

Section C- OON- General- Base 1 Screen

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

File Help

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

Yes

No

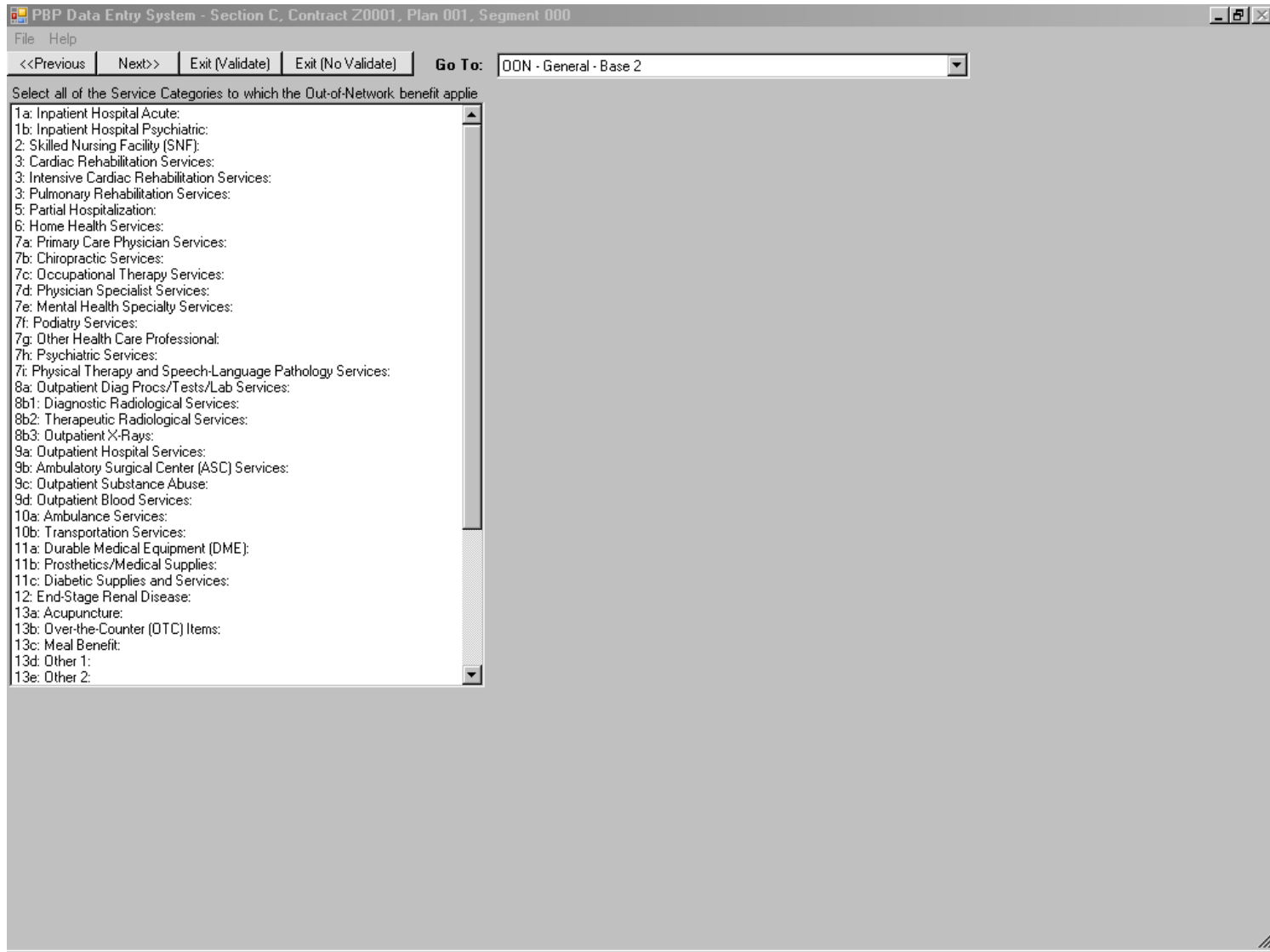
The Maximum Plan Benefit Coverage amount for Out-of-Network Non-Medicare-covered benefits should be entered in Section D.

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

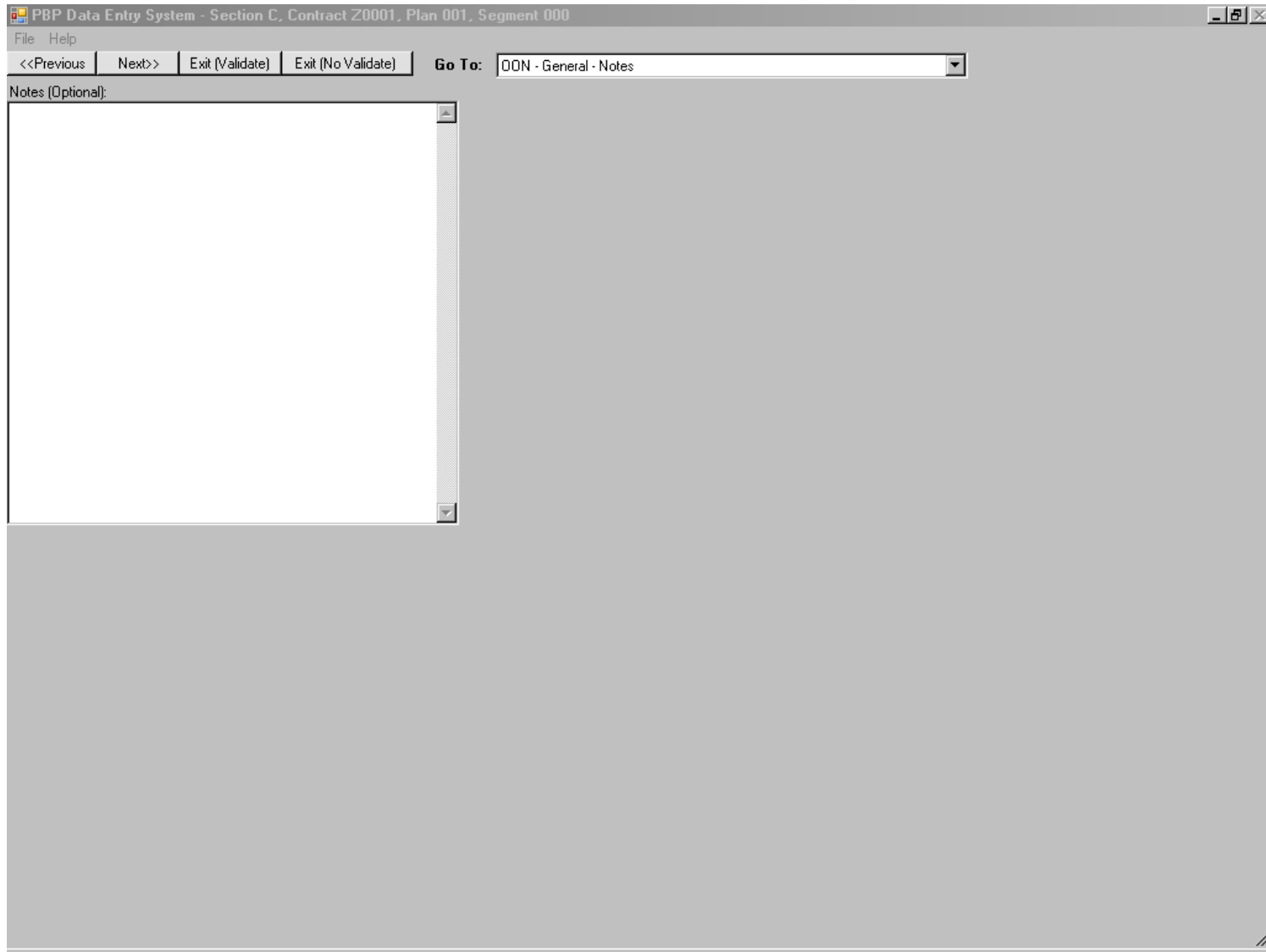
The Deductible for Out-of-Network benefits should be entered in Section D.

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

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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

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

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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:
<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 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

Section C- OON- Inpatient- Base 3 Screen

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

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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:

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

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 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:
<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"/>

Section C- OON- Inpatient- Base 4 Screen

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

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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:
<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 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

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

File Help

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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	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>



Section C- OON- SNF- Base 2 Screen

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

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<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: OON - SNF - Base 2

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- 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: OON - Number of Groups

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

Section C- OON-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: OON - Groups - Base 1

Enter Label for this Group (Optional):

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

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diag Procs/Tests/Lab Services:
- 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:
- 9d: Outpatient Blood Services:
- 10a: Ambulance Services:
- 10b: Transportation Services:
- 11a: Durable Medical Equipment (DME):
- 11b: Prosthetics/Medical Supplies:
- 11c: Diabetic Supplies and Services:
- 12: End-Stage Renal Disease:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:

Is there a maximum plan benefit coverage amount for this group?

Yes  
 No

Indicate maximum plan benefit coverage amount:

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 2012 Data Entry System Screens

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

File Help

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

Is there an OON Deductible for this group?  
 Yes  
 No

Enter Deductible Amount for this group:

Indicate whether a separate physician/professional service cost share applies:  
 Yes  
 No  
 Sometimes, describe

Is there an enrollee Coinsurance for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:

Indicate Maximum Coinsurance percentage for a separate physician/professional service:

Is there an enrollee Copayment for a separate physician/professional service?  
 Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:

Indicate Maximum Copayment amount for a separate physician/professional service:

Section C- POS-General - Base 1 Screen

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

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

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 Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diag Procs/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:
- 8b3: Outpatient X-Rays:
- 9a: Outpatient Hospital Services:
- 9b: Ambulatory Surgical Center (ASC) 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 Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 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 year  
 Every six months  
 Every three months

Section C- POS-General - Base 2 Screen

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

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

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 year  
 Every six months  
 Every three months

Is there a POS Deductible?

Yes  
 No

Enter Deductible Amount:

Section C- POS-General - Base 3 Screen

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

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<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - General - Base 3

Is Authorization required for POS?  
 Yes  
 No

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

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diag Procs/Tests/Lab Services:
- 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

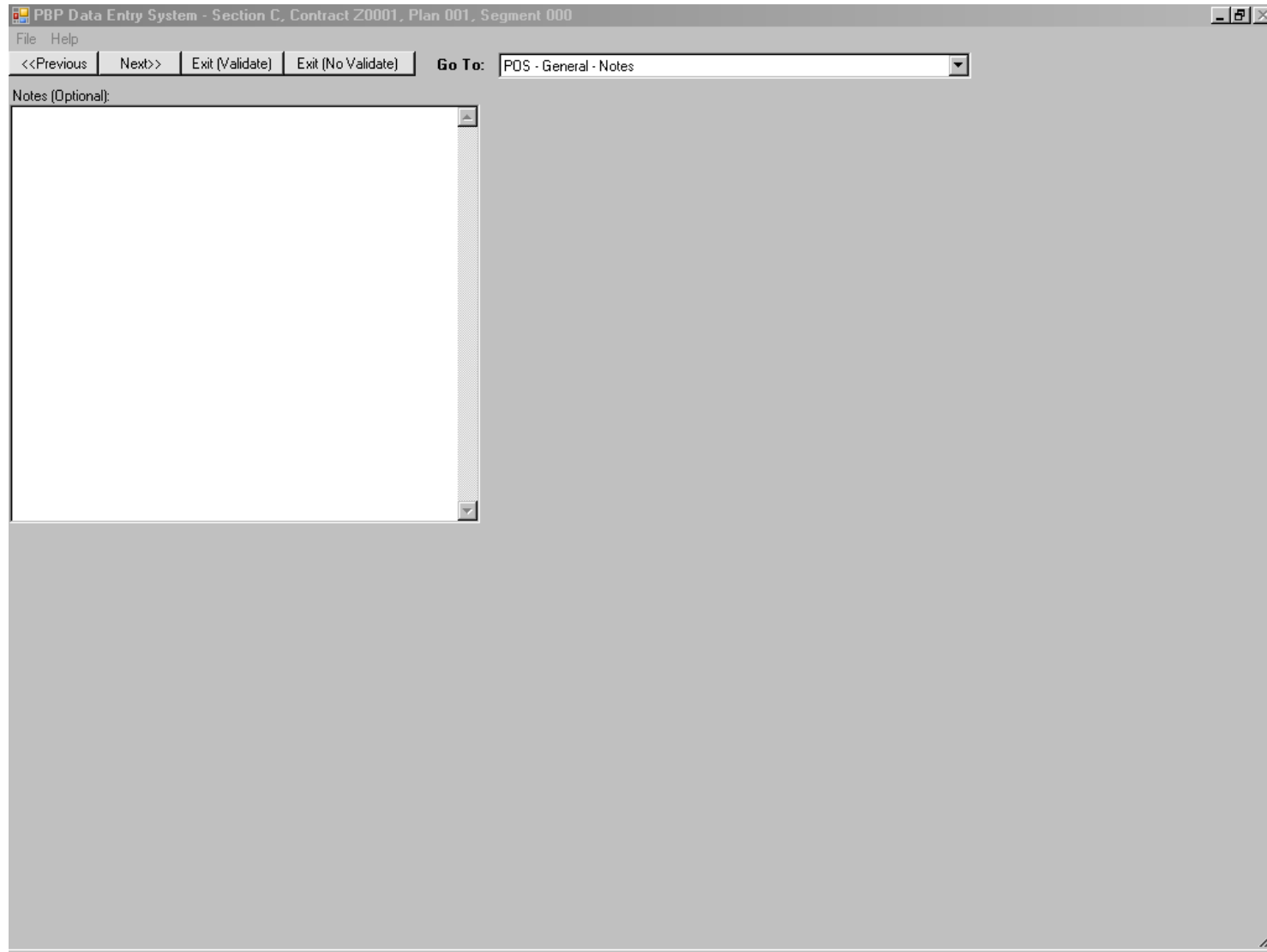
Is a referral required for POS?  
 Yes  
 No

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

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Hospital Psychiatric:
- 2: Skilled Nursing Facility (SNF):
- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diag Procs/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:
- 8b3: Outpatient X-Rays:
- 9a: Outpatient Hospital Services:



Section C- POS-General – Notes Screen



Section C- POS-Inpatient – Base 1 Screen

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

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Is there a POS Maximum Plan Benefit Coverage for Inpatient Hospital Services?

Yes  
 No

Select the Maximum Plan Benefit Coverage periodicity:

Every year  
 Every six months  
 Every three months

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:

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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	Begin Day Interval	End Day Interval
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Section C- POS-Inpatient – Base 3 Screen

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

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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):

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

Indicate Coinsurance percentage for POS Inpatient Psychiatric Hospital stay:

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

Indicate the number of day intervals for the POS 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- POS-Inpatient – Base 4 Screen

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

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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:
_____	_____	_____

Section C- POS-Inpatient – Base 5 Screen

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

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

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<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - SNF - Base 1

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:	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-SNF – Base 2 Screen



Section C- POS- Number of Groups Screen

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

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<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - Number of Groups

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

Section C- POS-Groups – Base 1 Screen

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

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Enter Label for this Group (Optional):

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

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Outpatient Diag Procs/Tests/Lab Services:
- 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:
- 9d: Outpatient Blood Services:
- 10a: Ambulance Services:
- 10b: Transportation Services:
- 11a: Durable Medical Equipment (DME):
- 11b: Prosthetics/Medical Supplies:
- 11c: Diabetic Supplies and Services:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:

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

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<<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 year  
 Every six months  
 Every three months

Is there a POS Deductible for this group?

Yes  
 No

Indicate Deductible amount for POS services:

Indicate whether a separate physician/professional service cost share applies:

Yes  
 No  
 Sometimes, describe

Is there an enrollee Coinsurance for a separate physician/professional service?

Yes  
 No

Indicate Minimum Coinsurance percentage for a separate physician/professional service:

Indicate Maximum Coinsurance percentage for a separate physician/professional service:

Is there an enrollee Copayment for a separate physician/professional service?

Yes  
 No

Indicate Minimum Copayment amount for a separate physician/professional service:

Indicate Maximum Copayment amount for a separate physician/professional service:

Section C- V/T-General – US 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

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer a US Visitor/Travel Program?

Yes  
 No

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

Mandatory  
 Optional

Notes (Optional):