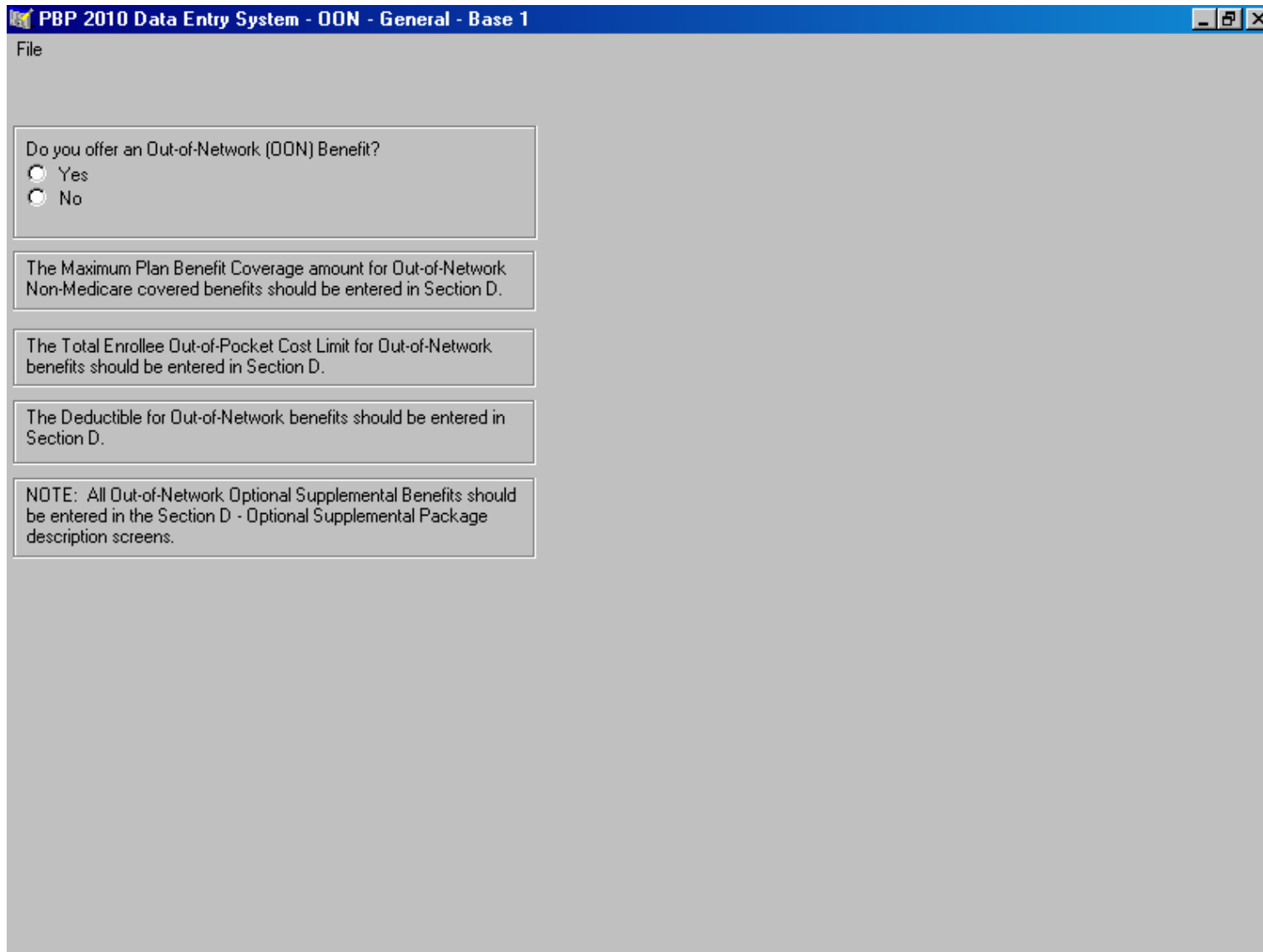


SECTION C – OON – GENERAL – BASE 1 SCREEN



PBP 2010 Data Entry System - OON - General - Base 1

File

Do you offer an Out-of-Network (OON) Benefit?

Yes

No

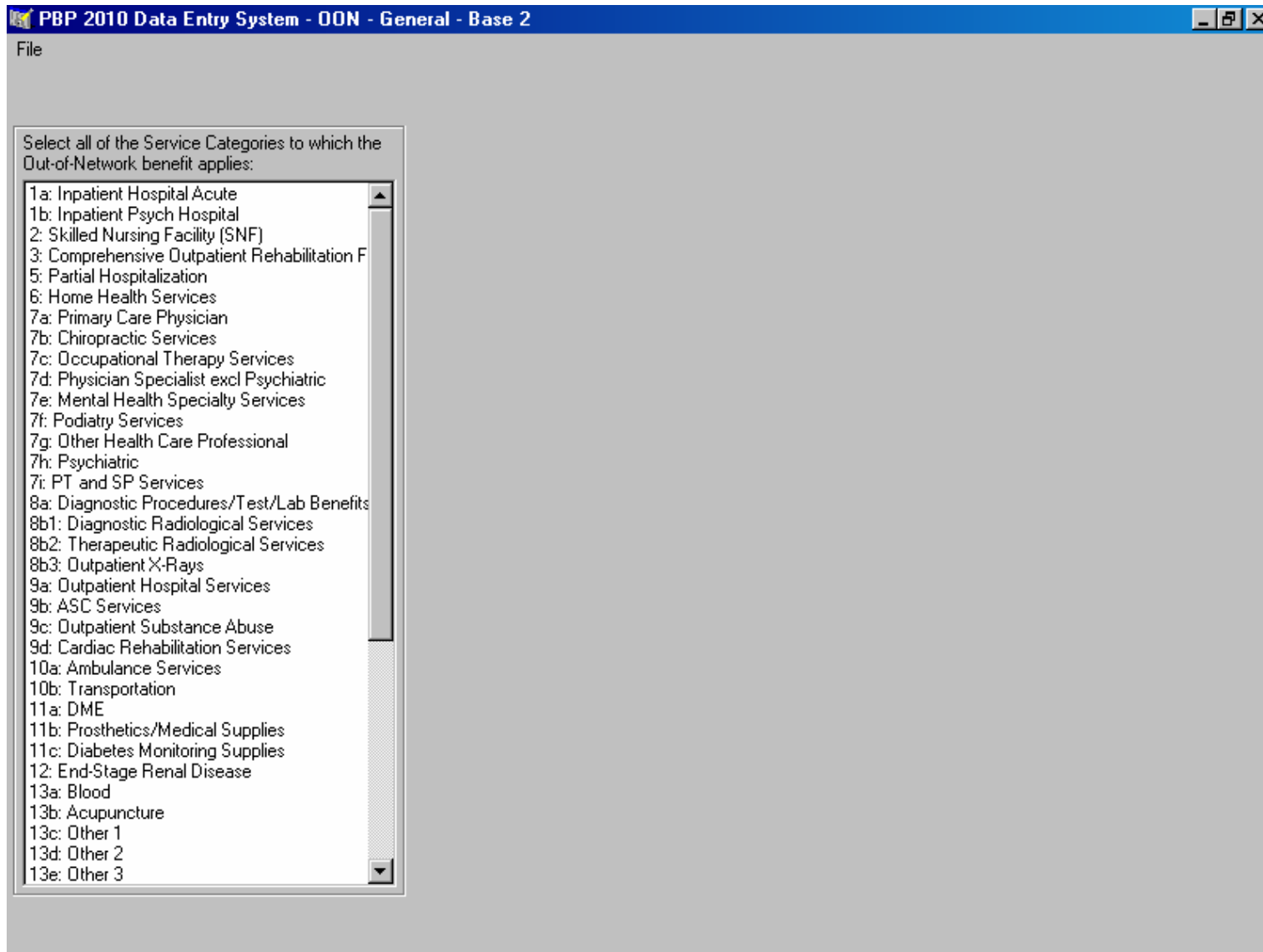
The Maximum Plan Benefit Coverage amount for Out-of-Network Non-Medicare covered benefits should be entered in Section D.

The Total Enrollee Out-of-Pocket Cost Limit for Out-of-Network benefits should be entered in Section D.

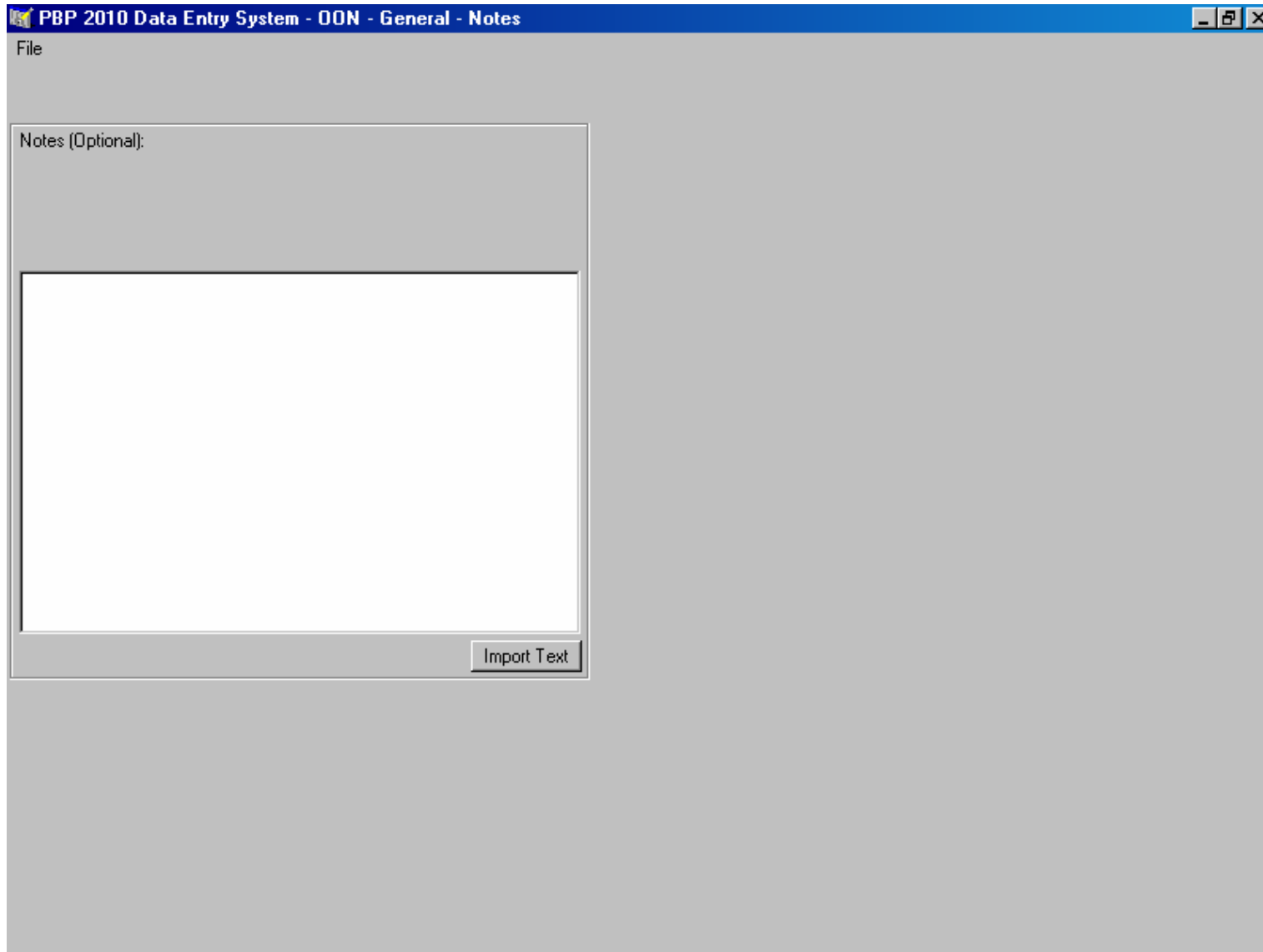
The Deductible for Out-of-Network benefits should be entered in Section D.

NOTE: All Out-of-Network Optional Supplemental Benefits should be entered in the Section D - Optional Supplemental Package description screens.

SECTION C – OON – GENERAL – BASE 2 SCREEN



SECTION C – OON – GENERAL – NOTES SCREEN



SECTION C – OON – INPATIENT – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)OON - Inpatient - Base 1

File

Is there an enrollee Coinsurance for OON Inpatient Hospital Services?
 Yes
 No

Select the type of OON Inpatient Hospital Services Benefit with Coinsurance:
 (1a) Inpatient Hospital - Acute
 (1b) Inpatient Psychiatric Hospital

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

Indicate Coinsurance percentage for OON Inpatient Hospital - Acute stay:

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

Indicate the coinsurance percentage and day interval(s) for OON Inpatient Hospital - Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – OON – INPATIENT – BASE 2 SCREEN

File

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

Yes
 No

Indicate Coinsurance percentage for OON Inpatient Psychiatric Hospital stay:

Indicate the number of day intervals for the OON Inpatient Psychiatric Hospital stay:

Zero (No Coinsurance per Day)
 One
 Two
 Three

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

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

SECTION C – OON – INPATIENT – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)OON - Inpatient - Base 3

File

Is there an enrollee Copayment for OON Inpatient Hospital Services?

Yes
 No

Select the type of OON Inpatient Hospital Services Benefit with Copayment:

(1a) Inpatient Hospital - Acute
 (1b) Inpatient Psychiatric Hospital

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 per stay for OON Inpatient Hospital - Acute stay:

Indicate the number of day intervals for the OON Inpatient Hospital - Acute stay:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for OON 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 – OON – INPATIENT – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)OON - Inpatient - Base 4

File

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 per stay for OON Inpatient Psychiatric Hospital:

Indicate the number of day intervals for the OON Inpatient Psychiatric Hospital stay:

Zero (No Copayment per Day)
 One
 Two
 Three

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

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

Is there an OON Deductible for Inpatient Hospital Services?

Yes
 No

Select the type of OON 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 – OON – SNF – BASE 1 SCREEN

File

Is there an enrollee Coinsurance for OON SNF Services?

Yes
 No

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 OON SNF stay:

Indicate the number of day intervals for the OON SNF stay:

Zero (No Coinsurance per Day)
 One
 Two
 Three

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

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

SECTION C – OON – SNF – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)OON - SNF - Base 2

File

Is there an enrollee Copayment for OON SNF Services?
 Yes
 No

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

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

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 per stay for OON SNF stay:

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

Is there an OON Deductible for SNF Services?
 Yes
 No

Enter Deductible amount for SNF:

SECTION C – OON – GROUPS – GROUP SCREEN

PBP 2010 Data Entry System - (repaint)OON - Number of Groups

File

Indicate the number of Out-of-Network groupings offered (excluding Inpatient Hospital and SNF Services):

SECTION C – OON – GROUPS – BASE 1 SCREEN

File

Enter Label for this Group (Optional):

Select the service categories included in the OON option for this Group:

- 3: 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: Podiatrist Services
- 7g: Other Health Care Professional Services
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech/Language Pathology Services
- 8a: Diagnostic Procedures/Test/Lab Benefits
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse Services
- 9d: Cardiac Rehabilitation Services
- 10a: Ambulance Services
- 10b: Transportation Services
- 11a: DME
- 11b: Prosthetics/Medical Supplies
- 11c: Diabetes Monitoring Supplies
- 12: End-Stage Renal Disease
- 13a: Outpatient Blood
- 13b: Acupuncture
- 13c: Other1
- 13d: Other2

Is there an OON Coinsurance for this Group?
 Yes
 No

Enter Minimum Coinsurance Percentage for this Group:

Enter Maximum Coinsurance Percentage for this Group:

Is there an OON Copayment for this Group?
 Yes
 No

Enter Minimum Copayment Amount for this Group:

Enter Maximum Copayment Amount for this Group:

SECTION C – OON – GROUPS – BASE 2 SCREEN

PBP 2010 Data Entry System - OON - Groups - Base 2

File

Is there an OON Deductible for this group?

Yes

No

Enter Deductible Amount for this group:

SECTION C – POS – GENERAL – BASE 1 SCREEN

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
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse 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

SECTION C – POS – GENERAL – BASE 2 SCREEN

File

Is there a PDS Maximum Enrollee Out-of-Pocket Cost amount?

Yes

No

Indicate PDS 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 PDS Deductible?

Yes

No

Enter Deductible Amount:

SECTION C – POS – GENERAL – BASE 3 SCREEN

PBP 2010 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
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse 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
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services

Enrollee must receive Authorization from one or more of the following:

None

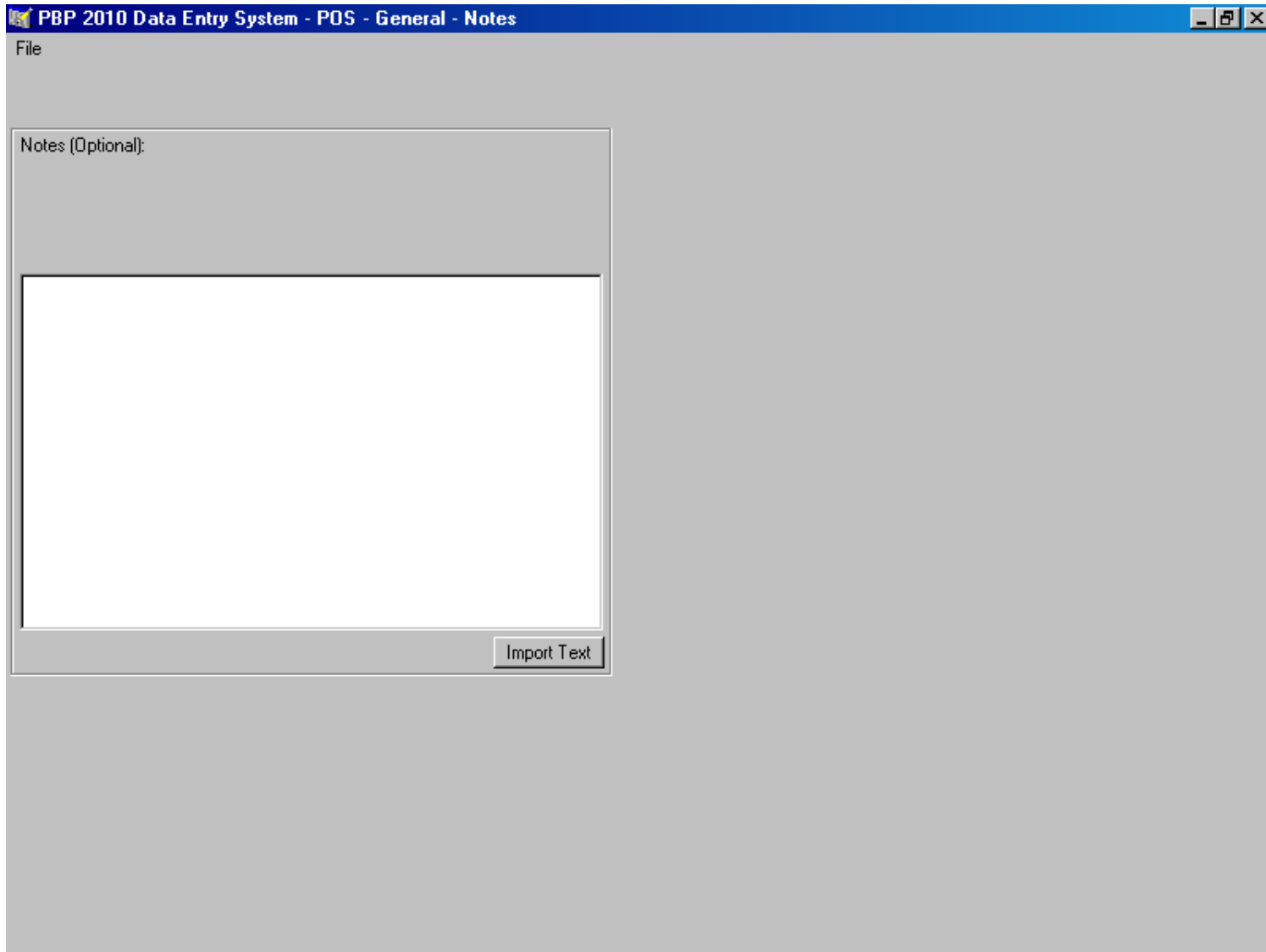
Primary Care Physician (Internist/Family Practice, General Practice)

Physician Specialist

Organization Medical Director/Utilization Management/Utilization Review

Other, describe

SECTION C – POS – GENERAL – NOTES SCREEN



SECTION C – POS – INPATIENT – BASE 1 SCREEN

File

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

SECTION C – POS – INPATIENT – BASE 2 SCREEN

File

Is there an enrollee Coinsurance for POS Inpatient Hospital Services?
 Yes
 No

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

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

Indicate Coinsurance percentage for POS Inpatient Hospital - Acute stay:

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

Indicate the coinsurance percentage and day interval(s) for POS Inpatient Hospital - Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – POS – INPATIENT – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)POS - Inpatient - Base 3

File

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

Yes
 No

Indicate Coinsurance percentage for POS Inpatient Psychiatric Hospital stay:

Indicate the number of day intervals for the POS Inpatient Psychiatric Hospital stay:

Zero (No Coinsurance per Day)
 One
 Two
 Three

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

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

SECTION C – POS – INPATIENT – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)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

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

SECTION C – POS – INPATIENT – BASE 5 SCREEN

PBP 2010 Data Entry System - (repaint)POS - Inpatient - Base 5

File

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

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 – SNF – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)POS - SNF - Base 1

File

Is there an enrollee Coinsurance for POS SNF Services?
 Yes
 No

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 POS SNF stay:

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

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

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

SECTION C – POS – SNF – BASE 2 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - (repaint)POS - SNF - Base 2". The window contains the following fields and controls:

- File** menu bar.
- Is there an enrollee Copayment for POS SNF Services?**
 - Yes
 - No
- 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 per stay for POS SNF stay:**
- Indicate the number of day intervals for the POS SNF stay:**
 - Zero (No Copayment per Day)
 - One
 - Two
 - Three
- Indicate the copayment amount and day interval(s) for POS SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999):**

Copayment Amt Interval 1: <input type="text"/>	Begin Day Interval 1: <input type="text"/>	End Day Interval 1: <input type="text"/>
Copayment Amt Interval 2: <input type="text"/>	Begin Day Interval 2: <input type="text"/>	End Day Interval 2: <input type="text"/>
Copayment Amt Interval 3: <input type="text"/>	Begin Day Interval 3: <input type="text"/>	End Day Interval 3: <input type="text"/>
- Is there a POS Deductible for SNF Services?**
 - Yes
 - No
- Enter Deductible amount for SNF:**

SECTION C – POS – GROUPS – GROUP SCREEN

PBP 2010 Data Entry System - POS - Number of Groups

File

Indicate the number of Point of Service groupings offered (excluding Inpatient Hospital Services) (Optional):

SECTION C – POS – GROUPS – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)POS - Groups - Base 1

File

Enter Label for this Group (Optional):

Select the service categories included in the POS option for this Group:

- 3: 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: Podiatrist Services
- 7g: Other Health Care Professional Services
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech/Language Pathology Services
- 8a: Diagnostic Procedures/Test/Lab Benefits
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse Services
- 9d: Cardiac Rehabilitation Services
- 10a: Ambulance Services
- 10b: Transportation Services
- 11a: DME
- 11b: Prosthetics/Medical Supplies
- 11c: Diabetes Monitoring Supplies
- 13a: Outpatient Blood
- 13b: Acupuncture
- 13c: Other1
- 13d: Other2
- 13e: Other3

Is there a POS Coinsurance for this Group?
 Yes
 No

Enter Minimum Coinsurance Percentage for this Group:

Enter Maximum Coinsurance Percentage for this Group:

Is there a POS Copayment for this Group?
 Yes
 No

Enter Minimum Copayment Amount for this Group:

Enter Maximum Copayment Amount for this Group:

SECTION C – POS – GROUPS – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)POS - Groups - Base 2

File

Is there a POS Maximum Plan Benefit Coverage amount for this group?

Yes

No

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, describe

Is there a POS Deductible for this group?

Yes

No

Indicate Deductible amount for POS services:

SECTION C – COST SHARE REDUCTION – GENERAL – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)Cost Share Reduction - General - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer reduced cost sharing for members that voluntarily pre-notify or voluntarily obtain prior authorization for services out-of-network? (PPOs only)

Yes
 No

Do you offer reduced cost sharing for members that pre-notify for services? (PFFS Only)

Yes
 No

Select all of the service categories for which reduced cost-sharing is available when members voluntarily obtain pre-authorization:

- 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
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse Services
- 9d: Cardiac Rehabilitation Services

SECTION C – COST SHARE REDUCTION – GENERAL –NOTES SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - Cost Share Reduction - General - Notes". The window has a standard Windows-style title bar with minimize, maximize, and close buttons. Below the title bar is a menu bar with a "File" option. The main content area is a light gray color. On the left side, there is a rectangular box containing the text "Notes (Optional):" above a large, empty white text input field. At the bottom right corner of this box is a button labeled "Import Text".

SECTION C – COST SHARE REDUCTION – INPATIENT – BASE 1 SCREEN

PBP 2010 Data Entry System - Cost Share Reduction - Inpatient - Base 1

File

Is there a reduced Coinsurance for Inpatient Hospital Services when enrollees voluntarily pre-authorize?

Yes
 No

Select the type of Inpatient Hospital Services Benefit with Coinsurance when enrollees voluntarily pre-authorize:

(1a) Inpatient Hospital - Acute
 (1b) Inpatient Psychiatric Hospital

Indicate Coinsurance percentage for Inpatient Acute when members voluntarily pre-authorize:

Indicate the number of day intervals for Inpatient Hospital when members voluntarily pre-authorize. (Acute stay)

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for Inpatient Hospital - Acute stay when members voluntarily pre-authorize (enter '999' if unlimited days)

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

SECTION C – COST SHARE REDUCTION – INPATIENT – BASE 2 SCREEN

PBP 2010 Data Entry System - Cost Share Reduction - Inpatient - Base 2

File

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 the Coinsurance percentage for Inpatient Psychiatric Hospital stay when members voluntarily pre-authorize:

Indicate the number of day intervals for the Inpatient Psychiatric Hospital stay when members voluntarily pre-authorize:

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for Inpatient Psychiatric Hospital stay when members voluntarily pre-authorize (enter '999' if unlimited days)

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

SECTION C – COST SHARE REDUCTION – INPATIENT – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)Cost Share Reduction - Inpatient - Base 3

File

Is there a reduced Copayment for Inpatient Hospital Services when the enrollees voluntarily pre-authorize?

Yes
 No

Select the type of Inpatient Hospital Services Benefit with Copayment when enrollees voluntarily pre-authorize:

(1a) Inpatient Hospital - Acute
 (1b) Inpatient Psychiatric Hospital

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 the Copayment per stay for Inpatient Hospital Acute when members voluntarily pre-authorize:

Indicate the number of day intervals for the Inpatient Hospital Acute stay when members voluntarily pre-authorize:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for Inpatient Hospital Acute when members voluntarily pre-authorize (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – COST SHARE REDUCTION – INPATIENT – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)Cost Share Reduction - Inpatient - Base 4

File

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

Is there a Deductible for Inpatient Hospital Services when members voluntarily pre-authorize?

Yes
 No

Indicate Copayment amount per stay for Inpatient Psychiatric Hospital stay when members voluntarily pre-authorize:

Select the type of Inpatient Hospital Services benefit with a Deductible when members voluntarily pre-authorize:

Inpatient Hospital - Acute
 Inpatient Psychiatric Hospital
 Combined for both Inpatient Hospital Acute and Inpatient Psychiatric Hospital

Indicate the number of day intervals for the Inpatient Psychiatric Hospital stay when members voluntarily pre-authorize:

Zero (No Copayment per Day)
 One
 Two
 Three

Enter Deductible amount for Inpatient Hospital - Acute:

Indicate the Copayment amount and day interval(s) for Inpatient Psychiatric Hospital stay when members voluntarily pre-authorize (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

Enter Deductible amount for Inpatient Psychiatric Hospital:

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

SECTION C – COST SHARE REDUCTION – SNF – BASE 1 SCREEN

File

Is there an enrollee Coinsurance for CSR SNF Services?
 Yes
 No

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 CSR SNF stay:

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

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

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

SECTION C – COST SHARE REDUCTION – SNF – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)Cost Share Reduction - SNF - Base 2

File

Is there an enrollee Copayment for CSR SNF Services?
 Yes
 No

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

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

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 per stay for CSR SNF stay:

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

Is there a CSR Deductible for SNF Services?
 Yes
 No

Enter Deductible amount for SNF:

SECTION C – COST SHARE REDUCTION – GROUPS – GROUP SCREEN

PBP 2010 Data Entry System - Cost Share Reduction - Number of Groups

File

Indicate how many groups you offer for reduced cost sharing when members voluntarily pre-authorize. (excluding Inpatient Hospital Services) (Optional):

SECTION C – COST SHARE REDUCTION – GROUPS – BASE 1 SCREEN

File

Enter Label for this Group (Optional):

Select the service categories included when members voluntarily pre-authorize for this Group:

- 3: 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: Podiatrist Services
- 7g: Other Health Care Professional Services
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech/Language Pathology Services
- 8a: Diagnostic Procedures/Test/Lab Benefits
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse Services
- 9d: Cardiac Rehabilitation Services
- 10a: Ambulance Services
- 10b: Transportation Services
- 11a: DME
- 11b: Prosthetics/Medical Supplies
- 11c: Diabetes Monitoring Supplies
- 12: End-Stage Renal Disease
- 13a: Outpatient Blood
- 13b: Acupuncture
- 13c: Other1

Is the cost sharing for this benefit the same as in Section B?
 Yes
 No

Is there reduced coinsurance when members voluntarily pre-authorize?
 Yes
 No

Enter Minimum Coinsurance Percentage for this Group:

Enter Maximum Coinsurance Percentage for this Group:

Is there reduced copayment when members voluntarily pre-authorize?
 Yes
 No

Enter Minimum Copayment Amount for this Group:

Enter Maximum Copayment Amount for this Group:

SECTION C – COST SHARE REDUCTION – GROUPS – BASE 2 SCREEN

File

Is there a Deductible for this group when members voluntarily pre-authorize?

Yes

No

Enter Deductible Amount for this group:

SECTION C – V/T – GENERAL –BASE 1 SCREEN

PBP 2010 Data Entry System - V/T - General - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer a Visitor/Travel Program?

Yes

No

Select type of benefit for the Visitor/Travel program:

Mandatory

Optional

SECTION C – V/T – GENERAL –U.S. – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - General - US - Base 1

File

Do you offer a US Visitor/Travel Program?

Yes

No

Select all of the Sub-service Categories that describe the Visitor/Travel - US Program:

- 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
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse Services

Select all of the Sub-service Categories that apply to the Visitor/Travel - US 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
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e: Mental Health Specialty Services - Non-Psychiatric
- 7f: Podiatry Services

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, describe

Is there a Maximum Plan Benefit Coverage amount for the Visitor/Travel - US Program?

Yes

No

SECTION C – V/T – GENERAL –U.S. – BASE 2 SCREEN

PBP 2010 Data Entry System - V/T - General - US - Base 2

File

Is Authorization required for the Visitor/Travel - US program?

Yes

No

Is a referral required for the Visitor/Travel - US program?

Yes

No

Select all of the Sub-service Categories that require Authorization for V/T - US:

- 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
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services

Select all of the Sub-service Categories that require a Referral for V/T - US:

- 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
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) 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 – V/T – GENERAL –U.S. – NOTES SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - V/T - General - US - Notes". The window has a standard Windows-style title bar with minimize, maximize, and close buttons. Below the title bar is a menu bar with a "File" option. The main content area is a large, empty rectangular box. Above this box, the text "Notes (Optional):" is displayed. At the bottom right of the box, there is a button labeled "Import Text".

SECTION C – V/T – INPATIENT – U.S. – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - Inpatient - US - Base 1

File

Is the cost sharing for this benefit the same as in Section B?
 Yes
 No

Is there an enrollee Coinsurance for V/T - US Inpatient Hospital Services?
 Yes
 No

Select the type of V/T - US Inpatient Hospital Services Benefit with Coinsurance:
 (1a) Inpatient Hospital - Acute
 (1b) Inpatient Psychiatric Hospital

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

Indicate Coinsurance percentage for V/T - US Inpatient Hospital - Acute stay:

Indicate the number of day intervals for the V/T - US Inpatient Hospital - Acute stay:
 Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for V/T - US Inpatient Hospital - Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – V/T – INPATIENT – U.S. – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - Inpatient - US - Base 2

File

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

Yes
 No

Indicate Coinsurance percentage for V/T - US Inpatient Psychiatric Hospital stay:

Indicate the number of day intervals for the V/T - US Inpatient Psychiatric Hospital stay:

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for V/T - US Inpatient Psychiatric Hospital stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – V/T – INPATIENT – U.S. – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - Inpatient - US - Base 3

File

Is there an enrollee Copayment for V/T - US Inpatient Hospital Services?

Yes
 No

Select the type of V/T - US Inpatient Hospital Services Benefit with Copayment:

(1a) Inpatient Hospital - Acute
 (1b) Inpatient Psychiatric Hospital

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 per stay for V/T - US Inpatient Hospital - Acute stay:

Indicate the number of day intervals for the V/T - US Inpatient Hospital - Acute stay:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for V/T - US Inpatient Hospital- Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – V/T – INPATIENT – U.S. – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - Inpatient - US - Base 4

File

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 per stay for V/T - US Inpatient Psychiatric Hospital:

Indicate the number of day intervals for the V/T - US Inpatient Psychiatric Hospital stay:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for V/T - US Inpatient Psychiatric Hospital stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – V/T – SNF – U.S. – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - SNF - US - Base 1

File

Is the cost sharing for this benefit the same as in Section B?
 Yes
 No

Is there an enrollee Coinsurance for V/T US SNF Services?
 Yes
 No

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 V/T US SNF stay:

Indicate the number of day intervals for the V/T US SNF stay:
 Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for V/T US SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – V/T – SNF – U.S. – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - SNF - US - Base 2

File

Is there an enrollee Copayment for V/T US SNF Services?
 Yes
 No

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 per stay for V/T US SNF

Indicate the number of day intervals for the V/T US SNF stay:
 Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for V/T US SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

Is there a V/T US Deductible for SNF Services?
 Yes
 No

Enter Deductible amount for SNF:

SECTION C – V/T – U.S. –NUMBER OF GROUPS SCREEN

PBP 2010 Data Entry System - V/T - Number of Groups - US

File

Indicate the number of Visitor/Travel - US groupings offered (excluding Inpatient Hospital Services) (Optional):

SECTION C – V/T – U.S. – GROUPS – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - Groups - US - Base 1

File

Enter Label for this Group (Optional):

Select the service categories included for this Group:

- 3: 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: Podiatrist Services
- 7g: Other Health Care Professional Services
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech/Language Pathology Services
- 8a: Diagnostic Procedures/Test/Lab Benefits
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse Services
- 9d: Cardiac Rehabilitation Services
- 10a: Ambulance Services
- 10b: Transportation Services
- 11a: DME
- 11b: Prosthetics/Medical Supplies
- 11c: Diabetes Monitoring Supplies
- 12: End-Stage Renal Disease
- 13a: Outpatient Blood
- 13b: Acupuncture
- 13c: Other1
- 13d: Other2
- 13e: Other3

Is there a V/T Coinsurance for this Group?

Yes

No

Enter Minimum Coinsurance Percentage for this Group:

Enter Maximum Coinsurance Percentage for this Group:

Is there a V/T Copayment for this Group?

Yes

No

Enter Minimum Copayment Amount for this Group:

Enter Maximum Copayment Amount for this Group:

SECTION C – V/T – GENERAL – FOREIGN – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - General - Foreign - Base 1

File

Do you offer a Foreign Visitor/Travel Program?

Yes
 No

Select all of the Sub-service Categories that describe the Visitor/Travel - Foreign Program:

- 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: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Service
- 8b: Outpatient X-Rays
- 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 apply to the Visitor/Travel - Foreign 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
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e: Mental Health Specialty Services - Non-Psychiatric
- 7f: Podiatry Services

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

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

Is there a Maximum Plan Benefit Coverage amount for the Visitor/Travel - Foreign Program?

Yes
 No

SECTION C – V/T – GENERAL – FOREIGN – BASE 2 SCREEN

File

Is there a Deductible for the Visitor/Travel - Foreign program?

Yes

No

Select all of the Sub-service Categories that apply to the V/T - Foreign Deductible:

- 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: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Se
- 8b: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse Services
- 9d: Cardiac Rehabilitation Services
- 10a: Ambulance Services
- 10b: Transportation Services
- 11a: DME

Indicate Deductible amount:

SECTION C – V/T – GENERAL – FOREIGN – BASE 3 SCREEN

PBP 2010 Data Entry System - V/T - General - Foreign - Base 3

File

Is Authorization required for the Visitor/Travel - Foreign program?

Yes
 No

Is a referral required for the Visitor/Travel - Foreign program?

Yes
 No

Select all of the Sub-service Categories that require Authorization for V/T - Foreign:

- 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: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Services
- 8b: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services

Select all of the Sub-service Categories that require a Referral for V/T - Foreign:

- 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: Outpatient Clinical/Diagnostic/Therapeutic Radiological Lab Service
- 8b: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services

Enrollee must receive Authorization from one or more of the following:

None

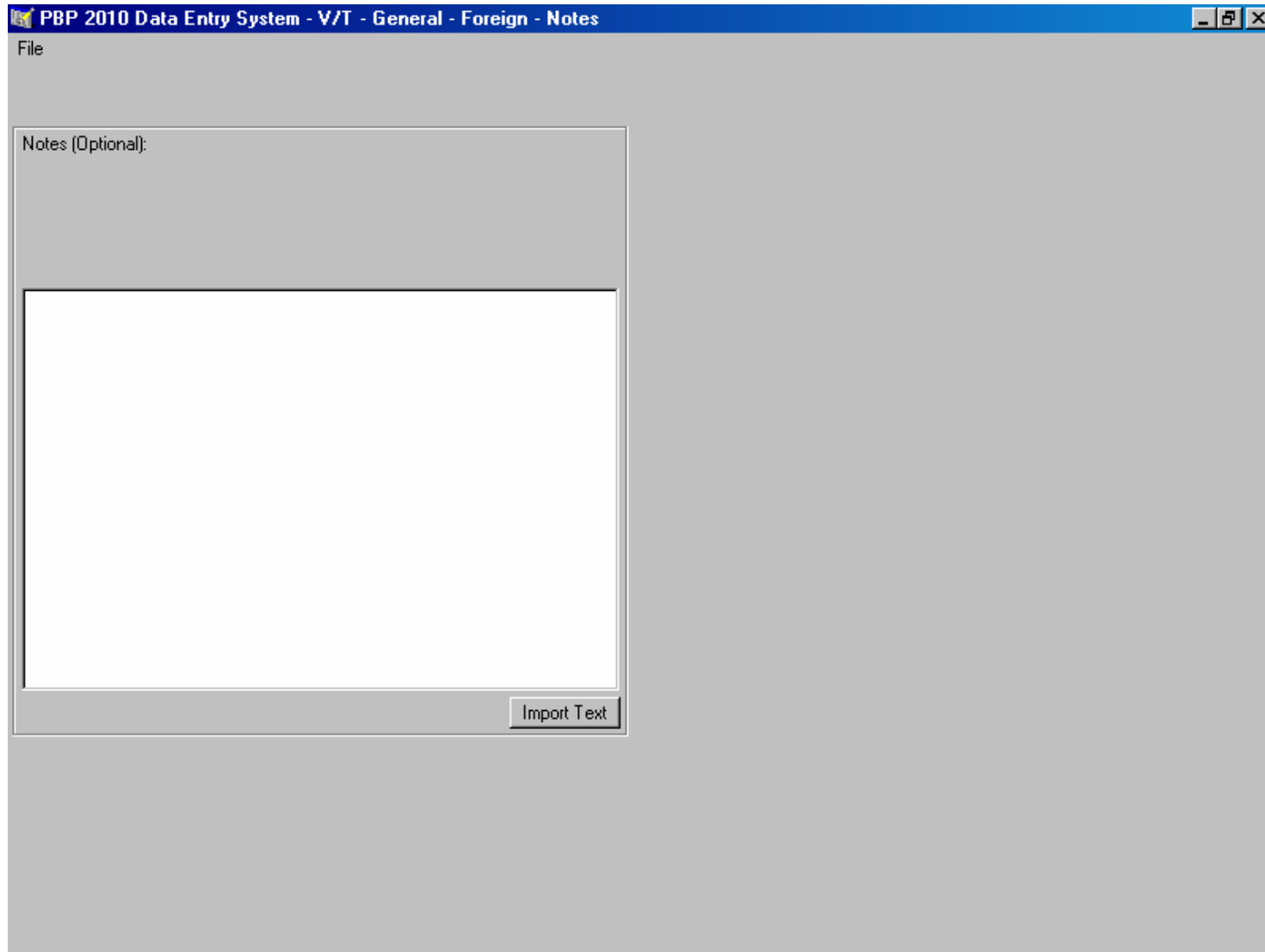
Primary Care Physician (Internist/Family Practice, General Practice)

Physician Specialist

Organization Medical Director/Utilization Management/Utilization Review

Other, describe

SECTION C – V/T – GENERAL – FOREIGN – NOTES SCREEN



SECTION C – V/T – INPATIENT – FOREIGN – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - Inpatient - Foreign - Base 1

File

Is the cost sharing for this benefit the same as in Section B?
 Yes
 No

Is there an enrollee Coinsurance for V/T - Foreign Inpatient Hospital Services?
 Yes
 No

Select the type of V/T - Foreign Inpatient Hospital Services Benefit with Coinsurance:
 (1a) Inpatient Hospital - Acute
 (1b) Inpatient Psychiatric Hospital

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

Indicate Coinsurance percentage for V/T - Foreign Inpatient Hospital - Acute stay:

Indicate the number of day intervals for the V/T - Foreign Inpatient Hospital - Acute stay:
 Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for V/T - Foreign Inpatient Hospital - Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – V/T – INPATIENT – FOREIGN – BASE 2 SCREEN

File

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

Yes
 No

Indicate Coinsurance percentage for V/T - Foreign Inpatient Psychiatric Hospital

Indicate the number of day intervals for the V/T - Foreign Inpatient Psychiatric Hospital stay:

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for V/T - Foreign Inpatient Psychiatric Hospital stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – V/T – INPATIENT – FOREIGN – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - Inpatient - Foreign - Base 3

File

Is there an enrollee Copayment for V/T- Foreign Inpatient Hospital Services?

Yes
 No

Select the type of V/T- Foreign Inpatient Hospital Services Benefit with Copayment:

(1a) Inpatient Hospital - Acute
 (1b) Inpatient Psychiatric Hospital

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 per stay for V/T- Foreign Inpatient Hospital - Acute

Indicate the number of day intervals for the V/T - Foreign Inpatient Hospital - Acute stay:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for V/T- Foreign Inpatient Hospital- Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – V/T – INPATIENT – FOREIGN – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)V/T - Inpatient - Foreign - Base 4

File

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 per stay for V/T - Foreign Inpatient Psychiatric Hospital:

Indicate the number of day intervals for the V/T - Foreign Inpatient Psychiatric Hospital stay:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for V/T - Foreign Inpatient Psychiatric Hospital stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

SECTION C – V/T – SNF – FOREIGN – BASE 1 SCREEN

File

PBP 2010 Data Entry System - (repaint)V/T - SNF - Foreign - Base 1

Is the cost sharing for this benefit the same as in Section B?
 Yes
 No

Is there an enrollee Coinsurance for V/T Foreign SNF Services?
 Yes
 No

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 V/T Foreign SNF stay:

Indicate the number of day intervals for the V/T Foreign SNF stay:
 Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for V/T Foreign SNF 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: _____

SECTION C – V/T – SNF – FOREIGN – BASE 2 SCREEN

PBP 2010 Data Entry System Screens

PBP 2010 Data Entry System - (repaint)V/T - SNF - Foreign - Base 2

File

Is there an enrollee Copayment for V/T Foreign SNF Services?
 Yes
 No

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 per stay for V/T Foreign SNF

Indicate the number of day intervals for the V/T Foreign SNF stay:
 Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for V/T Foreign SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

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

Is there a V/T Foreign Deductible for SNF Services?
 Yes
 No

Enter Deductible amount for SNF:

SECTION C – V/T – FOREIGN – NUMBER OF GROUPS SCREEN

PBP 2010 Data Entry System - V/T - Number of Groups - Foreign

File

Indicate the number of Visitor/Travel - Foreign groupings offered (excluding Inpatient Hospital Services) (Optional):

SECTION C – V/T – GROUPS – FOREIGN – BASE 1 SCREEN

PBP 2010 Data Entry System - V/T - Groups - Foreign - Base 1

File

Enter Label for this Group (Optional):

Select the service categories included for this Group:

- 3: 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: Podiatrist Services
- 7g: Other Health Care Professional Services
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech/Language Pathology Services
- 8a: Diagnostic Procedures/Test/Lab Benefits
- 8b1: Diagnostic Radiological Services
- 8b2: Therapeutic Radiological Services
- 8b3: Outpatient X-Rays
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse Services
- 9d: Cardiac Rehabilitation Services
- 10a: Ambulance Services
- 10b: Transportation Services
- 11a: DME
- 11b: Prosthetics/Medical Supplies
- 11c: Diabetes Monitoring Supplies
- 12: End-Stage Renal Disease
- 13a: Outpatient Blood
- 13b: Acupuncture
- 13c: Other1
- 13d: Other2
- 13e: Other3

Is there a V/T Coinsurance for this Group?
 Yes
 No

Enter Minimum Coinsurance Percentage for this Group:

Enter Maximum Coinsurance Percentage for this Group:

Select the Coinsurance Coverage Basis:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Other, describe

Is there a V/T Copayment for this Group?
 Yes
 No

Enter Minimum Copayment Amount for this Group:

Enter Maximum Copayment Amount for this Group: