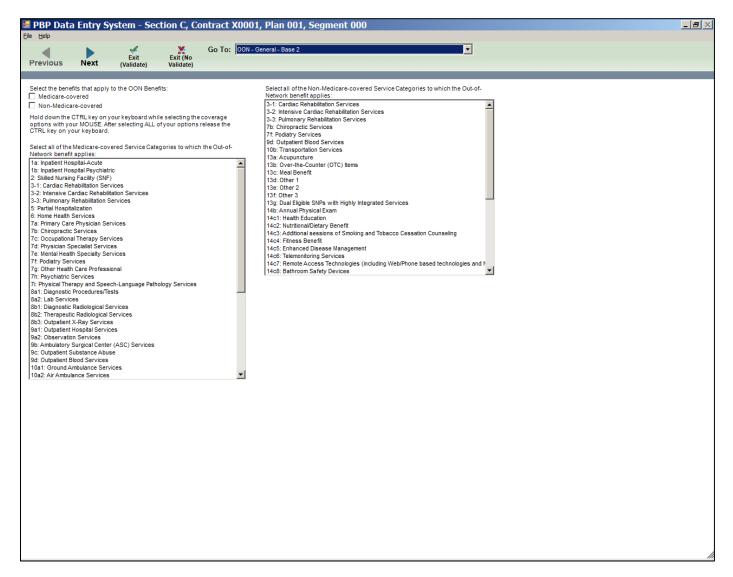
OON – General – Base 1

	a Entry Sy	/stem - Sec	ction C, Co	ntract X0001, Plan 0	001, Segment 000		_
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Do you offer ar	Out-of-Netwo	rk (OON) Benefit	?				
O Yes O No							
				3			
'he Maximum I Ion-Medicare-	Plan Benefit Co covered benef	overage amount f its should be ente	or Out-of-Networ ered in Section D	rk			
he Total Enro benefits should	llee Out-of-Poo be entered in	ket Cost Limit for Section D.	Out-of-Network				
he Deductible Section D.	for Out-of-Net	work benefits sho	ould be entered in	n			
NOTE: All Out- hould be ente Package descri	-of-Network Op red in the Secti iption screens.	tional Suppleme on D - Optional S	ntal Benefits Supplemental				

OON – General – Base 2



OON – General – Notes

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ote may includervice category	e additional informat . Do not repeat infor	ion to describ mation capture	e benefit in th ed in data er	nis try.		
otes:				<u>*</u>		
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PBP Data Entry System - Section C, Cont	tract X0001, Plan 001, Segment 000	_ 6
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revious Next (Validate) Validate)		
there an enrollee Coinsurance for OON Inpatient Hospital	Indicate the coinsurance percentage and day interval(s) for OON Inpatient	
rvices?	Hospital-Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):	
No	Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:	
ect the type of OON Inpatient Hospital Services Benefit with insurance: (1a) Inpatient Hospital-Acute (1b) Inpatient Psychiatric Hospital	Coinsurance % Interval 2: End Day Interval 2: End Day Interval 2:	
o you charge the Medicare-defined cost shares for Inpatient ospital-Acute Services? (These are the total charges for all rvices provided to the enrolle in the inpatient/facility.)	Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3:	
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ndicate Coinsurance percentagefor OON Inpatient Hospital- cute stay:		
dicate the number of day intervals for the OON Inpatient ospital-Acute stay:		
Zero (No Coinsurance per Day)		
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Vious Next Exit Exit Exit Or Dr: ONI- Inpatient - Base 2 rou charge the Medicare-defined cost shares for Inpatient childric Services? (These are the total charges for all charges for	BP Data Entry System - Section C, Cont	ntract X0001, Plan 001, Segment 000	E
WOUS Next (Validate) Volus Validate)		Go To: OON - Inpatient - Base 2	
childric Services? (These are the total charges for all ices provided to the enrollee in the inpatient facility.) Psychiatric Hospital stay (enter '999' if unlimited days are offered; e.g., 1 to 999): Yes Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1: No Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: Iticate Coinsurance percentage for OON Inpatient Psychiatric Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2: iticate the number of day intervals for the OON Inpatient chospital stay: Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3: Zero (No Coinsurance per Day) One No Max Andrea Max Andrea No No Max Andrea Max Andrea Max Andrea	evious Next (Validate) Validate)		
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licate the number of day intervals for the OON Inpatient chiatric Hospital stay: Zero (No Coinsurance per Day) One Two	dicate Coinsurance percentage for OON Inpatient Psychiatric ospital stay:	Coinsurance % Interval 2: End Day Interval 2: End Day Interval 2:	
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Institution Copayment: Cone (1s) Inpatient Hospital-Acute Cone Objour Charge the Medicare-defined cost shares for Inpatient Hospital-Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.) Indicate the copayment amount and day interval (s) for OON Inpatient Hospital-Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.) Indicate the copayment Amt Interval 1 End Day Interval 1: Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	O Yes O No	Indicate the number of day intervals for the OON Inpatient Hospital-Acute stay:	
(1b) Inpatient Psychiatric Hospital O Three Do you charge the Medicare-defined cost shares for inpatient Hospital-Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.) 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): O Yes Copayment Amt Interval 1 End Day Interval 1: Mo Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2: End Day Interval 2:	Select the type of OON Inpatient Hospital Services Benefit with Copayment: □ (1a) Inpatient Hospital-Acute	O One	
Dy Our lagge in tervices provided to bus shares information in patient Hospital-Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.) Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999): C Yes Copayment Amt Interval 1 End Day Interval 1: C Yes Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2: End Day Interval 2:	(1b) Inpatient Psychiatric Hospital	C Three	
in the inpatient facility.) Copayment Amt Interval 1 Begin Day Interval 1: Copayment Amt Interval 2 Begin Day Interval 2: Copayment Amt Interval 2: Copayment	Inpatient Hospital-Acute Services? (These are the	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 2 Begin Day Interval 2: End Day Interval 2:	in the inpatient facility.) C Yes	Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	
Copeyment Amt Interval 3 Begin Day Interval 3:	O No	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
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e <u>H</u> elp	4	X Exit (No	Go To: 🖸	ON - Inpatient - Base 4
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Do you charge the Medicare-def	ned cost shares for	r Innatient Dry	vehistric	Is there an OON Deductible for Inpatient Hospital Services?
Services? (These are the total cl enrollee in the inpatient facility.)	harges for all servic	es provided	to the	C Yes C No
O Yes O No				
Indicate Copayment amount fo	or OON Inpatient Ps	sychiatric Hos	spital:	Select the type of OON Inpatient Hospital Services benefit with a Deductible: Inpatient Hospital-Acute Inpatient Psychiatric Hospital
Indicate the number of day inter Hospital stay:	vals for the OON In	patient Psych	niatric	Combined for both Inpatient Hospital-Acute and Inpatient Psychiatric Hospital
C Zero (No Copayment per Do C One C Two	ay)			Enter Deductible amount for Inpatient Hospital-Acute:
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Hospital stay (enter '999' if unlin Copayment Amt Interval 1 Begi			999): Interval 1:	Enter Deductible amount for combined Inpatient Hospital-Acute and Inpatient PsychiatricHospital:
Copayment Amt Interval 2 Begi	n Day Interval 2:	End Day	Interval 2:	
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OON – SNF – Base 1

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ere an enrollee Coinsurance for OON SNF Services?	Indicate the coinsurance percentage and day interva '999' if unlimited days are offered; e.g., 1 to 999):	al(s) for OON SNF stay (enter	
lo	Coinsurance % Interval 1: Begin Day Interval 1:	End Day Interval 1:	
you charge the Medicare-defined cost shares? (These are the charges for all services provided to the enrollee in the SNF.)	Coinsurance % Interval 2: Begin Day Interval 2:	End Day Interval 2:	
Yes No			
	Coinsurance % Interval 3: Begin Day Interval 3:	End Day Interval 3:	
dicate Coinsurance percentage for OON SNF stay:			
licate the number of day intervals for the OON SNF stay:			
Zero (No Coinsurance per Day) One Two			
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OON – SNF – Base 2

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Is there an enrollee Copayment for OON SNF Services?	Indicate the copayment amount and day interval(s) for OON SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999):	
K⊘ NO	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 SNF.)	Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
C No	Copayment Amt Interval 3: End Day Interval 3:	
Indicate Copayment amount for OON SNF stay:		
Indicate the number of day intervals for the OON SNF stay:	Is there an OON Deductible for SNF Services? C Yes C No	
C Zero (No Copaymentper Day) C One C Two	Enter Deductible amount for SNF:	
C Three		

OON – Number of Groups

Indicate the number of Out-of-Network groupings offered (excluding inpatient Hospital and SNF Services):	<u></u>
Indicate the number of Out-of-Network groupings offered (excluding inpatientHospital and SNF Services):	

OON – Groups – Base 1

Previous Next (Validate) Go To: Validate) Go To: Go To: Validate)		
inter Label for this Group (Optional):	Select the Non-Medicare-covered service adegories included in the OON option for this Group: S-1: Cardiac Rehabilitation Services S-3: Putimonary Rehabilitation Services Tr: Chirppractic Services Tr: Chirppractic Services Gr: Chirppractic Services Tr: Chirprect Tr: Services	

OON – Groups – Base 2

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vious	Next	Exit (Validate)	Exit (No Validate)		_	_	_	_	
ere an OON Yes	Coinsurance	for this Group?							
No									
nter Minimun	n Coinsurance	e Percentage for ti	his Group:						
nter Maximur	n Coinsuranc	e Percentage for t	his Group:						
	Copayment	orthis Group?							
Yes No									
Enter Minimu	m Copaymen	t Amount for this	Group:						
Enter Maxim	um Copaymer	nt Amount for this	Group:						
Yes	N Deductible	for this group?							
No									
nter Deduct	ible Amount fo	or this group:							

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Help	To: POS - General - Base 1
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CLICK FOR DESCRIPTION OF BENEFIT	Select all of the Non-Medicare-covered Service Categories that describe the POS option: 3-1: Cardiac Rehabilitation Services
o you offer a Point-of-Service (POS) option?	3-1: Lardiac Kenabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Putmonary Rehabilitation Services
No	6: Home Health Services 7b: Chiropractic Services
elect type of benefit for the POS option:	7C: Occupational Therapy Services 77: Podatry Services
) Mandatory) Optional	7/c Physical Therapy and Speech-Language Pathology Services 9d: Outpatient Blood Services
Population Population	10b: Transportation Services 11a: Durable Medical Equipment (DME) 11b: Prosthetics/Medical Supples 13a: Acupancture 13b: Over-the-Counter (OTC) items 13b: Other 1 13b: Other 2 13b: Other 2 13b: Other 3 13b: Dual Eligible SNPs with Highly Integrated Services 13b: Addinand Services 14b: Annual Physical Exam 14c:1: Health Education ▼

PBP Data Entry System - Section C, Contract X	(0001, Plan 001, Segment 000
e Help	POS - General - Base 2
Previous Next (Validate) Go To:	PUS - General - Base 2
(Valuate) Valuate)	
s there a Maximum Plan Benefit Coverage amount for POS?	Select all of the Non-Medicare-covered Service Categories that apply to the POS Maximum Plan Benefit Coverage:
O Yes O No	3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services
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: Ta: Inpatient Hospital Psychiatric 2: Skiled Nursing Facility (SNF) 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 7: Chropractic Services 7: Chropractic Services 7: Chropracting Nervices 74: Physician Specialist Services 74: Physician Specialist Services	3-3: Pulmonary Rehabilitation Services 6: Home Heath Services 7b: Chiropractic Services 7c: Postarty Services 77: Physical Therapy and Speech-Language Pathology Services 96: Outpatient Blood Services 10b: Transportation Services 11b: Urable Medical Equipment (DME) 11b: Prosthetics/Medical Supples 13a: Acugunoture 13b: Over-the-Counter (OTC) Items 13c: Meal Benefit 13e: Other 3 Indicate Maximum Plan Benefit Coverage amount: Select the Maximum Plan Benefit Coverage periodicity: C Every three years
7e: Mental Health Specialty Services 7f: Podiatry Services 7g: Other Health Care Professional	O Every two years O Every year
h: Psychiatric Services 7i: Physical Therapy and Speech-Language Pathology Services 8a1: Diagnostic Procedures/Tests	C Every six months C Every three months C Other, Describe

lelp		
Exit Exit (No	To: POS - General - Base 3	
vious Next (Validate) Validate)		
re a POS Maximum Enrollee Out-of-Pocket Cost amount?		
es	Is there a POS Deductible?	
10	C. Yes	
	C No	
cate POS Maximum Enrollee Out-of-Pocket Cost:	Enter Deductible Amount:	
ect the Maximum Enrollee Out-of-Pocket Cost periodicity:		
Every three years		
Every two years		
Every year		
Every six months		
Every three months Other, Describe		
ourer, Describe		

PBP Data Entry System - Section C, Contract X00	01, Plan 001, Segment 000
ile <u>H</u> elp	
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Previous Next (Validate) Validate)	
Is Authorization required for POS?	Selectall of the Non-Medicare-covered Service Categories that require prior
C Yes C No	Authorization for POS: 3-1: Cardiac Rehabilitation Services
Select the benefits that apply to the Authorization for POS: Medicare-covered Hold acre-covered Hold acre-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 prior Authorization for POS: 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital-Acute 1c: Cocupational Therapy Services 7b: Chorpatical Therapy Services 7c: Occupatient Care Professional 7b: Physical Therapy Services 1c: Diagnostic Procedures/TestsLab Services 8b: Diagnostic Radiological Services 1b: Dispital Radiological Services 1c: Derive Radiological Services 1c: Derive Radiological Services 1c: Dispital-Radiological Services 1c: Dispital-Radiolo	 Lebrance Cardias Distabilistica Services 33. Pulnomay Rehabilistica Services 15. Chargendas Services 17. Polyskal Therisy and Speech-Language Pathobyy Services 17. Polyskal Therisy and Speech-Language Pathobyy Services 18. Portabilistica Services 19. Portabilistica Services <

BP Data Entry System - Section C, Contract X000	01, Plan 001, Segment 000	
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evious Next (Validate) Go To: POS	- General - Dase 5	
(Vanuale) Vanuale)		
referral required for POS?	Select all of the Non-Medicare-covered Service Categories that apply to the POS Referral:	
Yes No Select the benefits that apply to the POS Referral: Medicare-covered Non-Medicare-covered	3-1: Cardiac Rehabilitation Services ▲ 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 6: Home Health Services 7b: Chiropractic Services	
lold down the CTRL key on your keyboard while selecting the coverage ptions with your MOUSE. After selecting ALL of your options release the TRL key on your keyboard.	7c: Occupational Therapy Services 7f: Podiatry Services 7i: Physical Therapy and Speech-Language Pathology Services 9d: Outpatient Blood Services 10b: Transportation Services	
elect all of the Medicare-covered Service Categories that apply to the POS eferral:	11a: Durable Medical Equipment (DME) 11b: Prosthetics/Medical Supplies	
a: Inpatient Hospital-Acute b: Inpatient Hospital Psychiatric 1: Skilled Nursing Facility (SNF) -1: Cardiac Rehabilitation Services -2: Intensive Cardiac Rehabilitation Services	13a: Acupuncture 13b: Over-the-Counter (OTC) Items 13c: Meal Benefit 13d: Other 1 13e: Other 2	
-3: Pulmonary Rehabilitation Services -3: Partial Hospitalization -3: Home Health Services -4: Primary Care Physician Services -5: Chiropractic Services	13f: Other 3 13g: Dual Eligible SNPs with Highly Integrated Services 13h: Additional Services 14b: Annual Physical Exam 14c: Eligible Supplemental Benefits as Defined in Chapter 4	
c: Occupational Therapy Services d: Physician Specialist Services e: Mental Heath Specialty Services f: Podiatry Services (f: Other Heath Care Professional	15: Medicare Part B Rx Drugs	
In Psychiatric Services i: Physical Therapy and Speech-Language Pathology Services a: Diagnostic Procedures/Tests/Lab Services b1: Diagnostic Radiological Services L2: Therapeutic Radiological Services		
bb3: Outpatient X-Ray Services		

PBP Data Entry System	- Section C, Contract	X0001, Plan 001, Segment 000	6
	Go To:	POS - General - Base 6	
Previous Next (Valida	ate) Validate)		
Does this POS benefit service the Unite erritories? If no please briefly describe	ed States and its geographic limitations in	Does this POS benefit include all practitioners who are state-licensed or state-certified and eligible to be paid by Medicareto furnish the	
erritories? If no, please briefly describe he following area. ○ Yes	33	or state-certified and eligible to be paid by Medicare to furnish the services? C Yes	
) No		C No	
ote may include additional information stegory. Do not repeat information cap	to describe benefit in this service otured in data entry.		
otes:			
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PBP Data Entry System - Section C, Contract	X0001, Plan 001, Segment 000	
	POS - Inpatient - Base 1	
vious Next (Validate) Exit Exit (No (Validate) Validate)		
nere a POS Maximum Plan Benefit Coverage for Inpatient Hospital vices?	Select the Maximum Plan Benefit Coverage periodicity:	
Yes	C Every three years C Every two years	
No	C Every wor years	
elect the type of POS Inpatient Hospital Services benefit with a aximum Plan Benefit Coverage: Inpatient Hospital-Acute Inpatient Psychiatric Hospital Combined for both Inpatient Hospital-Acute and Inpatient Psychiatric Hospital	C Every six months C Every three months C Other, Describe	
Psychiatric Hospital		
Enter Maximum Plan Benefit Coverage amount for Inpatient Hospital-Acute:		
Enter Maximum Plan Benefit Coverage amount for Inpatient Sychiatric Hospital:		
nter Maximum Dian Ronalit Coursess amount for accelerat		
nter Maximum Plan Benefit Coverage amount for combined npatient Hospital-Acute and Inpatient Psychiatric Hospital:		

Help Belp Belp	a Entry S	ystem - Se	ction C, Co	ontract	X0001, Plan 001, Segment 000	_ _ _ ×
		X Exit	Exit (No	Go To:	POS - Inpatient - Base 2	
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Is there an enro	ollee Coinsura	nce for POS Inpat	tient Hospital Se	vice	Indicate the coinsurance percentage and day interval(s) for POS Inpatient	
C Yes C No					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:	
	e of POS Inpa	tient Hospital Ser	vices Benefitwit	h		
☐ (1a) Inpati ☐ (1b) Inpati	ent Hospital-A				Coinsurance % Interval 2: End Day Interval 2: End Day Interval 2:	
Hospital-Acu	te Services? (e-defined cost sh These are the to rollee in the inpa	tal charges for a	it I	Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:	
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tious Next Exit (No Validate) Go To Validate) Go To Validate) Control of the Medicare-defined cost shares for Inpatient natric Services? (These are the total charges for all services ded to the enrollee in the inpatient facility.)	O: POS - Inpatient - Base 3 Indicate the coinsurance p Psychiatric Hospital stay (e Coinsurance % Interval 1:	ercentage and day interval enter '999' if unlimited days		
VIOUS NEXT (Validate) Validate) bucharge the Medicare-defined cost shares for Inpatient hiatric Services? (These are the total charges for all services ded to the enrollee in the inpatient facility.) es	Psychiatric Hospital stay (e	ercentage and day interval enter '999' if unlimited days		
niatric Services? (These are the total charges for all services ded to the enrollee in the inpatient facility.)	Psychiatric Hospital stay (e	ercentage and day interval enter '999' if unlimited days		
es	Coinsurance % Interval 1:		(s) for POS Inpatient are offered; e.g., 1 to 999)	
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cate Coinsurance percentage for POS Inpatient Psychiatric pital stay:	Coinsurance % Interval 2:	Begin Day Interval 2:	End Day Interval 2:	
cate the number of day intervals for the POS Inpatient	Coinsurance % Interval 3:	Begin Day Interval 3:	End Day Interval 3:	
chiatric Hospital stay: Zero (No Coinsurance per Day)				
One Two Three				

Go To: POS - Inpatient - Base 4	PBP Data Entry System - Section C, Contrac	ct X0001, Plan 001, Segment 000
evicus Next (Validate) Ves indicate Copayment for POS Inpatient Hospital Services? indicate Copayment amount per stay for POS Inpatient Hospital-Acute stay: Yes indicate the number of day intervals for the POS Inpatient Hospital-Acute stay: No indicate the number of day intervals for the POS Inpatient Hospital-Acute stay: Indicate the number of day intervals for the POS Inpatient Hospital-Acute stay: Opayment: Carro (No Copayment per Day) One One Two Indicate the copayment amount and day interval(s) for POS inpatient Hospital-Acute stay: Do you charge the Medicare-defined cost shares for Inpatient Hospital-Acute stry (enter 1999 if unlimited days are offered; e.g., 1 to 999): Cyes Copayment Amt Interval 1: Begin Day Interval 2: Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:		Fo: POS - Inpatient - Base 4
Yes Indicate the number of day intervals for the POS Inpatient Hospital-Acute stay: Participatient Hospital Services Benefit with opsymmet. C Zero (No Copayment per Day) (1a) Inpatient Hospital-Acute C Intree Do you charge the Medicare-defined cost shares for Inpatient Hospital-Acute Services? (These are the total charges for all services provided to the enrollee in the inpatientfacility.) 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): C Yes Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1: Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	evious Next (Validate) Validate)	
Yes Indicate the number of day intervals for the POS Inpatient Hospital-Acute stay: Ject the type of POS Inpatient Hospital Services Benefit with payament. C Zero (No Copayment per Day) (1a) Inpatient Hospital-Acute O ne (1b) Inpatient Psychiatric Hospital C Two Do you charge the Medicare-defined cost shares for Inpatient Hospital-Acute Services? (These are the total charges for all revelses provided to the enrollee in the inpatientfacility.) 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): C yes Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1: Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:		
No Indicate the number of day intervals for the POS Inpatient Hospital-Acute stay: elect the type of POS Inpatient Hospital Services Benefit with opayment. Carro (No Copayment per Day) (1a) Inpatient Hospital-Acute Cone (1b) Inpatient Psychiatric Hospital Three Do you charge the Medicare-defined cost shares for Inpatient Hospital-Acute Services? (These are the total charges for all services provided to the enrollee in the inpatientfacility.) 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): C Yes Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1: End Day Interval 1: End Day Interval 2: End Da		Indicate Copayment amount per stay for POS Inpatient Hospital-Acute stay:
elect the type of POS Inpatient Hospital Services Benefit with payment: C Zero (No Copayment per Day) (1a) Inpatient Hospital-Acute O ne (1b) Inpatient Psychiatric Hospital Three Do you charge the Medicare-defined cost shares for Inpatient Hospital-Acute Services? (These are the total charges for all ervices provided to the enrollee in the inpatientfacility.) Indicate the copayment amount and day interval(s) for POS Inpatient Hospital-Acute stay (enter '99') if unlimited days are offered; e.g., 1 to 999): C Yes Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1: End Day Interval 2: End Day Interval 2: End Day Interval 2:	No	
opsyment: C One (1a) Inpatient Hospital-Acute C Two (1b) Inpatient Psychiatric Hospital C Three Do you charge the Medicare-defined cost shares for Inpatient tospital-Acute Services? (These are the total charges for all nervices provided to the enrollee in the inpatient facility.) Indicate the copayment amount and day interval(s) for POS Inpatient Hospital- Acute stay (enter '99' if unlimited days are offered; e.g., 1 to 999): C Yes Copayment Amt Interval 1: Begin Day Interval 1: C No End Day Interval 2: End Day Interval 2: Copayment Amt Interval 2: Begin Day Interval 2: Copayment Amt Interval 2: End Day Interval 2: End Day Interval 2:	elect the type of POS Innatiant Hospital Services Benefitwith	
(1b) Inpatient Psychiatric Hospital Three Do you charge the Medicare-defined cost shares for Inpatient tospital-Acute Services? (These are the total charges for all locates the copayment amount and day interval(s) for POS Inpatient Hospital-Acute Services? (These are the total charges for all acute stay (enter '99' if unlimited days are offered; e.g., 1 to 999): C Yes	opayment:	O One
cervices provided to the enrollee in the inpatient facility.) Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1: End Day Interval 1: Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2: En		
cervices provided to the enrollee in the inpatient facility.) Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1: End Day Interval 1: Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2: En		
C Yes Copayment Amt Interval 1: Begin Day Interval 1: End Day Interval 1: End Day Interval 1: Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 2:	lo you charge the Medicare-defined cost shares for inpatient lospital-Acute Services? (These are the total charges for all	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):
C No Copayment Amt Interval 2: End Day Interval 2: End Day Interval 2:		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 Antt Interval 3: Englin Day Interval 3: End Day Interval 3:		
		Consument Amt Interval 3: Banin Dav Interval 3: End Dav Interval 3:

PBP Data Entry System - Section C, Contract X000	01, Plan 001, Segment 000
Elle Help	Impatient - Base 5
Exit Exit (No	Impatient - Base 5
Previous Next (Validate) Validate)	
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.) C Yes C No	Is there a POS Deductible for Inpatient Hospital Services?
Indicate Copayment amount per stay for POS Inpatient Psychiatric Hospital:	Select the type of POS Inpatient Hospital Services benefit with a Deductible: Inpatient Aspital-Acute Inpatient Psychiatric Hospital Combined for both Inpatient Hospital-Acute and Inpatient Psychiatric Hospital
C Zero (No Copayment per Day) C One C Two C Three	Enter Deductible amount for Inpatient Hospital-Acute:
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):	Enter Deductible amount for Inpatient Psychiatric Hospital:
Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	Enter Deductible amount for combined Inpatient Hospital-Acute and Inpatient Psychiatric Hospital:
Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 2:	
Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3:	

POS – SNF – Base 1

PBP Data Entry System - Section C, Contra Help	act X0001, Plan 001, Segment 000	
Ga	To: POS-SNF-Base 1	
Previous Next (Validate) Validate)		
Is there an enrollee Coinsurance for POS SNF Services?	Indicate the coinsurance percentage and day Interval(s) for POS SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999):	
C No Do you charge the Medicare-defined cost shares? (These are the	Coinsurance % Interval 1: Begin Day Interval 1:	
C Yes C No	Coinsurance % Interval 2: End Day Interval 2: End Day Interval 2:	
C No	Coinsurance % Interval 3: End Day Interval 3: End Day Interval 3:	
Indicate Coinsurance percentage for POS SNF stay:		
Indicate the number of day intervals for the POS SNF stay:		
C Zero (No Coinsurance per Day) C One		
C Two C Three		

POS – SNF – Base 2

BP Data Entry System - Secti Help	ion C, Contr	act X0001, Plan 001, Segment 000	6
evious Next (Validate)	Go Exit (No Validate)	D TO: POS - SNF - Base 2	
ere an enrollee Copayment for POS SNF Ser /es	vices?	Indicate the copayment amount and day interval(s) for POS SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999):	
lo		Copayment Amt Interval 1 Begin Day Interval 1: End Day Interval 1:	
ou charge the Medicare-defined cost shares? e total charges for all services provided to the inpatient facility.)	? (These he enrollee	Copayment Amt Interval 2: End Day Interval 2:	
es 0		Copayment Amt Interval 3: End Day Interval 3:	
cate Copayment amount per stay for POS SN	NF stay:	Is there a POS Deductible for SNF Services?	
cate the number of day intervals for the POS Zero (No Copayment per Day)	SSNF stay:	C Yes C No	
One Two Three		Enter Deductible amount for SNF:	
	0	,	

POS – Number of Groups

BPBP Data	a Entry Sy	stem - Sec	tion C, Co	ontract X0001, Plan 001, Segment 000	_ 8 ×
•	•	Exit	Exit (No Validate)	Go To: POS - Number of Groups	
Previous	Next	(Validate)	Validate)		
Indicate the nu groupings offe	mber of Point o red (excluding I	fService npatientHospital			
Services and S	NF Services):				

POS – Groups – Base 1

POS – Groups – Base 2

PBP Data Entry System - Section C, Contract . Help	X0001, Plan 001, Segment 000
Go To:	POS - Groups - Base 2
evious Next (Validate) Validate)	
here a POS Maximum Plan Benefit Coverage amount for this group? Yes	
Yes No	
dicate Maximum Plan Benefit Coverage amount:	
elect the Maximum Plan Benefit Coverage periodicity:	
Every three years Every two years	
Every year	
C Every six months	
C Every three months O Other, Describe	
here a POS Deductible for this group?	
Yes	
No	

V/T – General – US

Image: Next Image: Next	PBP Data Entry System - Section C, Contra	act X0001, Plan 001, Segment 000	
CLICK FOR DESCRIPTION OF BENEFIT vyou offer a US Visitor/Travel Program? The V/T benefit must furnish all plan-covered services in its designated V/T service area(s), including all Medicare Parts A and B services and all mandatory and optional supplemental benefits, at in-network cost -sharing levels, consistent with Medicare access and availability requirements at 42 CFR §422.112 elect type of benefit for the US Visitor/Travel program: Select geographic area: C In the United States and its territories	Exit Exit (No	To: V/T - General - US	
you offer a US Visitor/Travel Program? The V/T benefit must furnish all plan-covered services in its designated V/T service area(s), including all Medicare Parts A and B services and all mandatory and optional supplemental benefits, at in-network cost -sharing levels, consistent with Medicare access and availability requirements at 42 CFR §422.112 No Select geographic area: C Instactory C In the United States and its territories	Previous Next (Validate) Validate)		_
Yes Medicare Parts A and B services and all mandatory and optional supplemental benefits, at in-network cost -sharing levels, consistent with Medicare access and availability requirements at 42 CFR §422.112 No select type of benefit for the US Visitor/Travel program: Select geographic area: C In the United States and its territories	CLICK FOR DESCRIPTION OF BENEFIT		
elect type of benefit for the US Visitor/Travel program: Select geographic area: Mandatory	Do you offer a US Visitor/Travel Program? C: Yes C: No	The V/T benefit must furnish all plan-covered services in its designated V/T service area(s), including all Medicare Parts A and B services and all mandatory and optional supplemental benefits, at in-network cost -sharing levels, consistent with Medicare access and availability requirements at 42 CFR §422.112	
C Optional	Select type of benefit for the US Visitor/Travel program:	Select geographic area:	
	C Mandatory C Optional		