

SECTION B – 17A – EYE EXAMS – BASE 1 SCREEN

PBP 2008 Data Entry System - #17a Eye Exams - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefit:

Routine Eye Exams

Select type of benefit for Routine Eye Exams:

Mandatory
 Optional

Is this benefit unlimited for Routine Eye Exams?

Yes
 No, indicate number

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

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

Is there a service-specific Maximum Plan Benefit Coverage amount?

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

Select the Coverage Basis for Maximum Plan Benefit Coverage:

Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Other, describe

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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

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

SECTION B – 17A – EYE EXAMS – BASE 2 SCREEN

PBP 2008 Data Entry System - #17a Eye Exams - Base 2

File

Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Coinsurance percentage for Routine Eye Exams: _____	Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No
Indicate Minimum Coinsurance percentage for Medicare Covered Benefits: _____	Indicate Maximum Coinsurance percentage for Routine Eye Exams: _____	Indicate Minimum Copayment amount for Medicare Covered Benefits: _____
Indicate Maximum Coinsurance percentage for Medicare Covered Benefits: _____	Select the Coverage Basis for Coinsurance for Routine Eye Exams: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Other, describe	Indicate Maximum Copayment amount for Medicare Covered Benefits: _____
Select the Coverage Basis for Coinsurance for Medicare Covered Benefits: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Other, describe	Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Copayment amount per Routine Eye Exam: _____
	Indicate Deductible Amount: _____	Indicate Maximum Copayment amount per Routine Eye Exam: _____

SECTION B – 17A – EYE EXAMS – BASE 3 SCREEN

File

Indicate whether a separate office visit cost share applies for services:

Yes

No

Sometimes, describe

Enrollee must receive Authorization from one or more of the following:

None

Primary Care Physician (Internist/Family Practice, General Practice)

Physician Specialist

Organization Medical Director/Utilization Management/Utilization Review

Other, describe

Is a referral required for Eye Exams?

Yes

No

Notes (Optional):

Import Text

SECTION B – 17B – EYE WEAR – BASE 1 SCREEN

PBP 2008 Data Entry System - #17b Eye Wear - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefits:

Contact Lenses
 Eye Glasses (Lenses and Frames)
 Eye Glass Lenses
 Eye Glass Frames
 Upgrades

Select type of benefit for Contact Lenses:

Mandatory
 Optional

Is this benefit unlimited for Contact Lenses?

Yes
 No, indicate number

Indicate quantity (number of pairs) for Contact Lenses:

Select Contact Lenses periodicity:

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

Select type of benefit for Eye Glasses (Lenses and Frames):

Mandatory
 Optional

Is this benefit unlimited for Eye Glasses (Lenses and Frames)?

Yes
 No, indicate number

Indicate quantity for Eye Glasses (Lenses and Frames):

Select Eye Glasses (Lenses and Frames) periodicity:

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

SECTION B – 17B – EYE WEAR – BASE 2 SCREEN

PBP 2008 Data Entry System - #17b Eye Wear - Base 2

File

Select type of benefit for Eye Glass Lenses: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select type of benefit for Eye Glass Frames: <input type="radio"/> Mandatory <input type="radio"/> Optional
Is this benefit unlimited for Eye Glass Lenses? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Eye Glass Frames? <input type="radio"/> Yes <input type="radio"/> No, indicate number
Indicate quantity (number of pairs) for Eye Glass Lenses: <input type="text"/>	Indicate quantity for Eye Glass Frames: <input type="text"/>
Select Eye Glass Lenses periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe	Select Eye Glass Frames periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe
Select type of benefit for Upgrades: <input type="radio"/> Mandatory <input type="radio"/> Optional	

SECTION B – 17B – EYE WEAR – BASE 3 SCREEN

PBP 2008 Data Entry System - #17b Eye Wear - Base 3

File

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Select the Maximum Plan Benefit Coverage Basis:</p> <p><input type="radio"/> Discount (___%) of Published Retail Price</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> Published Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>
<p>Select the Maximum Plan Benefit Coverage type:</p> <p><input type="radio"/> Covered under Eye Exams Category 17a</p> <p><input type="radio"/> Plan-specified amount per period</p>		<p>Select the Maximum Enrollee Out-of-Pocket Cost type:</p> <p><input type="radio"/> Covered under Eye Exams Category 17a</p> <p><input type="radio"/> Plan-specified amount per period</p>
<p>Indicate Maximum Plan Benefit Coverage amount:</p> <p><input type="text"/></p>	<p>Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage:</p> <p><input type="text"/></p>	<p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <p><input type="text"/></p>
<p>Select the Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>		<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>

SECTION B – 17B – EYE WEAR – BASE 4 SCREEN

PBP 2008 Data Entry System - #17b Eye Wear - Base 4

File

<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Indicate Coinsurance percentage for Eye Glasses (Lenses and Frames):</p> <p><input type="text"/></p>	<p>Indicate Coinsurance percentage for Eye Glass Frames:</p> <p><input type="text"/></p>
<p>Indicate Coinsurance percentage for Medicare Covered Benefits:</p> <p><input type="text"/></p>	<p>Select the Coinsurance Coverage Basis for Eye Glasses (Lenses and Frames):</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>	<p>Select the Coinsurance Coverage Basis for Eye Glass Frames:</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>
<p>Select the Coinsurance Coverage Basis for Medicare Covered Benefits:</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>	<p>Indicate Coinsurance percentage for Eye Glass Lenses:</p> <p><input type="text"/></p>	<p>Indicate Coinsurance percentage for Upgrades:</p> <p><input type="text"/></p>
<p>Indicate Coinsurance percentage for Contact Lenses:</p> <p><input type="text"/></p>	<p>Select the Coinsurance Coverage Basis for Eye Glass Lenses:</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>	<p>Select the Coinsurance Coverage Basis for Upgrades:</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>
<p>Select the Coinsurance Coverage Basis for Contact Lenses:</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>		

SECTION B – 17B – EYE WEAR – BASE 5 SCREEN

PBP 2008 Data Entry System - #17b Eye Wear - Base 5

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount for Medicare Covered Benefits:

Indicate Copayment amount for Contact Lenses:

Indicate Copayment amount for Eye Glasses (Lenses and Frames):

Indicate Copayment amount for Eye Glass Lenses:

Indicate Copayment amount for Eye Glass Frames:

Indicate Copayment amount for Upgrades:

Enrollee must receive Authorization from one or more of the following:
 None
 Primary Care Physician (Internist/Family Practice, General Practice)
 Physician Specialist
 Organization Medical Director/Utilization Management/Utilization Review
 Other, describe

Is a referral required for Eye Wear?
 Yes
 No

SECTION B – 17B – EYE WEAR – BASE 6 SCREEN

The screenshot shows a software window titled "PBP 2008 Data Entry System - #17b Eye Wear - Base 6". The window has a standard Windows-style title bar with minimize, maximize, and close buttons. Below the title bar is a menu bar with a "File" option. The main content area is divided into several sections: a small rectangular field labeled "Eye Wear Notes", a larger section labeled "Notes (Optional):" which contains a large, empty white rectangular area for text entry, and a button labeled "Import Text" located in the bottom right corner of the main content area.