

SECTION C – OON – GENERAL – BASE 1 SCREEN

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: OON - General - Base 1

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

Yes

No

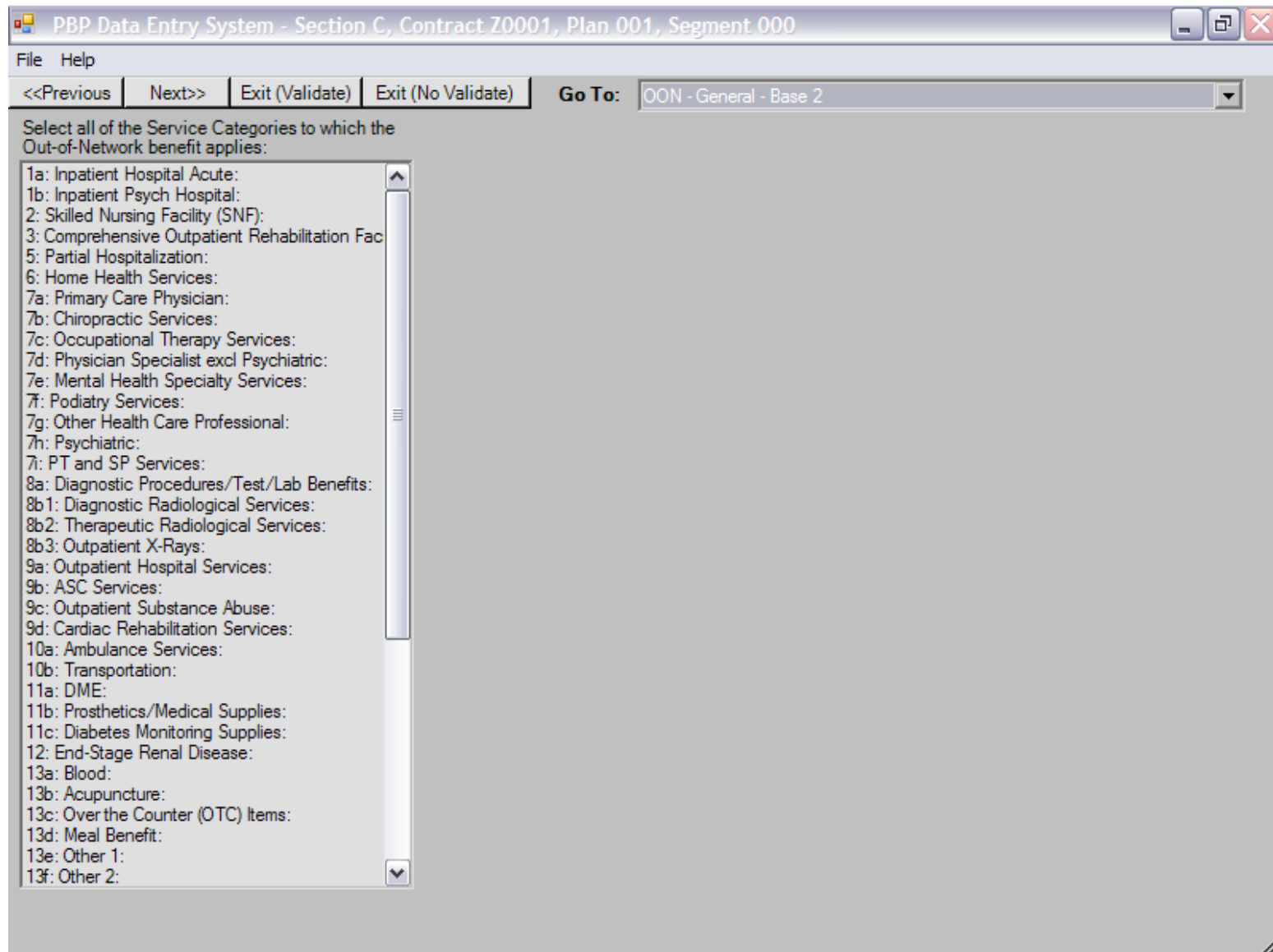
The Maximum Plan Benefit Coverage amount for Out-of-Network Non-Medicare-covered benefits should be entered in Section D.

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

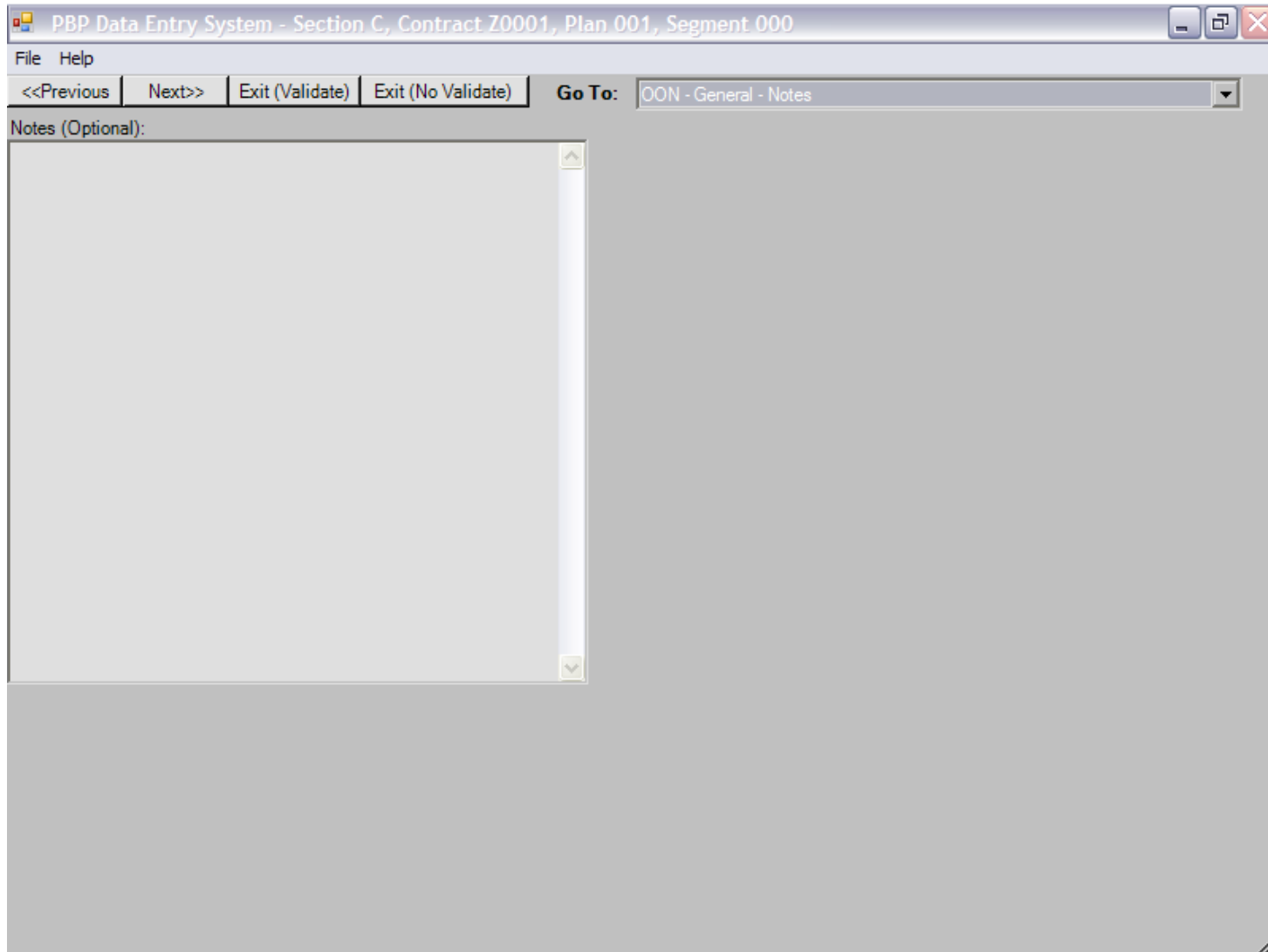
The Deductible for Out-of-Network benefits should be entered in Section D.

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

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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 for Inpatient Acute Services? (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:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION C – OON – INPATIENT – BASE 2 SCREEN

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

Yes
 No

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: Begin Day Interval 1: End Day Interval 1:

Indicate Coinsurance percentage for OON Inpatient Psychiatric Hospital stay:

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

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

Zero (No Coinsurance per Day)
 One
 Two
 Three

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

SECTION C – OON – INPATIENT – BASE 3 SCREEN

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

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

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

(1a) Inpatient Hospital - Acute

(1b) Inpatient Psychiatric Hospital

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

Zero (No Copayment per Day)

One

Two

Three

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

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

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Do you charge the Medicare-defined cost shares for Inpatient Psychiatric Services? (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: 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 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

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

SECTION C – OON – SNF – BASE 2 SCREEN

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Is there an enrollee Copayment 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 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

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

Is there an OON Deductible for SNF Services?
 Yes
 No

Enter Deductible amount for SNF:

SECTION C – OON – GROUPS – GROUP SCREEN

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

SECTION C – OON – GROUPS – BASE 1 SCREEN

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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:
- 7: 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: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:

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

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Is there an OON Deductible for this group?

Yes

No

Enter Deductible Amount for this group:

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CLICK 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:
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:

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:
7c: Occupational Therapy Services:
7d: Physician Specialist 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

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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:

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Is Authorization 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:
- 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

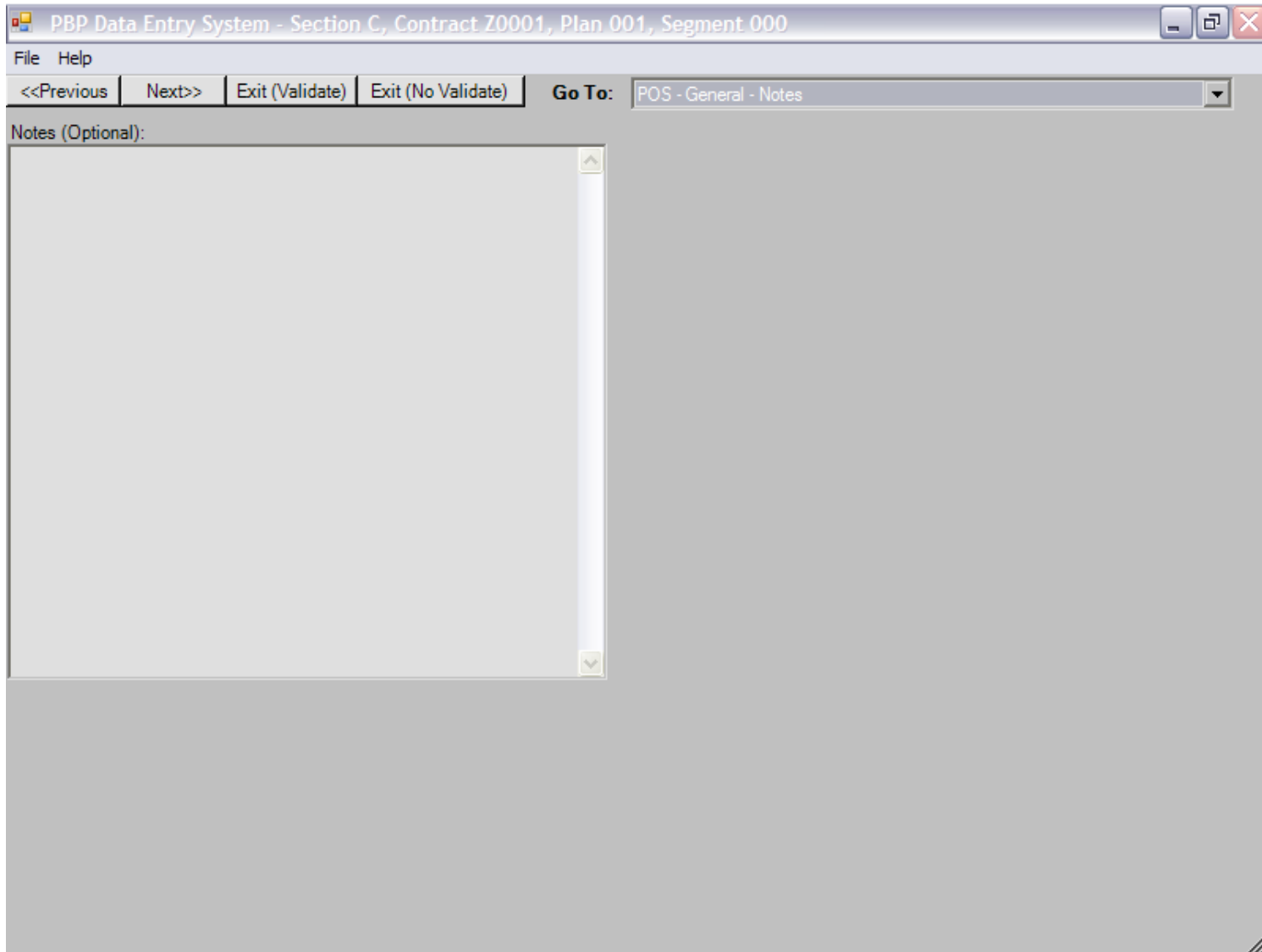
Is a referral required for POS?

Yes
 No

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:
- 9c: Outpatient Substance Abuse Services:

SECTION C – POS – GENERAL – NOTES SCREEN



SECTION C – POS – INPATIENT – BASE 1 SCREEN

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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

SECTION C – POS – INPATIENT – BASE 2 SCREEN

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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 for Inpatient Acute Services? (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:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION C – POS – INPATIENT – BASE 3 SCREEN

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

Yes
 No

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):

Indicate Coinsurance percentage for POS Inpatient Psychiatric Hospital stay: <input type="text"/>	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"/>
Indicate the number of day intervals for the POS Inpatient Psychiatric Hospital stay: <input type="radio"/> Zero (No Coinsurance per Day) <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three	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

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Go To: POS - Inpatient - Base 4

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 for for Inpatient Acute Services? (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: 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:

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Do you charge the Medicare-defined cost shares for for Inpatient Psychiatric Services? (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 9)

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:

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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	Begin Day Interval	End Day Interval
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

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

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

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

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

Is there a POS Deductible for SNF Services?
 Yes
 No

Enter Deductible amount for SNF:

SECTION C – POS – GROUPS – GROUP SCREEN

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

SECTION C – POS – GROUPS – BASE 1 SCREEN

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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: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:

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 Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) **Go To:** POS - Groups - Base 2

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 – V/T – GENERAL –BASE 1 SCREEN

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - General - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer a Visitor/Travel Program?

Yes

No

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

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - General - US - Base 1

Do you offer a US Visitor/Travel Program?

Yes
 No

Select type of benefit for the US Visitor/Travel program:

Mandatory
 Optional

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:
9d: Cardiac Rehabilitation Services:
10a: Ambulance Services:

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

Yes
 No

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:
7g: Other Health Care Professional Services:
7h: Psychiatric Services:
7i: Physical Therapy and Speech-Language Pathology Services:
8a: Diagnostic Procedures/Test/Lab Benefits:

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

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - General - US - Base 2

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:
- 9c: Outpatient Substance Abuse Services:
- 9d: Cardiac Rehabilitation Services:

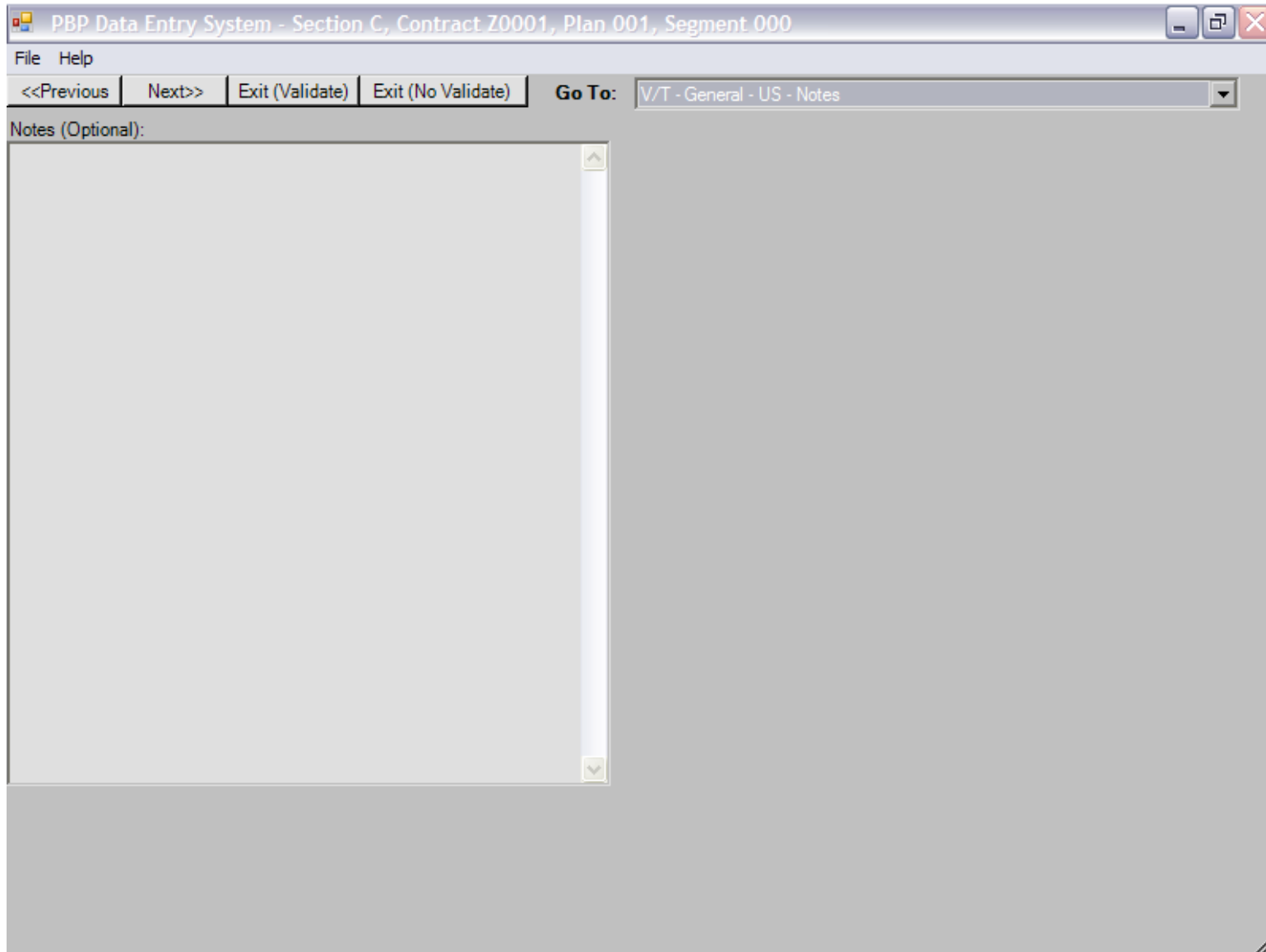
Select all of the Sub-service Categories that require a Referral for V/T - US:

- 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:
- 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 – V/T – GENERAL –U.S. – NOTES SCREEN



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

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - Inpatient - US - 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 - 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 for Inpatient Acute Services? (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:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) **Go To:** V/T - Inpatient - US - Base 2

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

Yes
 No

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

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

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

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate)

Go To: V/T - Inpatient - US - Base 3

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	Begin Day Interval	End Day Interval
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 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 for Inpatient Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Yes
 No

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

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - Inpatient - US - Base 4

Do you charge the Medicare-defined cost shares for for Inpatient Psychiatric Services? (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: 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 – V/T – SNF – U.S. – BASE 1 SCREEN

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - SNF - US - 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 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:	Begin Day Interval 1:	End Day Interval 1:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - SNF - US - Base 2

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

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: Begin Day Interval 1: End Day Interval 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

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

Indicate Copayment amount per stay for V/T US SNF stay:

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

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

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 Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - Number of Groups - US

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

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

PBP Data Entry System - Section C, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: V/T - Groups - US - Base 1

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: Over the Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:

Is the cost sharing for this benefit the same as in Section B?

Yes

No

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: