

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

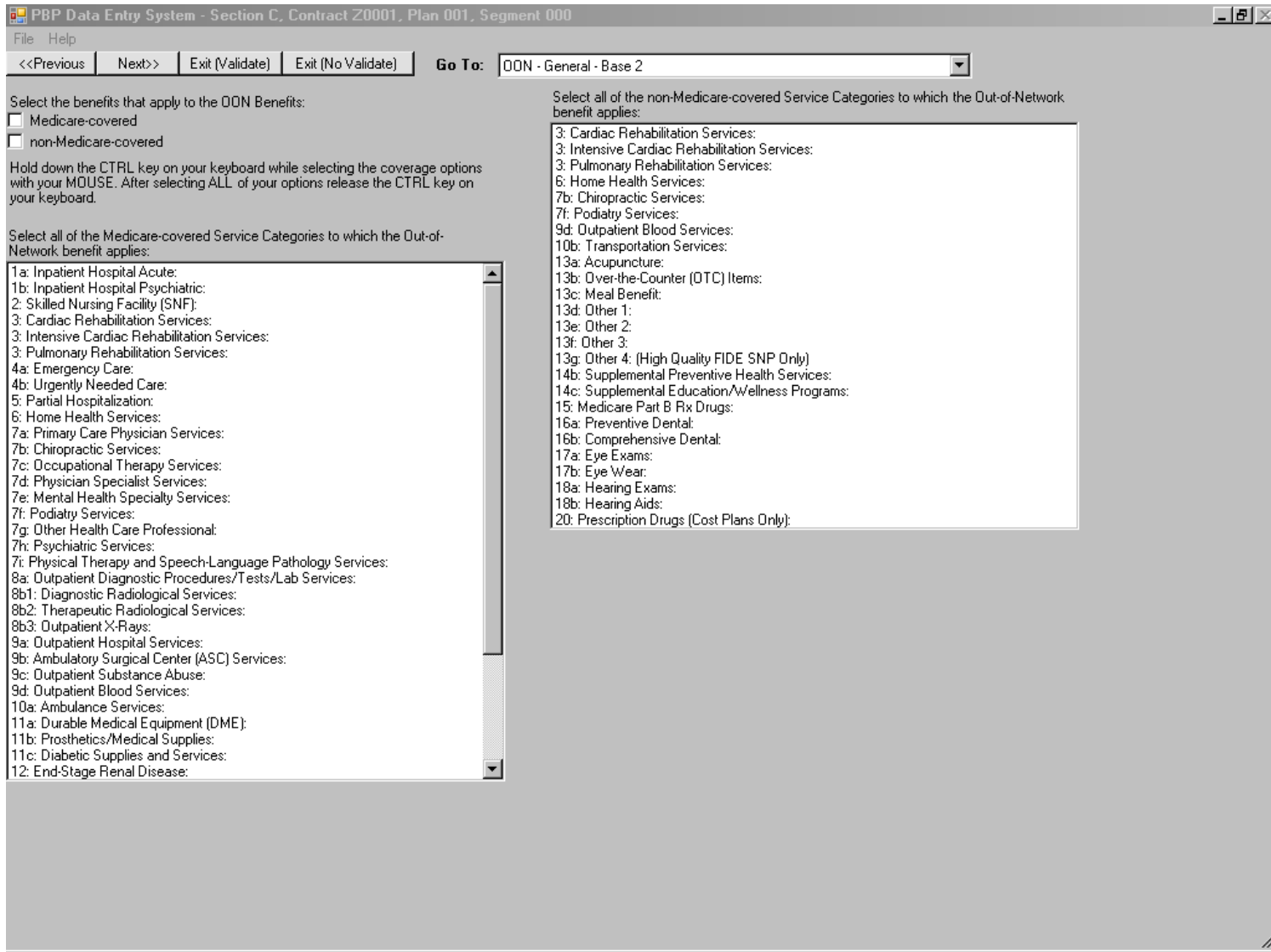
The Maximum Plan Benefit Coverage amount for Out-of-Network Non-Medicare-covered benefits should be entered in Section D.

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

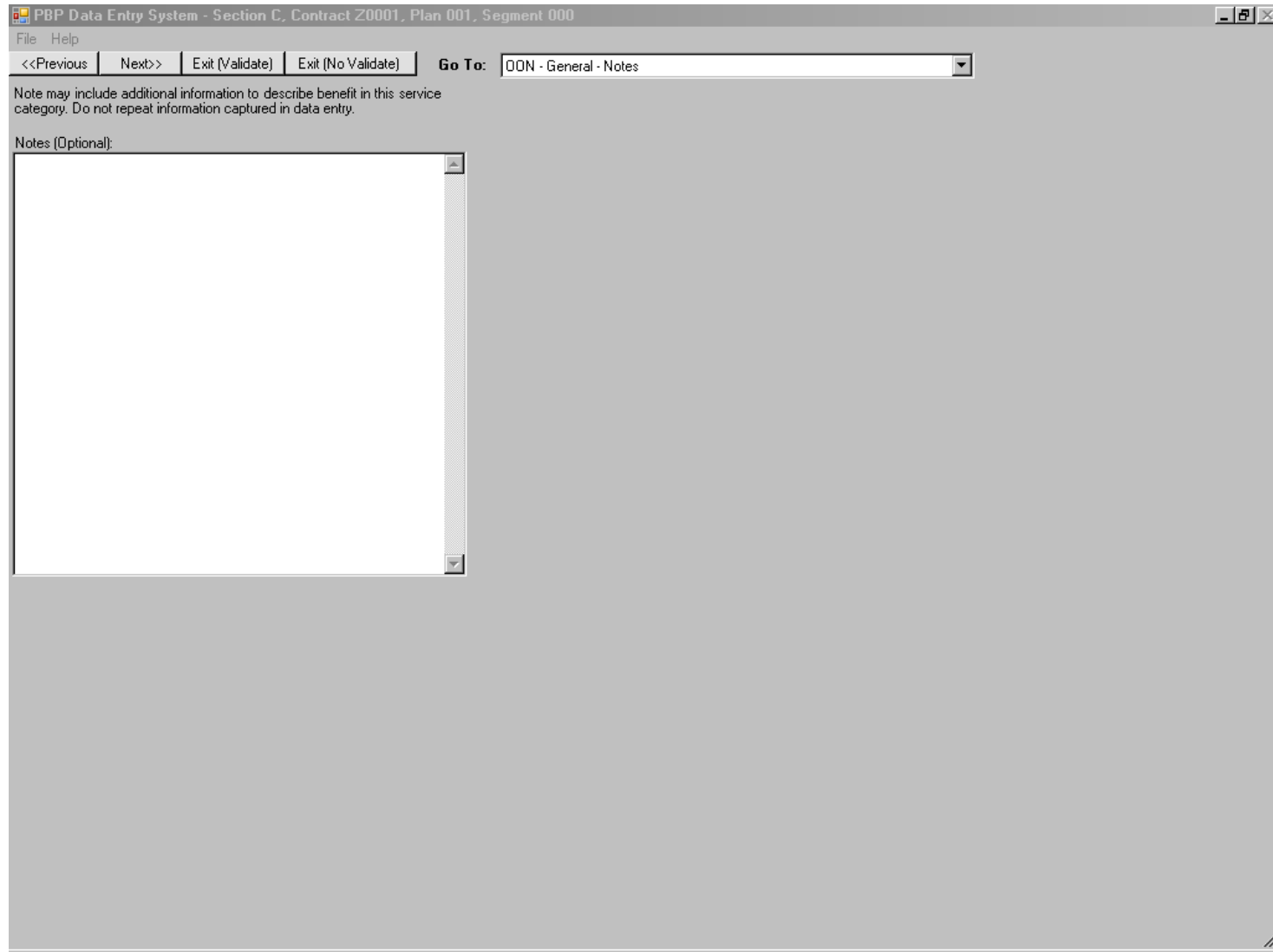
The Deductible for Out-of-Network benefits should be entered in Section D.

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

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 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:
[]

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

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- Skilled Nursing Facility- 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 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- Skilled Nursing Facility- 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:
[Text Input]

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

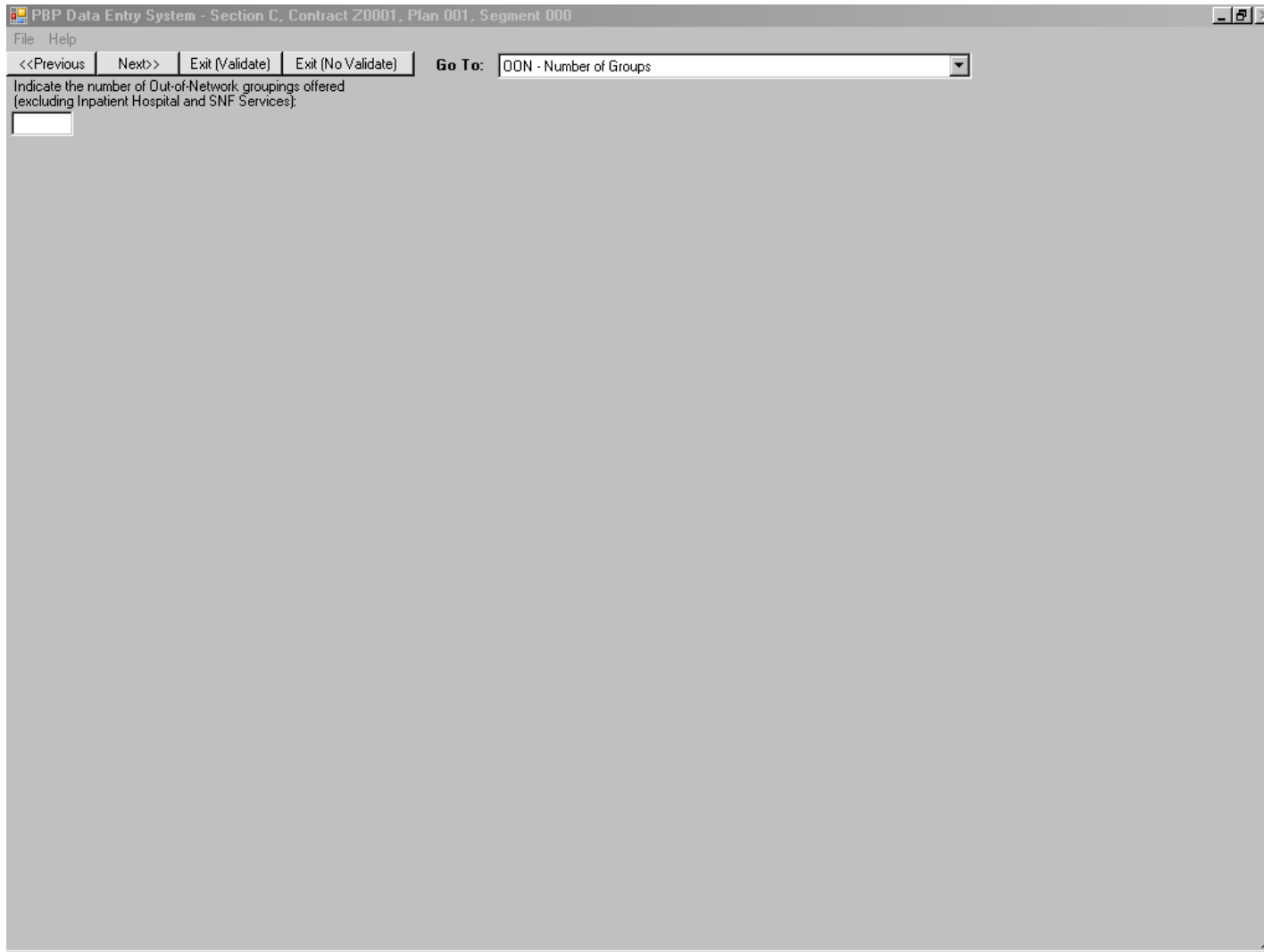
Indicate the copayment amount and day interval(s) for OON SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999):

Copayment Amt Interval	Begin Day Interval	End Day Interval
[Text Input]	[Text Input]	[Text Input]
[Text Input]	[Text Input]	[Text Input]
[Text Input]	[Text Input]	[Text Input]

Is there an OON Deductible for SNF Services?
 Yes
 No

Enter Deductible amount for SNF:
[Text Input]

Section C- OON- Number of Groups- Screen



Section C- OON- Groups- Base 1 Screen

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

File Help

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Enter Label for this Group (Optional):

Select the benefits that apply to the OON Groups:

Medicare-covered

non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

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

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4a: Emergency Care:
- 4b: Urgently Needed Care:
- 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 Diagnostic Procedures/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:

Select the non-Medicare-covered service categories included in the OON option for this Group:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 6: Home Health Services:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:
- 13f: Other 3:
- 13g: Other 4: (High Quality FIDE SNP Only)
- 14b: Supplemental Preventive Health Services:
- 14c: Supplemental Education/Wellness Programs:
- 15: Medicare Part B Rx Drugs:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:
- 20: Prescription Drugs (Cost Plans Only):

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

Yes

No

Indicate maximum plan benefit coverage amount:

Section C- OON- 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: OON - Groups - Base 2

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:
[]

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:
 Sometimes, describe
 No

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

File Help

<<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 the benefits that apply to the POS Benefit:

Medicare-covered
 non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Medicare-covered 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:
- 4a: Emergency Care:
- 4b: Urgently Needed Care:
- 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 Diagnostic Procedures/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:

Select all of the non-Medicare-covered Service Categories that describe the POS option:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 6: Home Health Services:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:
- 13f: Other 3:
- 13g: Other 4: (High Quality FIDE SNP Only)
- 14b: Supplemental Preventive Health Services:
- 14c: Supplemental Education/Wellness Programs:
- 15: Medicare Part B Rx Drugs:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:

Section C- POS- General- Base 2 Screen

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

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Is there a Maximum Plan Benefit Coverage amount for POS?

Yes
 No

Select the benefits that apply to the Maximum Plan Benefit Coverage Amount:

Medicare-covered
 non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Medicare-covered 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:
- 4a: Emergency Care:
- 4b: Urgently Needed Care:
- 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:

Select all of the non-Medicare-covered Service Categories that apply to the POS Maximum Plan Benefit Coverage:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 6: Home Health Services:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:
- 13f: Other 3:
- 13g: Other 4: (High Quality FIDE SNP Only)
- 14b: Supplemental Preventive Health Services:
- 14c: Supplemental Education/Wellness Programs:
- 15: Medicare Part B Rx Drugs:
- 16a: Preventive Dental:

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 3 Screen

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

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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:

Is there a POS Deductible?

Yes

No

Enter Deductible Amount:

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

Every three years

Every two years

Every year

Every six months

Every three months

Other, Describe

Section C- POS- General- Base 4 Screen

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

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Is Authorization required for POS?
 Yes
 No

Select the benefits that apply to the Authorization for POS:
 Medicare-covered
 non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Medicare-covered 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;
- 4a: Emergency Care;
- 4b: Urgently Needed Care;
- 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;
- 7i: Psychiatric Services;
- 7i: Physical Therapy and Speech-Language Pathology Services;
- 8a: Outpatient Diagnostic Procedures/Tests/Lab Services;
- 8b1: Diagnostic Radiological Services;
- 8b2: Therapeutic Radiological Services;

Select all of the non-Medicare-covered Service Categories that require Authorization for POS:

- 3: Cardiac Rehabilitation Services;
- 3: Intensive Cardiac Rehabilitation Services;
- 3: Pulmonary Rehabilitation Services;
- 6: Home Health Services;
- 7b: Chiropractic Services;
- 7f: Podiatry Services;
- 9d: Outpatient Blood Services;
- 10b: Transportation Services;
- 13a: Acupuncture;
- 13b: Over-the-Counter (OTC) Items;
- 13c: Meal Benefit;
- 13d: Other 1;
- 13e: Other 2;
- 13f: Other 3;
- 13g: Other 4: (High Quality FIDE SNP Only)
- 14b: Supplemental Preventive Health Services;
- 14c: Supplemental Education/Wellness Programs;
- 15: Medicare Part B Rx Drugs;
- 16a: Preventive Dental;
- 16b: Comprehensive Dental;
- 17a: Eye Exams;
- 17b: Eye Wear;
- 18a: Hearing Exams;
- 18b: Hearing Aids;
- 20: Prescription Drugs (Cost Plans Only);

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- Base 5 Screen

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

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Is a referral required for POS?

Yes
 No

Select the benefits that apply to the POS Referral:

Medicare-covered
 non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

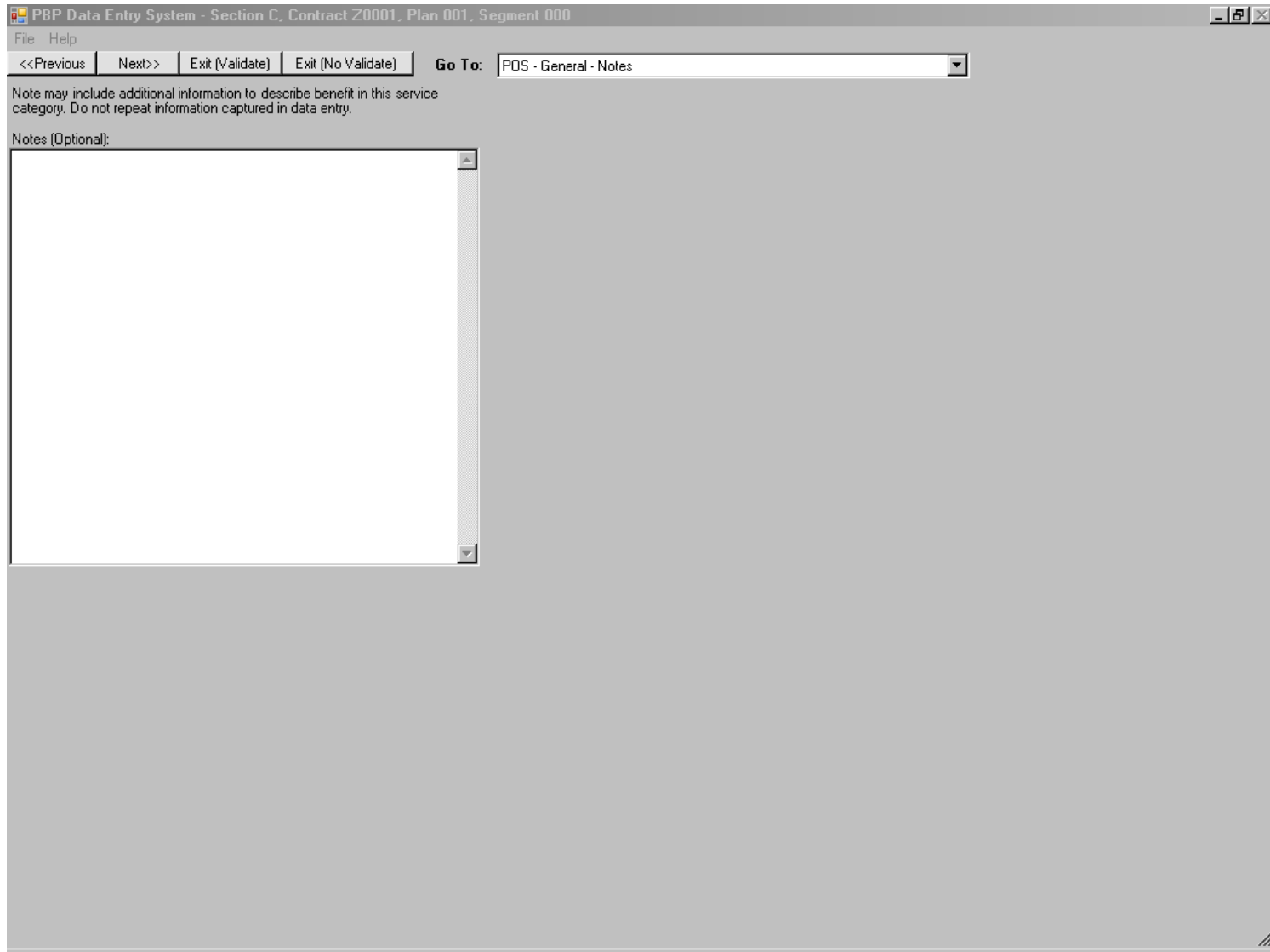
Select all of the Medicare-covered Service Categories that apply to the POS Referral:

- 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:
- 4a: Emergency Care:
- 4b: Urgently Needed Care:
- 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 Diagnostic Procedures/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:

Select all of the non-Medicare-covered Service Categories that apply to the POS Referral:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 6: Home Health Services:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture:
- 13b: Over-the-Counter (OTC) Items:
- 13c: Meal Benefit:
- 13d: Other 1:
- 13e: Other 2:
- 13f: Other 3:
- 13g: Other 4: (High Quality FIDE SNP Only)
- 14b: Supplemental Preventive Health Services:
- 14c: Supplemental Education/Wellness Programs:
- 15: Medicare Part B Rx Drugs:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:
- 20: Prescription Drugs (Cost Plans Only):

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

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

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

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

Zero (No Coinsurance per Day)
 One
 Two
 Three

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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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) Go To: POS - Inpatient - Base 5

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- Skilled Nursing Facility- 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: POS - SNF - Base 1

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

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

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- Skilled Nursing Facility- 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 - SNF - Base 2

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

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: 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:
[] [] []

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

Indicate Copayment amount per stay for POS SNF stay:
[]

Is there a POS Deductible for SNF Services?
 Yes
 No

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

Enter Deductible amount for SNF:
[]

Section C- POS- 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: 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

File Help

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

Enter Label for this Group (Optional):

Select the benefits that apply to the POS Benefits for this Group:

Medicare-covered

non-Medicare-covered

Hold down the CTRL key on your keyboard while selecting the coverage options with your MOUSE. After selecting ALL of your options release the CTRL key on your keyboard.

Select all of the Medicare-covered Service Categories that apply to the POS:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 4a: Emergency Care:
- 4b: Urgently Needed Care:
- 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 Diagnostic Procedures/Tests/Lab Services:
- 8b1: Diagnostic Radiological Services:
- 8b2: Therapeutic Radiological Services:
- 8b3: Outpatient X-Rays:
- 9a: Outpatient Hospital Services:

Select all of the non-Medicare-covered Service Categories that apply to the POS:

- 3: Cardiac Rehabilitation Services:
- 3: Intensive Cardiac Rehabilitation Services:
- 3: Pulmonary Rehabilitation Services:
- 6: Home Health Services:
- 7b: Chiropractic Services:
- 7f: Podiatry Services:
- 9d: Outpatient Blood Services:
- 10b: Transportation Services:
- 13a: Acupuncture:

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:

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

Sometimes, describe
 No

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- Visitor/Travel- 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

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

Notes (Optional):