OON – General – Base 1

OON – General – Base 2

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)

Go To: OON - General - Base 2

Select the benefits that apply to the OON Benefits:
☐ 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 to which the Out-of-Network benefit applies:

1a: Inpatient Hospital-Acute
1b: Inpatient Hospital Psychiatric
2: Skilled Nursing Facility (SNF)
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: 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
8a1: Diagnostic Procedures/Tests
8a2: Lab Services
8b1: Diagnostic Radiological Services
8b2: Therapeutic Radiological Services
8b3: Outpatient X-Ray Services
9a1: Outpatient Hospital Services
9a2: Observation Services
9b: Ambulatory Surgical Center (ASC) Services
9c: Outpatient Substance Abuse
9d: Outpatient Blood Services
10a1: Ground Ambulance Services
10a2: Air Ambulance Services

Select all of the Non-Medicare-covered Service Categories to which the Out-of-Network benefit applies:

3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: Pulmonary Rehabilitation 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: Dual Eligible SNPs with Highly Integrated Services
14b: Annual Physical Exam
14c1: Health Education
14c2: Nutritional/Dietary Benefit
14c3: Additional sessions of Smoking and Tobacco Cessation Counseling
14c4: Fitness Benefit
14c5: Enhanced Disease Management
14c6: Telemonitoring Services
14c7: Remote Access Technologies (including Web/Phone based technologies and M
14c8: Bathroom Safety Devices

OON – General – Notes

OON – Inpatient – Base 1

OON – Inpatient – Base 2

OON – Inpatient – Base 3

```
PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000          _ 8 x
File  Help

   ◄         ►         ✔           ✘        Go To:  OON - Inpatient - Base 3          ▼
Previous    Next      Exit       Exit (No
                    (Validate)   Validate)
```

Is there an enrollee Copayment for OON Inpatient Hospital Services?

- ○ Yes
- ○ No

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

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

- ○ Yes
- ○ No

Indicate Copayment amount for OON Inpatient Hospital-Acute stay:

[   ]

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

- ○ Zero (No Copayment per Day)
- ○ One
- ○ Two
- ○ Three

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

Copayment Amt Interval 1   Begin Day Interval 1:   End Day Interval 1:
[   ]   [   ]   [   ]

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

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

OON – Inpatient – Base 4

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: OON - Inpatient - Base 4

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 for OON Inpatient Psychiatric Hospital:
[   ]

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

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

Copayment Amt Interval 1   Begin Day Interval 1:   End Day Interval 1:
[   ]   [   ]   [   ]

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

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

Is there an OON Deductible for Inpatient Hospital Services?
○ Yes
○ No

Select the type of OON Inpatient Hospital Services benefit with a Deductible:
☐ Inpatient Hospital-Acute
☐ Inpatient Psychiatric Hospital
☐ Combined for both Inpatient Hospital-Acute and Inpatient Psychiatric Hospital

Enter Deductible amount for Inpatient Hospital-Acute:
[   ]

Enter Deductible amount for Inpatient Psychiatric Hospital:
[   ]

Enter Deductible amount for combined Inpatient Hospital-Acute and Inpatient Psychiatric Hospital:
[   ]

OON – SNF – Base 1

OON – SNF – Base 2

OON – Number of Groups

OON – Groups – Base 1

PBP Data Entry System - Section C, Contract X0001, 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 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:

3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: 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
8a1: Diagnostic Procedures/Tests
8a2: Lab Services
8b1: Diagnostic Radiological Services
8b2: Therapeutic Radiological Services
8b3: Outpatient X-Ray Services
9a1: Outpatient Hospital Services
9a2: Observation Services
9b: Ambulatory Surgical Center (ASC) Services
9c: Outpatient Substance Abuse

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

3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: Pulmonary Rehabilitation 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: Dual Eligible SNPs with Highly Integrated Services
14b: Annual Physical Exam
14c1: Health Education
14c2: Nutritional/Dietary Benefit
14c3: Additional sessions of Smoking and Tobacco Cessation Counseling
14c4: Fitness Benefit
14c5: Enhanced Disease Management
14c6: Telemonitoring Services
14c7: Remote Access Technologies (including Web/Phone based technologies)
14c8: Bathroom Safety Devices

Is there a maximum plan benefit coverage amount for this group?
- ☐ Yes
- ☐ No

Indicate maximum plan benefit coverage amount:

OON – Groups – Base 2

POS – General – Base 1

POS – General – Base 2

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File   Help

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

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)
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: 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
8a1: Diagnostic Procedures/Tests
```

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

```
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: Pulmonary Rehabilitation Services
6: Home Health Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7f: Podiatry Services
7i: Physical Therapy and Speech-Language Pathology Services
9d: Outpatient Blood Services
10b: Transportation Services
11a: Durable Medical Equipment (DME)
11b: Prosthetics/Medical Supplies
13a: Acupuncture
13b: Over-the-Counter (OTC) Items
13c: Meal Benefit
13d: Other 1
13e: Other 2
13f: Other 3
```

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

POS – General – Base 3

POS – General – Base 4

File   Help

◄ Previous   ► Next   ✔ Exit (Validate)   ✘ Exit (No Validate)   Go To: [POS - General - Base 4 ▼]

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 prior Authorization for POS:

```
1a: Inpatient Hospital-Acute
1b: Inpatient Hospital Psychiatric
2: Skilled Nursing Facility (SNF)
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: 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: Diagnostic Procedures/Tests/Lab Services
8b1: Diagnostic Radiological Services
8b2: Therapeutic Radiological Services
```

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

```
3-1: Cardiac Rehabilitation Services
3-2: Intensive Cardiac Rehabilitation Services
3-3: Pulmonary Rehabilitation Services
6: Home Health Services
7b: Chiropractic Services
7c: Occupational Therapy Services
7f: Podiatry Services
7i: Physical Therapy and Speech-Language Pathology Services
9d: Outpatient Blood Services
10b: Transportation Services
11a: Durable Medical Equipment (DME)
11b: Prosthetics/Medical Supplies
13a: Acupuncture
13b: Over-the-Counter (OTC) Items
13c: Meal Benefit
13d: Other 1
13e: Other 2
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
15: Medicare Part B Rx Drugs
```

POS – General – Base 5

POS – General – Base 6

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CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

POS – Inpatient – Base 1

POS – Inpatient – Base 2

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File   Help

Previous   Next   Exit (Validate)   Exit (No Validate)   Go To: POS - Inpatient - Base 2

Is there an enrollee Coinsurance for POS Inpatient Hospital Service
○ 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 Hospital-Acute Services? (These are the total charges for all services provided to the enrollee in the inpatient facility.)
○ Yes
○ No

Indicate Coinsurance percentage for POS Inpatient Hospital-Acute stay:

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

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

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

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

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

POS – Inpatient – Base 3

POS – Inpatient – Base 4

POS – Inpatient – Base 5

POS – SNF – Base 1

PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000

File   Help

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:
[   ]   [   ]   [   ]

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

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

POS – SNF – Base 2

POS – Number of Groups

POS – Groups – Base 1

POS – Groups – Base 2

V/T – General – US

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CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING