#### OON – General – Base 1

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Do you offer an C Yes	n Out-of-Netwo	ork (OON) Benefit	?				
C No							
The Maximum I Non-Medicare-	Plan Benefit C covered bene	overage amount f fits should be ente	or Out-of-Netwo ered in Section [	irk ).			
The Total Enrol benefits should		cket Cost Limit for Section D.	Out-of-Network				
The Deductible Section D.	for Out-of-Ne	twork benefits sho	ould be entered i	in			
NOTE: All Out- should be ente Package descri	red in the Sect	ptional Suppleme tion D - Optional S 5.	ntal Benefits Supplemental				
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#### OON – General – Base 2

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File Help		
Previous Next (Validate) Go To: Validate)	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-on Network benefit applies: 1a: 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 Heatth Services 7a: Primary Care Physician Services 7b: Chiropractic Services 7c: Occupational Therapy Services 7c: Occupational Therapy Services 7c: Mental Heatth Specialist Services 7c: Occupational Therapy Services 7c: Option Pressional 7h: Physical Therapy and Speech-Language Pathology Services 7k: Opioid Treatment Program Services 8a1: Diagnostic Procedures/Tests 8a2: Lab Services 8b1: Diagnostic Radiological Services 8b2: Therapeutic Radiological Services 9a2: Observation Services 9a3: Observation Services 9a4: Outpatient X-Ray Services 9a5: Observation Services 9a5: Outpatient X-Ray Services 9a5: Outpatient Substance Abuse 9d: Outpatient Biood Services	The 7b: Chiropractic Services 7b: Podiatry Services 9d: Outhatient Blood Services	< >

# OON – General – Notes

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Previous	de additional i	Exit	Validate) cribe benefit in t	his	OON - General - Notes		
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File Help     Previous Next     Exit     Co To:     Oo To:        Is there an enrollee Coinsurance for OON Inpatient Hospital
Services?   Hospital-Acute stay (enter '999' if unlimited days are offered; e.g., 1 to 999):   Yes   No   Select the type of OON Inpatient Hospital Services Benefit with Coinsurance:   (1a) Inpatient Hospital-Acute   (1b) Inpatient Psychiatric Hospital   Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:   Coinsurance % Interval 2: Begin Day Interval 2:   Coinsurance % Interval 3: Begin Day Interval 3:   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:
C Two C Three

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Psychiatric Ser	vices? (Thes	-defined cost shar se are the total cha ollee in the inpatier	rges for all	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):		
C Yes C No				Coinsurance % Interval 1: Eegin Day Interval 1: End Day Interval 1:		
Indicate Coins Hospital stay:	urance perce	ntage for OON Inp	atient Psychiatri	c Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:		
Indicate the nu Psychiatric Ho		intervals for the O	ON Inpatient	Coinsurance % Interval 3: Eegin Day Interval 3: End Day Interval 3:		
C Zero (No C C One C Two		per Day)				
C Three						

PBP Data Entry System - Section C, Contract X0001, Pla File Help	n 001, Segment 000	_	×
Previous Next (Validate) Validate)	Go To: OON - Inpatient - Base 3	•	
Previous     Next     (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 Hospital-Acute         \[         \] (1b) Inpatient Hospital-Acute         \[         \] (1b) 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:         One         One         One         Indicate the copayment per Day)         One         Chree         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 2:       End Day Interval 2:         Copayment Amt Interval 3       Begin Day Interval 3:         Copayment Amt Interval 3       Begin Day Interval 3:         End Day Interval 3:       End Day Interval 3:         Copayment Amt Interval 3       Begin Day Interval 3:         End Day Interval 3:       End Day Interval 3:	]	
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evious	Next	Exit	Exit (No	Go To: 🔽	ON - Inpatient - Base 4
evious	Next	(Validate)	Validate)	_	
		defined cost shares			Is there an OON Deductible for Inpatient Hospital Services?
vices? (The: ollee in the ir	se are the tota patient facilit	l charges for all ser y.)	vices provid	ed to the	C Yes
Yes					C No
No					Select the type of OON Inpatient Hospital Services benefit with a
dicate Copa	vment amour	t for OON Inpatient	Psychiatric	Hospital:	Deductible:
					Inpatient Psychiatric Hospital
					Combined for both Inpatient Hospital-Acute and Inpatient Psychiatric Hospital
licate the nur spital stay:	nber of day in	tervals for the OON	Inpatient Ps	ychiatric	i ayonnonio ayonn
	opaymentpe	Day)			Enter Deductible amount for Inpatient Hospital-Acute:
One Two					
Three					Enter Deductible amount for Inpatient Psychiatric Hospital:
ionto the coo	oumontor	intand day interval(		anotiont Douch int	
pital stay (e	nter '999' if ur	nlimited days are of	fered; e.g., 1	to 999):	unc
					Enter Deductible amount for combined Inpatient Hospital-Acute and Inpatient PsychiatricHospital:
ayment Amt	Interval 1 B	egin Day Interval 1:	End D	ay Interval 1:	
			I		
ayment Amt	Interval 2 B	egin Day Interval 2:	End D	ay Interval 2:	
ayment Amt	Interval 3 B	egin Day Interval 3:	End D	ay Interval 3:	
Note S	creen				

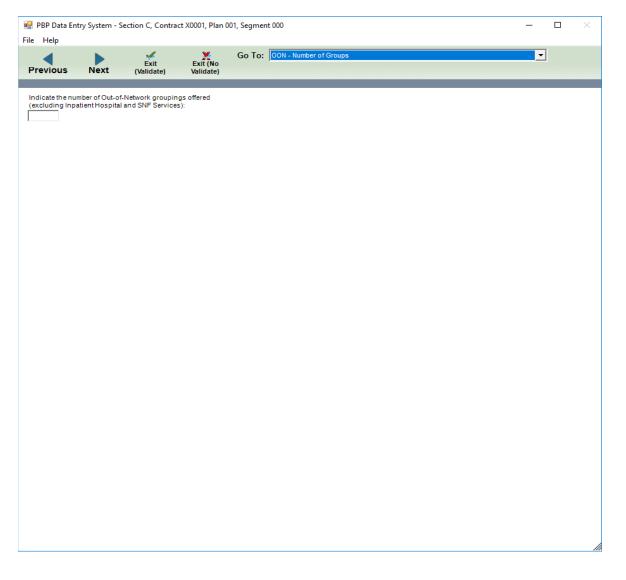
# OON - SNF - Base 1

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	To: OON - SNF - Base 1	•	
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 1: End Day Interval 1: Coinsurance % Interval 2: Begin Day Interval 2: Coinsurance % Interval 3: Begin Day Interval 3: Coinsurance % Interval 3: End Day Interval 3: Note Screen	, ]	

# OON – SNF – Base 2

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Previous Next (Validate) Exit (No Validate)	Go To: OON - SNF - Base 2	-	
Is there an enrollee Copayment for OON SNF Services?          Yes         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 for OON SNF stay:         Careo (No Copayment per Day)         One         Three	Indicate the copayment amount and day interval(s) for OON SNF stay (enter '999' if unlimited days are offered; e.g., 1 to 999): Copayment Amt Interval 1 Begin Day Interval 1: Copayment Amt Interval 2 Begin Day Interval 2: Copayment Amt Interval 3 Begin Day Interval 3: Is there an OON Deductible for SNF Services? Yes No Enter Deductible amount for SNF: Note Screen		

# OON – Number of Groups



# OON – Groups – Base 1

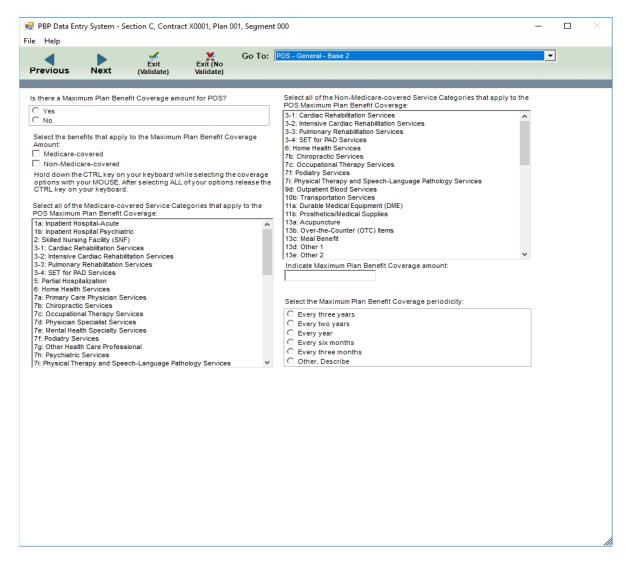
Exit Exit (No	Go To:	DON - Groups - Base 1
Previous Next (Validate) Validate)	_	
inter Label for this Group (Optional):	release the	Select the Non-Medicare-covered service categories included in the OON option 3-1: Cardiac Rehabilitation Services 3-2: Intensive Cardiac Rehabilitation Services 3-3: Pulmonary Rehabilitation Services 7b: Chiropractic Services 7b: Chiropractic Services 7b: Chiropractic Services 7b: Chiropractic Services 9d: Outpatient Blood 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: Finess Benefit 14c5: Enhanced Disease Management 14c6: Telemonitoring Services 14c7: Remote Access Technologies (including Web/Phone-based technologies and 14c8: Home and Bathroom Safety Devices and Modifications 1s there a maximum plan benefit coverage amount:  Indicate maximum plan benefit coverage amount:

Page 11 of 29

# OON – Groups – Base 2

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File Help						
Previous	Next	Exit (Validate)	Exit (No Validate)	Go To:	OON - Groups - Base 2	
	Coinsuranc	e for this Group?				
C Yes C No						
Enter Minimur	n Coinsuranc	e Percentage for t	his Group:			
Enter Maximu	m Coinsurano	ce Percentage for t	his Group:			
Is there an OON	Copayment	for this Group?				
C Yes C No						
Enter Minimu	um Copaymer	nt Amount for this (	Group:			
Enter Maxim	um Copayme	nt Amount for this	Group:			
1						
	N Deductible	for this group?				
C Yes C No						
Enter Deduct	ible Amount f	orthis group:				
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File Help					
Previous Next	Exit (Validate)	Exit (No Validate)	Go To:	POS - General - Base 1	
CLICK FOR DESCRIPTION O Do you offer a Point-of-Service Yes No Select type of benefit for the PO GMandatory Optional Select the benefits that apply to Medicare-covered Non-Medicare-covered Hold down the CTRL key on you coverage options with your MO options release the CTRL key o Select all of the Medicare-cover the POS option: 1a: Inpatient Hospital-Acute 1b: Inpatient Hospital Psychiatric S: Partial Hospital Psychiatric S: Partial Hospital Psychiatric S: Partial Hospitalization Services 7a: Primary Care Physician Services 7a: Primary Care Physician Services 7a: Primary Care Physician Services 7a: Occupational Therapy Service 7b: Chiropractic Services 7c: Occupational Therapy Service 7c: Mental Health Specialist Services 7c: Offer Health Care Professior 7h: Physician Therapy and Speech 7k: Opioid Treatment Program Service	(POS) option? S option: S option: the POS Benefit: ur keyboard while USE. After selecti n your keyboard. red Service Categ ces ion Services vices ices ices ices ices ices ices ices ices ices ices	ng ALL of your		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: Fulmonary Rehabilitation Services 3-4: SET for PAD Services 7: Coupational Therapy Services 7: Coupational Therapy Services 7: Podiatry Services 7: Podiatry Services 9: Outpatient Blood Services 10: Dresthetics/Medical Supplies 13: Accupuncture 13: Other 1 13: Other 1 13: Other 1 13: Other 3 13: Duffer 3 13: Cother 3 13: Additional Services 14: Annual Physical Exam 14: Health Education	



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PBP Data Entry Help	System - S	ection C, Contra	ct X0001, Plan 0	01, Segmen	t 000 —		×
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there a POS Ma: Yes No Indicate POS Ma:	ximum Enro ximum Enro num Enrollo years ears ponths months	Exit	Validate) et Cost amount? et Cost:	?	POS - General - Base 3         Is there a POS Deductible?         Yes         No         Enter Deductible Amount:		

		Section C, Contra				
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Is Authorizatio	en required for covered icare-covered icare-covered e CTRL key on rour MOUSE. A your keyboarc e Medicare-co for POS: ospital-Acute ospital-Acute ospital-Acute ospital-Acute cospital-Acute cospital-Acute cospital-Acute cospital-Acute ospital-Acute cospital-Acute ospita	(Validate) POS? POS? Poly to the Authorize your keyboard wh after selecting ALL vered Service Cate tric F) rvices litation Services ervices ervices ervices sional ech-Language Path	Validate) ation for POS: tile selecting the of your options egories that req	release the	Select all of the Non-Medicare-covered Service Categories that requi 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 7: Cocupational Therapy Services 7: Prostical Therapy and Speech-Language Pathology Services 9: Outpatient Blood Services 10b: Transportation Services 11a: Durable Medical Equipment (DME) 11b: Prosthetics/Medicial Supplies 13a: Acupuncture 13b: Over-the-Counter (OTC) Items 13b: Over-the-Counter (OTC) Items 13b: Other 1 13b: Other 2 13f: Other 3 13g: Dual Eligible SNPs with Highly Integrated Services 14b: Annual Physical Exam 14c: Other Defined Supplemental Benefits	repri

Page 16 of 29

🖳 PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000	- 🗆 X
File Help	
Previous Next (Validate) Go To: POS - Gen	eral - Base 5
○ Yes       33         ○ No       33         Select the benefits that apply to the POS Referral:       33         ○ MonMedicare-covered       34         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.       77         Select all of the Medicare-covered Service Categories that apply to the POS Referral:       11         1a: Inpatient Hospital-Acute       11         1b: Inpatient Hospital Psychiatric       12         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       11         5: Partial HospitalIzation       11         6: Home Health Services       12         7: Primary Care Physician Services       13         7: Primary Care Physician Services       14	A contract of the Non-Medicare-covered Service Categories that apply to the Nor Referral: -1: Cardiac Rehabilitation Services -2: Intensive Cardiac Rehabilitation Services -3: Pulmonary Rehabilitation Services -4: SET for PAD Services -3: Home Health Services -4: SET for PAD Services -5: Cocupational Therapy Services -7: Podiatry Services -7: Podiatry Services -7: Physical Therapy and Speech-Language Pathology Services -7: Podiatry Services -7: Physical Therapy and Speech-Language Pathology Services -7: Podiatry Services -7: Physical Therapy and Speech-Language Pathology Services -7: Physical Services -7: Physical Equipment (DME) -7: Physical Equipment (OTC) Items -7: Physical Benefit -7: Physical Exam -7: Physical Exam

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revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	POS - General - Base 6	-	
	o, please brief	e the United State ly describe geogra		in	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					C Yes C No		
ote may inclu ategory. Do no	de additional i ot repeat infor	information to des mation captured ir	cribe benefit in th 1 data entry.	is service			
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				$\checkmark$			

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Services?  Yes No Select the ty; Maximum Pla Inpatienti Inpatienti Combinei Psychiatr Enter Maxim Hospital-Ac Enter Maxim Psychiatric Enter Maxim Enter Maxim Psychiatric Enter Maxim	be of POS Inpa in Benefit Covid Hospital-Acute Psychiatric Ho: 1 for both Inpat ic Hospital num Plan Bene Hospital:	-	vices benefit wi e and inpatient unt for inpatient unt for inpatient	th a	Select the Maximum Plan Benefit Coverage periodicity:         C Every two years         C Every year         C Every six months         C Every three months         O Other, Describe		

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Acute stay:	POS Inpatie Hospital-Acc Psychiatric H services? (T d to the enro surance pero surance pero umber of day e stay:	nt Hospital Servi ite lospital defined cost sha hese are the tota lilee in the inpatie centage for POS I	ices Benefit with res for Inpatien I charges for al ent facility.)	t i iai-	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: Note Screen		

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revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	POS - Inpatient - Base 3		
sychiatric Ser	vices? (Thes	defined cost shar e are the total cha e inpatient facility.	rges for all servi	ces	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)		
ੇ Yes ∂No					Coinsurance % Interval 1: Begin Day Interval 1: End Day Interval 1:		
Indicate Coin Hospital stay	surance perc	entage for POS Inp	patient Psychiatr	ic	Coinsurance % Interval 2: Begin Day Interval 2: End Day Interval 2:		
Indicate the r Psychiatric H	number of day ospital stay:	intervals for the P	OS Inpatient		Coinsurance % Interval 3: Begin Day Interval 3: End Day Interval 3:		
C One C Two	Coinsurance	per Day)			Note Screen	٦	
C Three							

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PBP Data Entry System - Section C, Contract X0001, Plan 001, Sec e Help	gment 000 —
•	To: POS - Inpatient - Base 4
	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         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 2: End Day Interval 2:          Copayment Amt Interval 2: Begin Day Interval 2: End Day Interval 3:    Copayment Amt Interval 3: Begin Day Interval 3: End Day Interval 3:

BP Data Entry System - Section C, Contract X0001, Plan 001, Segment 000	- • ×
Previous Next (Validate) Go To: POS-	Inpatient - Base 5
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         Indicate the copayment amount and day interval(s) for POS inpatient Psychiatric Hospital stay:         Copayment Amt Interval 1         Begin Day Interval 1:         End Day Interval 2:         Copayment Amt Interval 3         Begin Day Interval 3:         End Day Interval 3:	Is there a POS Deductible for Inpatient Hospital Services?

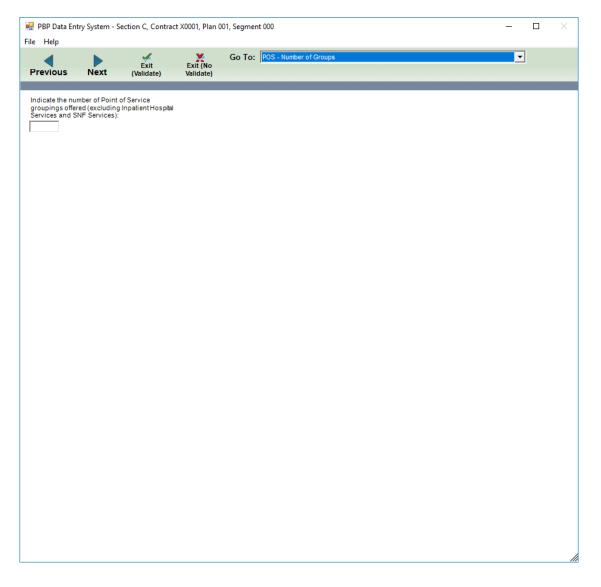
# POS – SNF – Base 1

PBP Data Entry System - e Help	- Section C, Contract X0001	lan 001, Segment 000	-	
revious Next	Exit Exit (Validate) Valid		•	
Yes No You charge the Medical total charges for all service Yes No Indicate Coinsurance pe	urance for POS SNF Service: are-defined cost shares? (Th es provided to the enrollee in ercentage for POS SNF stay: day intervals for the POS SN rce per Day)	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

🚽 PBP Data Entry System - Section C, Contract X0001, Plan ( ile Help		_	×
Previous Next (Validate)	Go To: POS - SNF - Base 2	-	
Is there an enrollee Copayment for POS SNF Services?  C 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.) C Yes No Indicate Copayment amount per stay for POS SNF stay: C Zero (No Copayment per Day) C One C Two C 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 1 Begin Day Interval 1: End Day Interval 2: Copayment Amt Interval 2 Begin Day Interval 2: End Day Interval 3: Copayment Amt Interval 3 Begin Day Interval 3: End Day Interval 3: Is there a POS Deductible for SNF Services? C Yes No Enter Deductible amount for SNF:		

### POS – Number of Groups



### POS – Groups – Base 1

🖳 PBP Data Entry System - Section C, Contract X0001, Plan 001, Segment (	— 000
rile Help Previous Next (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: 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 3-3: Pulmonary Rehabilitation Services 3-4: SET for PAD Services S: Partial Hospitalization 6 Home Health Services 7a: Primary Care Physician Services 7b: Chiropractic Services 7c: Occupational Therapy Services 7c: Other Health Specialty Services 7c: Other Health Care Professional 7h: Psychiatric Services 8a1: Diagnostic Procedures/Tests 8a2: Lab Services 8b1: Diagnostic Radiological 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: SET for PAD Services         6: Home Health Services         7: Occupational Therapy Services         7: Occupational Therapy and Speech-Language Pathology Services         9: Outpatient Blood Services         1: Stere a POS Coinsurance for this Group?         Yes         No         Enter Minimum Coinsurance Percentage for this Group:         Is there a POS Copayment for this Group?         Yes         No         Is there a POS Copayment for this Group?         Yes         No         Inter Maximum Coinsurance Percentage for this Group:         Is there a POS Copayment for this Group?         Yes         No         Enter Minimum Copayment Amount for this Group:         Enter Minimum Copayment Amount for this Group:         Enter Maximum Copayment Amount for this Group:

# POS – Groups – Base 2

revious	Next	Exit (Validate)	Exit (No Validate)	Go To:	POS - Groups - Base 2	<b>•</b>	
there a POS	Maximum Plar	Benefit Coverag	e amount for thi	s group?			
) Yes							
) No							
ndicate Maxi	mum Plan Ben	efit Coverage amo	ount:				
Select the M	aximum Plan B	enefit Coverage p	eriodicity:				
C Every the C Every tw	ree years						
C Every ye	ar						
C Every siz							
C Other, D							
	Deductible for	this group?					
C Yes C No							

# V/T – General – US

Previous       Next       Exit (No Validate)       Go To:       V/T - General - US         CLICK FOR DESCRIPTION OF BENEFIT	😸 PBP Data Entry System - Section C, Co File Help	ontract X0001, Plan 001, Segm	nent 000 — 🗆 🗙
Do 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 cos sharing levels, consistent with Medicare access and availability requirements at 42 CFR §422.112         Select type of benefit for the US Visitor/Travel program:       Select geographic area:         C       Mandatory         C       In the United States and its territories	Exit	Exit (No	o: V/T - General - US
	Do you offer a US Visitor/Travel Program C Yes No Select type of benefit for the US Visitor/T C Mandatory	?	Medicare Parts Aand 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 geographic area: C In the United States and its territories