

# CY 2020 PBP Data Entry System Screens

## OON – General – Base 1

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

File Help

Go To: OON - General - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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.

# CY 2020 PBP Data Entry System Screens

## OON – General – Base 2

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

File Help

Go To: OON - General - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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:

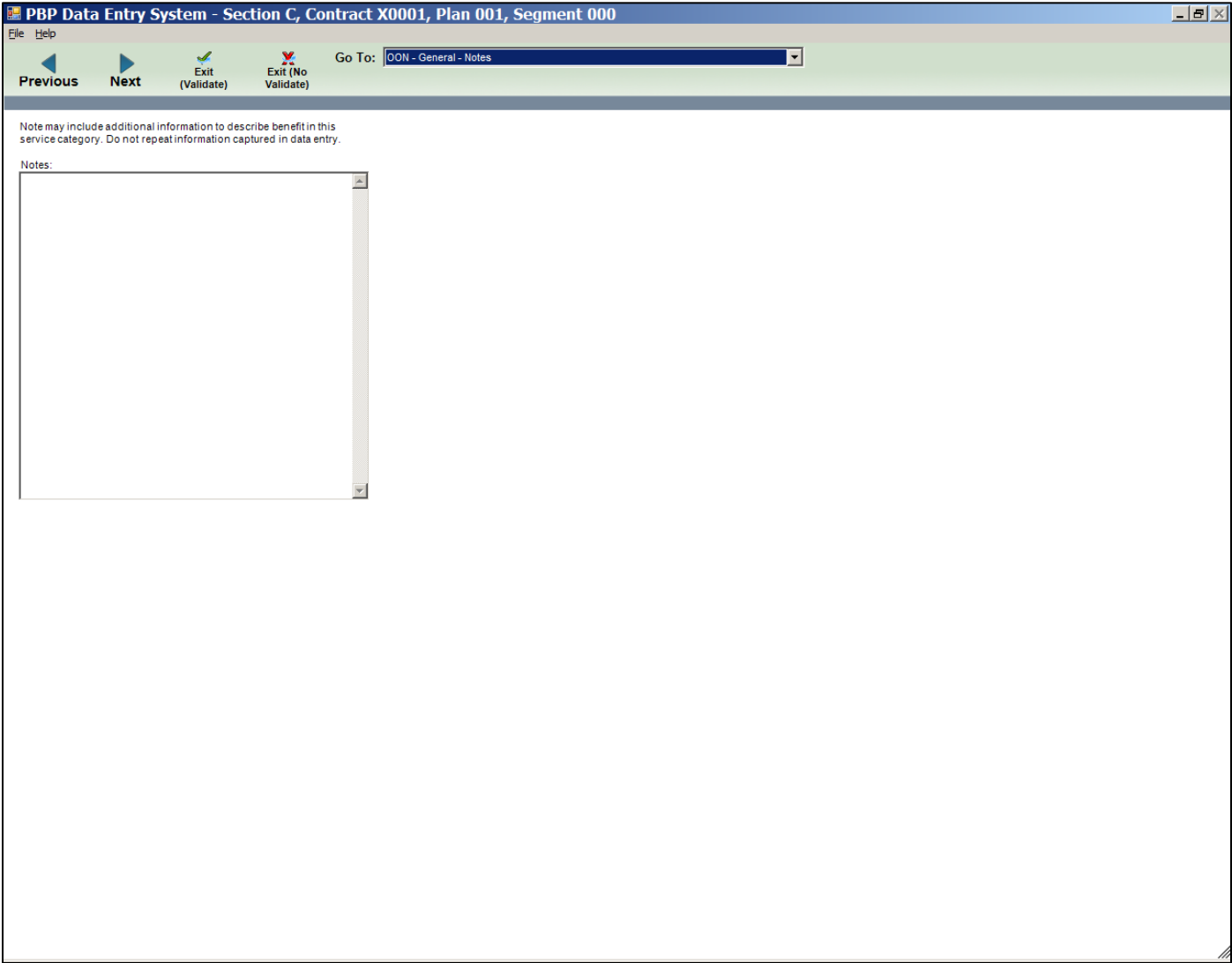
- 1a: Inpatient Hospital-Acute
- 1b: Inpatient Hospital Psychiatric
- 2: Skilled Nursing Facility (SNF)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 5: Partial Hospitalization
- 6: Home Health 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
- 7j: Additional Telehealth Services
- 7k: Opioid Treatment 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 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
- 3-4: SET for PAD 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 I

# CY 2020 PBP Data Entry System Screens

## OON – General – Notes



# CY 2020 PBP Data Entry System Screens

## OON – Inpatient – Base 1

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

File Help

Go To: OON - Inpatient - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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 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 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"/>

# CY 2020 PBP Data Entry System Screens

## OON – Inpatient – Base 2

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

File Help

Go To: OON - Inpatient - Base 2

Previous Next Exit (Validate) Exit (No 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.)

Yes  
 No

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

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

Indicate Coinsurance percentage for OON Inpatient Psychiatric Hospital stay:

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

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

Zero (No Coinsurance per Day)  
 One  
 Two  
 Three

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

# CY 2020 PBP Data Entry System Screens

## OON – Inpatient – Base 3

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

File Help

Go To: OON - Inpatient - Base 3

Previous Next Exit (Validate) Exit (No 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:
[ ]	[ ]	[ ]

# CY 2020 PBP Data Entry System Screens

## OOO – Inpatient – Base 4

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

File Help

Go To: **OOO - Inpatient - Base 4**

Previous Next Exit (Validate) Exit (No 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.)

Yes  
 No

Indicate Copayment amount for OOO Inpatient Psychiatric Hospital:

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

Zero (No Copayment per Day)  
 One  
 Two  
 Three

Indicate the copayment amount and day interval(s) for OOO 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 OOO Deductible for Inpatient Hospital Services?

Yes  
 No

Select the type of OOO 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:

# CY 2020 PBP Data Entry System Screens

OON – SNF – Base 1

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

File Help

Go To: OON - SNF - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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"/>



# CY 2020 PBP Data Entry System Screens

OON – SNF – Base 2

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

File Help

Go To: OON - SNF - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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

Do you charge the Medicare-defined costshares? (These are the total charges for all services provided to the enrollee in the SNF.)  
 Yes  
 No

Indicate Copayment amount 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	Begin Day Interval	End Day Interval
[ ]	[ ]	[ ]
[ ]	[ ]	[ ]
[ ]	[ ]	[ ]

Is there an OON Deductible for SNF Services?  
 Yes  
 No

Enter Deductible amount for SNF:  
[ ]

# CY 2020 PBP Data Entry System Screens

OON – Number of Groups

The screenshot shows a software window titled "PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons. A "Go To:" dropdown menu is set to "OON - Number of Groups". The main content area contains the instruction: "Indicate the number of Out-of-Network groupings offered (excluding Inpatient Hospital and SNF Services):" followed by a text input field.

# CY 2020 PBP Data Entry System Screens

## OON – Groups – Base 1

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

File Help

Go To: OON - Groups - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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
- 3-4: SET for PAD 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
- 7j: Additional Telehealth Services
- 7k: Opioid Treatment 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

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
- 3-4: SET for PAD 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 technologie

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

Yes

No

Indicate maximum plan benefit coverage amount:

# CY 2020 PBP Data Entry System Screens

## OON – Groups – Base 2

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

File Help

Go To: OON - Groups - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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:

# CY 2020 PBP Data Entry System Screens

## POS – General – Base 1

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

File Help

Go To: POS - General - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD 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
- 7j: Additional Telehealth Services

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

- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD 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

# CY 2020 PBP Data Entry System Screens

## POS – General – Base 2

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

File Help

Go To: POS - General - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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
- 3-4: SET for PAD 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

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
- 3-4: SET for PAD 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

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

# CY 2020 PBP Data Entry System Screens

## POS – General – Base 3

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

File Help

Go To: POS - General - Base 3

Previous Next Exit (Validate) Exit (No Validate)

Is there a POS Maximum Enrollee Out-of-Pocket Cost amount?

Yes  
 No

Indicate POS Maximum Enrollee Out-of-Pocket Cost:

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

Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

Is there a POS Deductible?

Yes  
 No

Enter Deductible Amount:

# CY 2020 PBP Data Entry System Screens

## POS – General – Base 4

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

File Help

Go To: POS - General - Base 4

Previous Next Exit (Validate) Exit (No Validate)

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
- 3-4: SET for PAD 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
- 7j: Additional Telehealth Services
- 7k: Opioid Treatment 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
- 3-4: SET for PAD 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: Other Defined Supplemental Benefits



# CY 2020 PBP Data Entry System Screens

## POS – General – Base 5

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

File Help

Go To: POS - General - Base 5

Previous Next Exit (Validate) Exit (No Validate)

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)
- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD 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
- 7j: Additional Telehealth Services
- 7k: Opioid Treatment Services
- 8a: Diagnostic Procedures/Tests/Lab Services

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

- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD 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: Other Defined Supplemental Benefits

# CY 2020 PBP Data Entry System Screens

## POS – General – Base 6

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

File Help

Go To: POS - General - Base 6

Previous Next Exit (Validate) Exit (No Validate)

Does this POS benefit service the United States and its territories? If no, please briefly describe geographic limitations in the following area.

Yes  No

Does this POS benefit include all practitioners who are state-licensed or state-certified and eligible to be paid by Medicare to furnish the services?

Yes  No

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

Notes:

[Large empty text area for notes]

# CY 2020 PBP Data Entry System Screens

## POS – Inpatient – Base 1

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

File Help

Go To: POS - Inpatient - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

Select the Maximum Plan Benefit Coverage periodicity:  
 Every three years  
 Every two years  
 Every year  
 Every six months  
 Every three months  
 Other, Describe

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:

# CY 2020 PBP Data Entry System Screens

## POS – Inpatient – Base 2

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

File Help

Go To: POS - Inpatient - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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	Begin Day Interval	End Day Interval
<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"/>

# CY 2020 PBP Data Entry System Screens

## POS – Inpatient – Base 3

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

File Help

Go To: POS - Inpatient - Base 3

Previous Next Exit (Validate) Exit (No 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.)

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:

# CY 2020 PBP Data Entry System Screens

## POS – Inpatient – Base 4

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

File Help

Go To: POS - Inpatient - Base 4

Previous Next Exit (Validate) Exit (No Validate)

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

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

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

Indicate the number of day intervals for the POS Inpatient Hospital-Acute stay:  
 Zero (No Copayment per Day)  
 One  
 Two  
 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.)  
 Yes  
 No

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:
<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"/>

# CY 2020 PBP Data Entry System Screens

## POS – Inpatient – Base 5

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

File Help

Go To: POS - Inpatient - Base 5

Previous Next Exit (Validate) Exit (No 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.)

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:

# CY 2020 PBP Data Entry System Screens

POS – SNF – Base 1

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

File Help

Go To: POS - SNF - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

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

Indicate Coinsurance percentage for POS SNF stay:

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

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

Coinsurance % Interval	Begin Day Interval	End Day Interval
<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"/>



# CY 2020 PBP Data Entry System Screens

POS – SNF – Base 2

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

File Help

Go To: POS - SNF - Base 2

Previous Next Exit (Validate) Exit (No Validate)

Is there an enrollee Copayment 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 inpatient facility.)  
 Yes  
 No

Indicate Copayment amount per stay for POS SNF stay:

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

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	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"/>

Is there a POS Deductible for SNF Services?  
 Yes  
 No

Enter Deductible amount for SNF:

# CY 2020 PBP Data Entry System Screens

## POS – Number of Groups

The screenshot shows a software window titled "PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000". The interface includes a menu bar with "File" and "Help", and a toolbar with "Previous", "Next", "Exit (Validate)", and "Exit (No Validate)" buttons. A "Go To:" dropdown menu is set to "POS - Number of Groups". The main content area contains the instruction: "Indicate the number of Point of Service groupings offered (excluding Inpatient Hospital Services and SNF Services):" followed by a single text input field.

# CY 2020 PBP Data Entry System Screens

## POS – Groups – Base 1

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

File Help

Go To: POS - Groups - Base 1

Previous Next Exit (Validate) Exit (No Validate)

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

- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD 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
- 7j: Additional Telehealth Services
- 7k: Opioid Treatment Services
- 8a1: Diagnostic Procedures/Tests
- 8a2: Lab Services

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

- 3-1: Cardiac Rehabilitation Services
- 3-2: Intensive Cardiac Rehabilitation Services
- 3-3: Pulmonary Rehabilitation Services
- 3-4: SET for PAD Services
- 6: Home Health Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7f: Podiatry Services
- 7i: Physical Therapy and Speech-Language Pathology Services

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:

# CY 2020 PBP Data Entry System Screens

## POS – Groups – Base 2

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

File Help

Go To: POS - Groups - Base 2

Previous Next Exit (Validate) Exit (No Validate)

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:

# CY 2020 PBP Data Entry System Screens

V/T – General – US

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

File Help

Go To: V/T - General - US

Previous Next Exit (Validate) Exit (No Validate)

CLICK FOR DESCRIPTION OF BENEFIT

Do you offer a US Visitor/Travel Program?

Yes  
 No

The VT benefit must furnish all plan-covered services in its designated VT 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

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

Mandatory  
 Optional

Select geographic area:

In the United States and its territories  
 Other - please define in the marketing materials (MAO must define the geographic areas within the United States and its territories where the VT benefit is available).