SECTION C – POS – GENERAL – BASE 1 SCREEN

PBP 2008 Data Entry System - POS - General - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer a Point-of-Service (POS) option?
- ○ Yes
- ○ No

Select type of benefit for the POS option:
- ○ Mandatory
- ○ Optional

Select all of the Sub-service Categories that describe the POS option:

- 1a: Inpatient Hospital Services Including Acute
- 1b: Inpatient Hospital Psychiatric Services
- 2: Skilled Nursing Facility (SNF)
- 3: Comprehensive Outpatient Rehabilitation Facility (CORF)
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e: Mental Health Specialty Services - Non-Psychiatric
- 7f: Podiatry Services
- 7g: Other Health Care Professional Services
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 8a: Diagnostic Procedures/Test/Lab Benefits
- 8b: Diagnostic/Therapeutic Radiological Services
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse Services
- 9d: Cardiac Rehabilitation Services
- 10a: Ambulance Services

Is there a Maximum Plan Benefit Coverage amount for POS?
- ○ Yes
- ○ No

Select all of the Sub-service Categories that apply to the POS Maximum Plan Benefit Coverage:

- 1a: Inpatient Hospital Services Including Acute
- 1b: Inpatient Hospital Psychiatric Services
- 2: Skilled Nursing Facility (SNF)
- 3: Comprehensive Outpatient Rehabilitation Facility (CORF)
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services

Indicate Maximum Plan Benefit Coverage amount:

_____

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

Select the Coverage Basis for Maximum Plan Benefit Coverage:
- ○ Published Fee Schedule
- ○ MA Organization Developed Fee Schedule
- ○ MA Organization Developed Cost Structure
- ○ Other, describe

SECTION C – POS – GENERAL – BASE 2 SCREEN

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PBP 2008 Data Entry System - POS - General - Base 2                           _ | 8 | X

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

Indicate POS 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
  ○ Other, describe

Is there a POS Deductible?
  ○ Yes
  ○ No

Enter Deductible Amount:

  [_____]

SECTION C – POS – GENERAL – BASE 3 SCREEN

PBP 2008 Data Entry System - POS - General - Base 3

File

Is Authorization required for POS?
- ○ Yes
- ○ No

**Is a referral required for POS?**
- ○ Yes
- ○ No

Select all of the Sub-service Categories that require Authorization for POS:

1a: Inpatient Hospital Services Including Acute
1b: Inpatient Hospital Psychiatric Services
2: Skilled Nursing Facility (SNF)
3: Comprehensive Outpatient Rehabilitation Facility (CORF)
5: Partial Hospitalization
6: Home Health Services
7a: Primary Care Physician Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7d: Physician Specialist Services
7e: Mental Health Specialty Services - Non-Psychiatric
7f: Podiatry Services
7g: Other Health Care Professional Services
7h: Psychiatric Services
7i: Physical Therapy and Speech-Language Pathology Services
8a: Diagnostic Procedures/Test/Lab Benefits
8b: Diagnostic/Therapeutic Radiological Services
9a: Outpatient Hospital Services
9b: Ambulatory Surgical Center (ASC) Services
9c: Outpatient Substance Abuse Services
9d: Cardiac Rehabilitation Services
10a: Ambulance Services

Select all of the Sub-service Categories that require a Referral for POS:

1a: Inpatient Hospital Services Including Acute
1b: Inpatient Hospital Psychiatric Services
2: Skilled Nursing Facility (SNF)
3: Comprehensive Outpatient Rehabilitation Facility (CORF)
5: Partial Hospitalization
6: Home Health Services
7a: Primary Care Physician Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7d: Physician Specialist Services
7e: Mental Health Specialty Services - Non-Psychiatric
7f: Podiatry Services
7g: Other Health Care Professional Services
7h: Psychiatric Services
7i: Physical Therapy and Speech-Language Pathology Services
8a: Diagnostic Procedures/Test/Lab Benefits
8b: Diagnostic/Therapeutic Radiological Services
9a: Outpatient Hospital Services
9b: Ambulatory Surgical Center (ASC) Services
9c: Outpatient Substance Abuse Services
9d: Cardiac Rehabilitation Services

Enrollee must receive Authorization from one or more of the following:
- ☐ None
- ☐ Primary Care Physician (Internist/Family Practice, General Practice)
- ☐ Physician Specialist
- ☐ Organization Medical Director/Utilization Management/Utilization Review
- ☐ Other, describe

SECTION C – POS – GENERAL – NOTES SCREEN
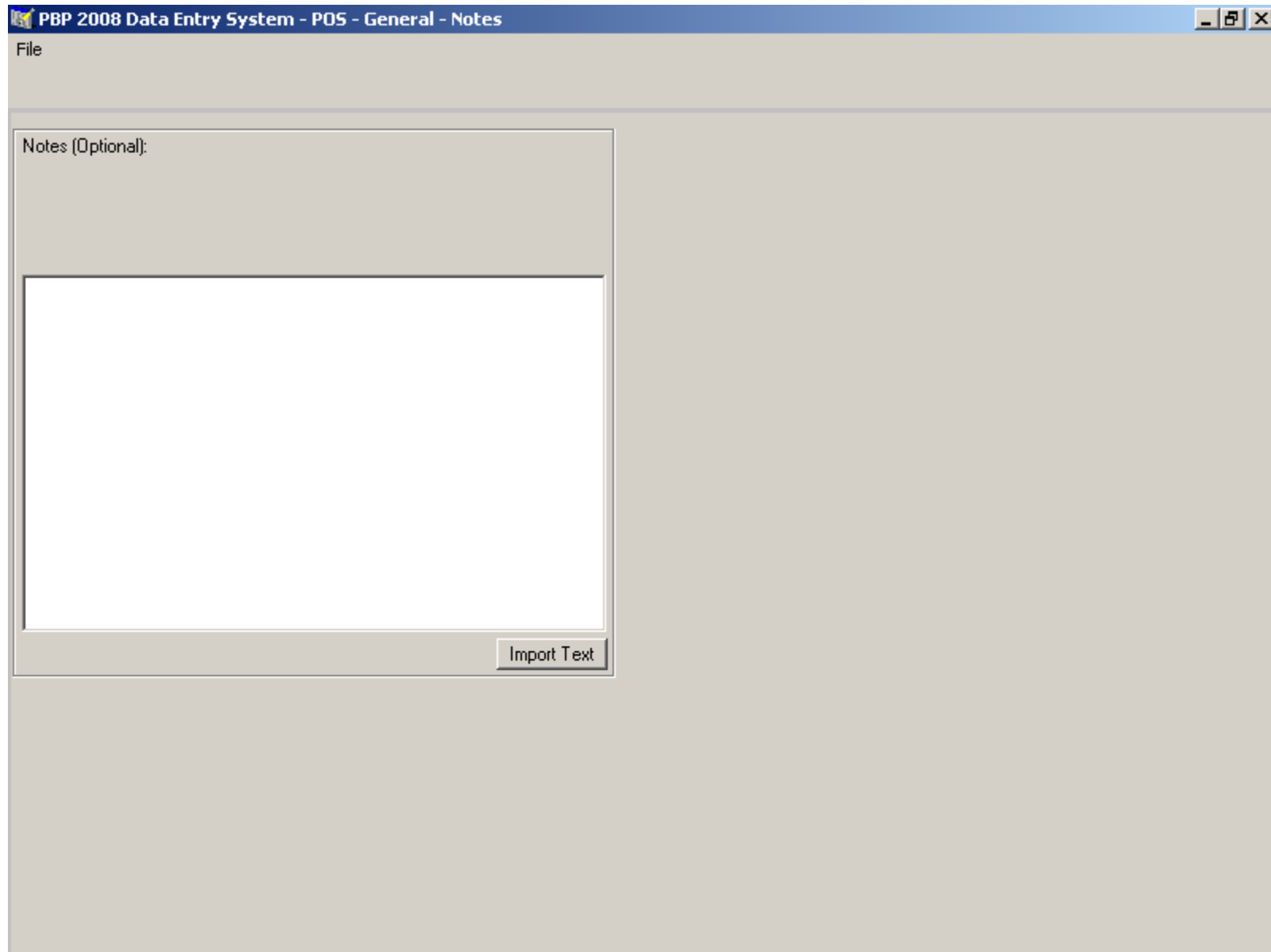
SECTION C – POS – INPATIENT – BASE 1 SCREEN

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PBP 2008 Data Entry System - (repaint)POS - Inpatient- Base 1          _ | ⊟ | ✕
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Is there a POS Maximum Plan Benefit Coverage for Inpatient Hospital Services?
- ○ Yes
- ○ No

Select the type of POS Inpatient Hospital Services benefit with a Maximum Plan Benefit Coverage:
- ☐ Inpatient Hospital- Acute
- ☐ Inpatient Psychiatric Hospital
- ☐ Combined for both Inpatient Hospital Acute and Inpatient Psychiatric Hospital

Enter Maximum Plan Benefit Coverage amount for Inpatient Hospital-Acute:

_____

Enter Maximum Plan Benefit Coverage amount for Inpatient Psychiatric Hospital:

_____

Enter Maximum Plan Benefit Coverage amount for combined Inpatient Hospital Acute and Inpatient Psychiatric Hospital:

_____

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

Select the Coverage Basis for Maximum Plan Benefit Coverage:
- ○ Published Fee Schedule
- ○ MA Organization Developed Fee Schedule
- ○ MA Organization Developed Cost Structure
- ○ Medicare Fee-for-Service Charge Structure
- ○ Other, describe

SECTION C – POS – INPATIENT – BASE 2 SCREEN

SECTION C – POS – INPATIENT – BASE 3 SCREEN

SECTION C – POS – INPATIENT – BASE 4 SCREEN

PBP 2008 Data Entry System - POS - Inpatient - Base 4

File

Is there an enrollee Copayment for POS Inpatient Hospital Services?
- ○ Yes
- ○ No

Select the type of POS Inpatient Hospital Services Benefit with Copayment:
- ☐ (1a) Inpatient Hospital - Acute
- ☐ (1b) Inpatient Psychiatric Hospital

Indicate Copayment amount per stay for POS Inpatient Hospital - Acute stay:

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

Indicate the copayment amount and day interval(s) for POS Inpatient Hospital - Acute 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:

SECTION C – POS – INPATIENT – BASE 5 SCREEN

PBP 2008 Data Entry System - (repaint)POS - Inpatient - Base 5

File

Indicate Copayment amount per stay for POS Inpatient Psychiatric Hospital:

_____

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

Indicate the copayment amount and day interval(s) for POS Inpatient Psychiatric Hospital 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:
_____	_____	_____

Is there a POS Deductible for Inpatient Hospital Services?
- ○ Yes
- ○ No

Select the type of POS Inpatient Hospital Services benefit with a Deductible:
- ☐ Inpatient Hospital- Acute
- ☐ Inpatient Psychiatric Hospital
- ☐ Combined for both Inpatient Hospital Acute and Inpatient Psychiatric Hospital

Enter Deductible amount for Inpatient Hospital- Acute:

_____

Enter Deductible amount for Inpatient Psychiatric Hospital:

_____

Enter Deductible amount for combined Inpatient Hospital Acute and Inpatient Psychiatric Hospital:

_____

SECTION C – POS – GROUPS – GROUP SCREEN

SECTION C – POS – GROUPS – BASE 1 SCREEN

SECTION C – POS – GROUPS – BASE 2 SCREEN