening:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Glaucoma Screening:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Diabetes Self-Management Training :

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Diabetes Self-Management Training:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Barium Enemas:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Barium Enemas:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered Digital Rectal Exams:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity for Medicare-covered Digital Rectal Exams:

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount for Medicare-covered EKG following Welcome Visit:

Select the Enrollee Out-of-Pocket Cost periodicity for Medicare-covered EKG following Welcome Visit:

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

#14e Other Medicare-covered Preventive Services – Base 2

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#14e Other Medicare-covered Preventive Services – Base 3

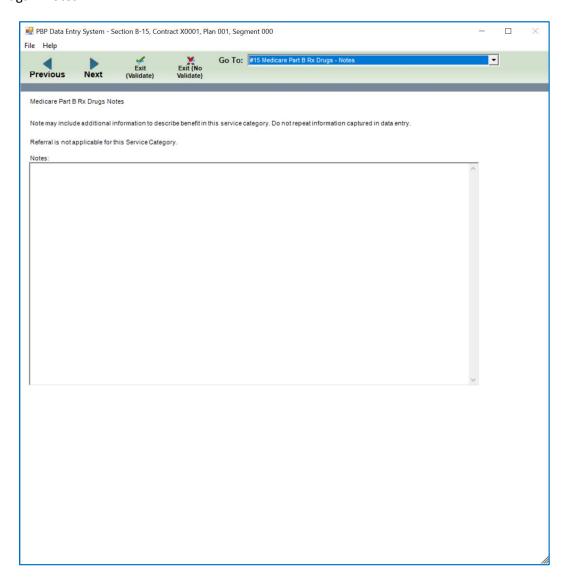#14e Other Medicare-covered Preventive Services – Base 4

#15 Medicare Part B Rx Drugs – Base 1

PBP Data Entry System - Section B-15, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #15 Medicare Part B Rx Drugs - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

Indicate Maximum Enrollee Out-of-Pocket Cost Amount:
[   ]

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

Is there an enrollee Coinsurance?
- ○ Yes
- ○ No

Select which Medicare Part B Rx Drugs have a Coinsurance (Select all that apply):
- ☐ Medicare Part B Chemotherapy/Radiation Drugs
- ☐ Other Medicare Part B Drugs

Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:
[   ]

Indicate the Maximum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:
[   ]

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:
[   ]

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:
[   ]

#15 Medicare Part B Rx Drugs – Base 2

Is there an enrollee Copayment?

○ Yes
○ No

Select which Medicare Part B Rx Drugs have a Copayment (Select all that apply):
☐ Medicare Part B Chemotherapy/Radiation Drugs
☐ Other Medicare Part B Drugs

Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:

Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy/Radiation Drugs:

Indicate Minimum Copayment Amount for other Medicare Part B Drugs:

Indicate Maximum Copayment Amount for other Medicare Part B Drugs:

Is there an enrollee Deductible?

○ Yes
○ No

Indicate Deductible Amount:

Is Authorization Required?

○ Yes
○ No

Does the plan offer step therapy?

○ Yes
○ No

Does the benefit step from (select all that apply):
☐ Part B to Part B?
☐ Part B to Part D?
☐ Part D to Part B?

#15 Medicare Part B Rx Drugs – Notes

#15 Home Infusion Bundled Services

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?

○ Yes
○ No

If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 10, 2022 at 11:59 am Eastern Time.

You must also ensure that your benefit includes not only the home infusion drug, but any services and supplies associated with the home infusion drug's administration.

If your organization elects to provide Part D home infusion drugs as part of a supplemental bundled service then those services must be provided at $0 cost sharing. As described in the CY 2010 Call Letter this waiver is conditioned on the application of zero cost sharing for the bundle of home infusion services provided under a supplemental benefit.

Does the plan pay for Part D drug home infusion services and supplies as a Medicaid benefit?

○ Yes
○ No

#16a Preventive Dental – Base 1

#16a Preventive Dental – Base 2

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#16a Preventive Dental – Base 3

#16a Preventive Dental – Base 4

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #16a Preventive Dental - Base 4

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:

#16a Preventive Dental – Base 5

#16b Comprehensive Dental – Base 1

#16b Comprehensive Dental – Base 2

#16b Comprehensive Dental – Base 3

#16b Comprehensive Dental – Base 4

#16b Comprehensive Dental – Base 5

#16b Comprehensive Dental – Base 6

PBP Data Entry System - Section B-16, Contract X0001, Plan 001, Segment 000

File   Help

Previous | Next | Exit (Validate) | Exit (No Validate) | Go To: #16b Comprehensive Dental - Base 6

Is authorization required?
- Yes
- No

Is a referral required for Comprehensive Dental Services?
- Yes
- No

Comprehensive Dental Services Notes

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

Medicare-covered Benefits Notes:

Non-routine Services Notes:

Diagnostic Services Notes:

Restorative Services Notes:

Endodontics Notes:

Periodontics Notes:

Extractions Notes:

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:

#17a Eye Exams – Base 1

CY 2023 PBP Data Entry System Screens

#17a Eye Exams – Base 2

#17a Eye Exams – Base 3

#17b Eyewear – Base 1

CY 2023 PBP Data Entry System Screens

#17b Eyewear – Base 3

12/27/2021
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

#17b Eyewear – Base 4

#17b Eyewear – Base 5

PBP Data Entry System - Section B-17, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #17b Eyewear - Base 5

Is there an enrollee Deductible?
- ○ Yes
- ○ No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- ○ Yes
- ○ No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Contact lenses:

Indicate Maximum Copayment amount for Contact lenses:

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

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

Indicate Minimum Copayment amount for Eyeglass lenses:

Indicate Maximum Copayment amount for Eyeglass lenses:

Indicate Minimum Copayment amount for Eyeglass frames:

Indicate Maximum Copayment amount for Eyeglass frames:

Indicate Minimum Copayment amount for Upgrades:

Indicate Maximum Copayment amount for Upgrades:

#17b Eyewear – Base 6

12/27/2021
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING
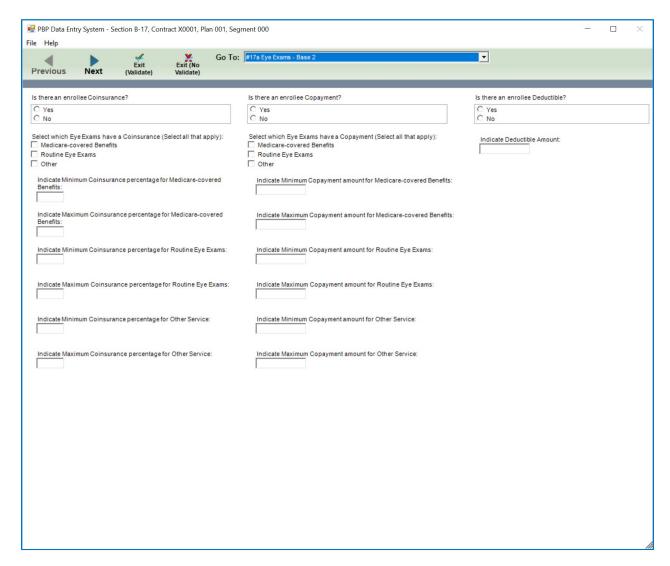
CY 2023 PBP Data Entry System Screens

#18a Hearing Exams – Base 1

CY 2023 PBP Data Entry System Screens

#18a Hearing Exams – Base 2

#18a Hearing Exams – Base 3

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File   Help

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

Is there an enrollee Copayment?
- ○ Yes
- ○ No

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

Indicate Minimum Copayment amount for Medicare-covered Benefits:

Indicate Maximum Copayment amount for Medicare-covered Benefits:

Indicate Minimum Copayment amount for Routine Hearing Exams:

Indicate Maximum Copayment amount for Routine Hearing Exams:

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

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

Is authorization required?
- ○ Yes
- ○ No

Is a referral required for Hearing Exams?
- ○ Yes
- ○ No

#18a Hearing Exams – Base 4

#18b Hearing Aids – Base 1

#18b Hearing Aids – Base 2

#18b Hearing Aids – Base 3

#18b Hearing Aids – Base 4

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #18b Hearing Aids - Base 4

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:

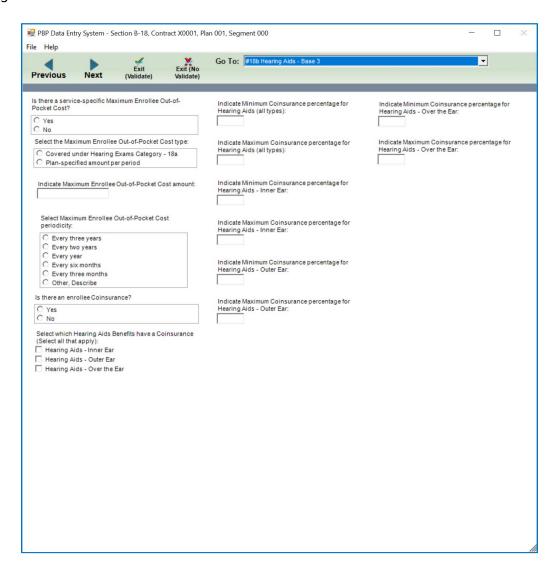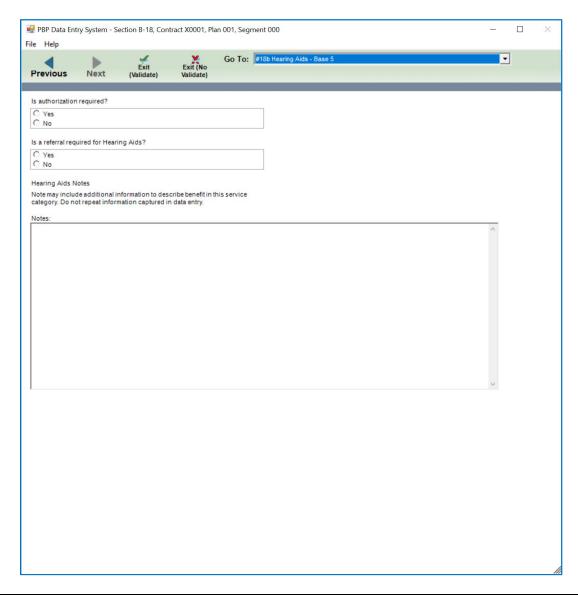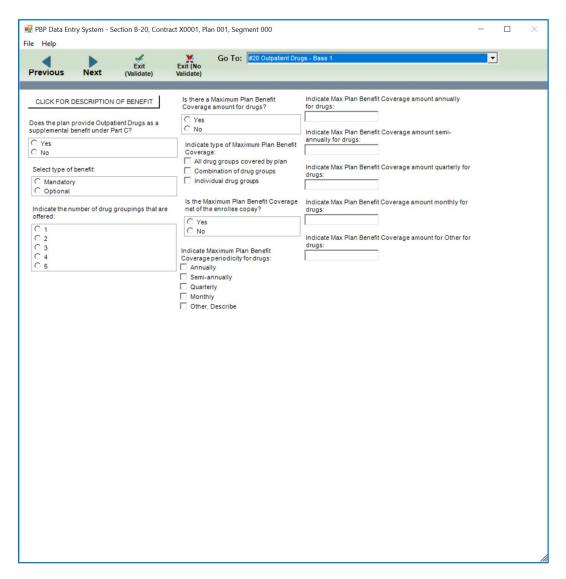Indicate Maximum Copayment amount per two Hearing Aids - Outer Ear:

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:

#18b Hearing Aids – Base 5

PBP Data Entry System - Section B-18, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #18b Hearing Aids - Base 5

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:

#20 Outpatient Drugs – Base 1
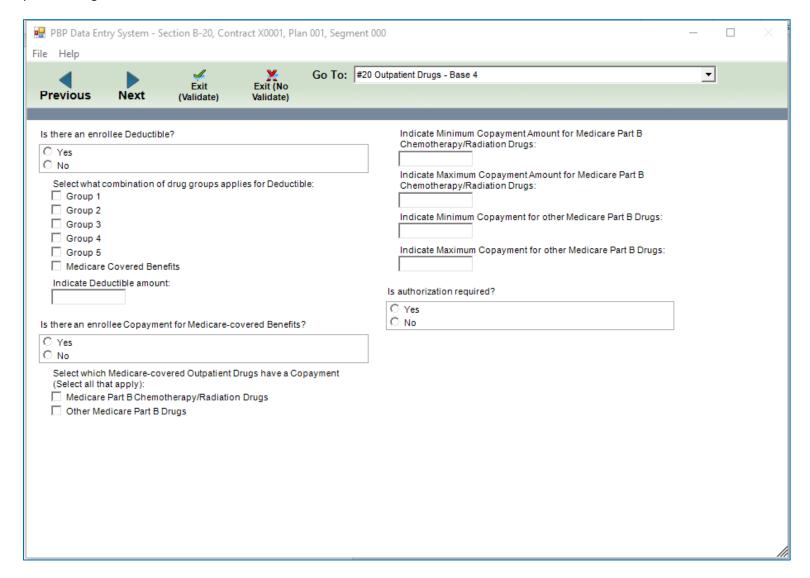
#20 Outpatient Drugs – Base 2

CY 2023 PBP Data Entry System Screens

#20 Outpatient Drugs – Base 3

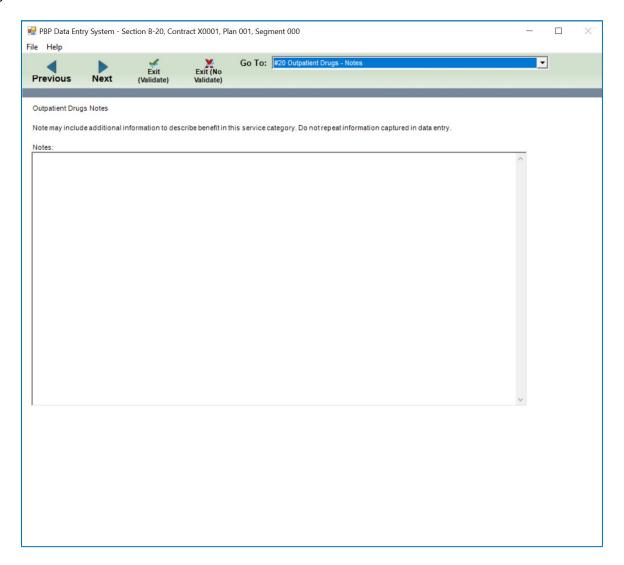PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File   Help

Go To: #20 Outpatient Drugs - Base 3

Previous   Next   Exit (Validate)   Exit (No Validate)

Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached?
- ○ Yes
- ○ No

Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived:
- ☐ Group 1
- ☐ Group 2
- ☐ Group 3
- ☐ Group 4
- ☐ Group 5

Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available?
- ○ Yes
- ○ No

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

Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost:
- ☐ Group 1
- ☐ Group 2
- ☐ Group 3
- ☐ Group 4
- ☐ Group 5
- ☐ Medicare Covered Benefits

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:
- ○ Every year
- ○ Every six months
- ○ Every three months

Is there an enrollee Coinsurance for Medicare-covered Benefits?
- ○ Yes
- ○ No

Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply):
- ☐ Medicare Part B Chemotherapy/Radiation Drugs
- ☐ Other Medicare Part B Drugs

Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:

Indicate Maximum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:

#20 Outpatient Drugs – Base 4

#20 Outpatient Drugs – Notes

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #20 Outpatient Drugs - Notes

Outpatient Drugs Notes

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

Notes:

#20 Outpatient Drugs – Group 1 – Base 1

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000   — ☐ ✕

File Help

◀ Previous   ▶ Next   ✔ Exit (Validate)   ✖ Exit (No Validate)   Go To: #20 Outpatient Drugs - Group 1 - Base 1 ▼

Select a label for Group 1:
[▼]

Select the drug type(s) covered for Group 1:
☐ Generic
☐ Preferred Brand
☐ Brand

Is there a Maximum Plan Benefit Coverage amount for Group 1?
○ Yes
○ No

Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:
☐ Annually
☐ Semi-annually
☐ Quarterly
☐ Monthly
☐ Per Prescription
☐ Other, Describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 1:
[ ]

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:
[ ]

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:
[ ]

Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:
[ ]

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:
[ ]

Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:
[ ]
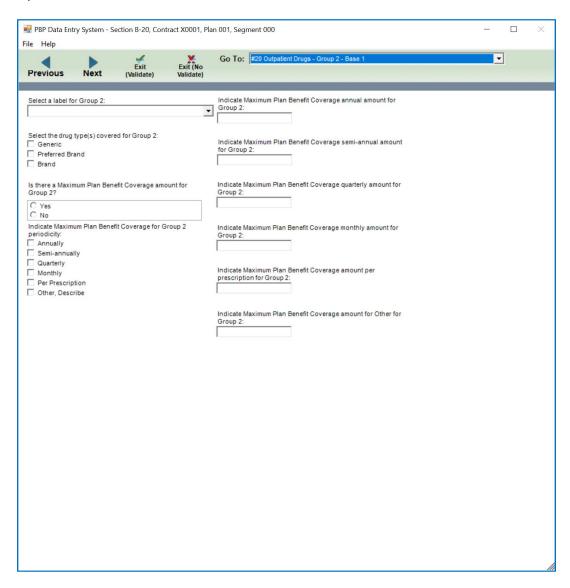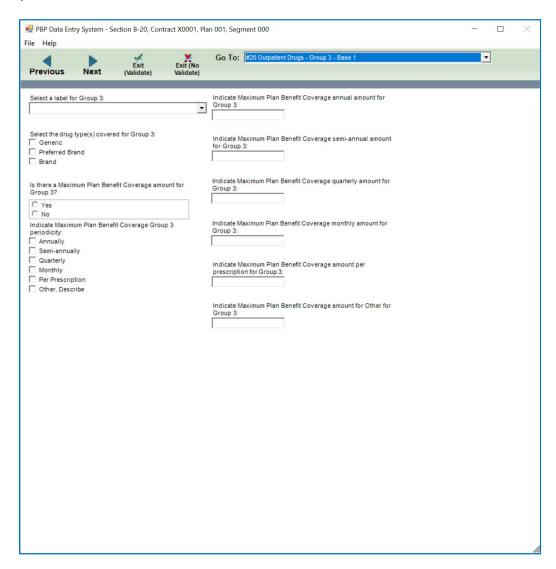
#20 Outpatient Drugs – Group 1 – Base 2

#20 Outpatient Drugs – Group 2 – Base 1
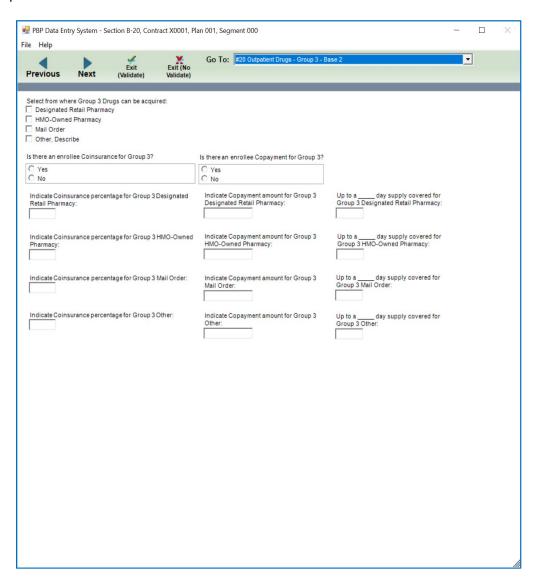
CY 2023 PBP Data Entry System Screens

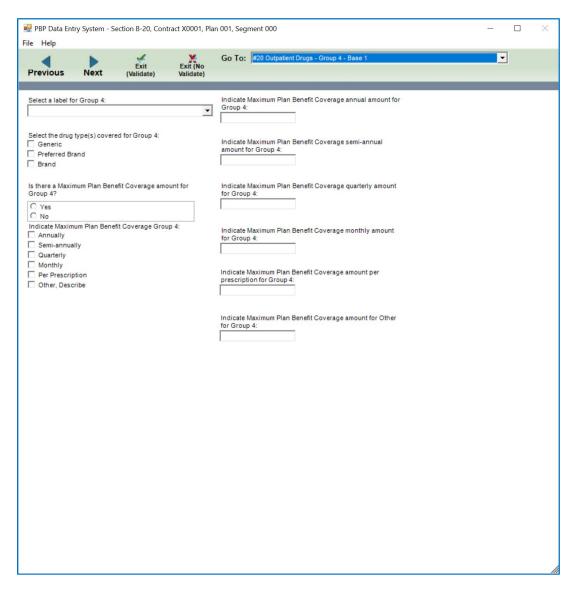#20 Outpatient Drugs – Group 2 – Base 2
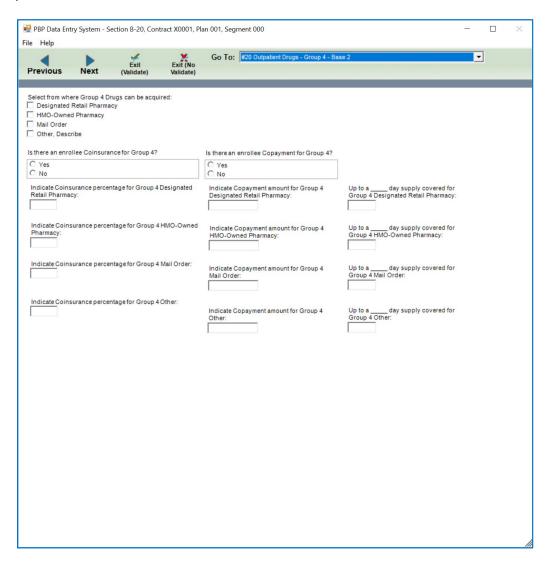
#20 Outpatient Drugs – Group 3 – Base 1
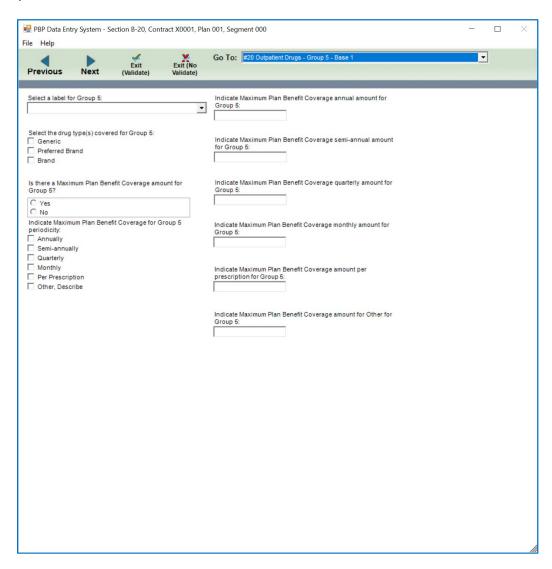
#20 Outpatient Drugs – Group 3 – Base 2

#20 Outpatient Drugs – Group 4 – Base 1

#20 Outpatient Drugs – Group 4 – Base 2

#20 Outpatient Drugs – Group 5 – Base 1

#20 Outpatient Drugs – Group 5 – Base 2

#20 Home Infusion Bundled Services

PBP Data Entry System - Section B-20, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: #20 Home Infusion Bundled Services

Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?

○ Yes
○ No

If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit?', you must indicate these specific medications in a flat file which must be uploaded through the Formulary Submission Module by Friday, June 10, 2022 at 11:59 am Eastern Time.

You must also ensure that your benefit includes not only the home infusion drug, but any services and supplies associated with the home infusion drug's administration.

If your organization elects to provide Part D home infusion drugs as part of a bundled service then those services must be provided at $0 cost sharing. As described in the CY 2010 Call Letter this waiver is conditioned on the application of zero cost sharing for the bundle of home infusion services provided under a supplemental benefit.