Section D – Step-Up – 7b – Chiropractic Services – Base 1 Screen

PBP 2008 Data Entry System - Step Up #7b Chiropractic Services - 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 Care

Select type of benefit for Routine Care:
- Mandatory
- Optional

Is this benefit unlimited for Routine Care?
- Yes
- No, indicate number

Indicate number of visits for Routine Care:

Select Routine Care 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 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 D – Step-Up – 7b – Chiropractic Services – Base 2 Screen

PBP 2008 Data Entry System - Step Up #7b Chiropractic Services - Base 2

File

Is there an enrollee Coinsurance?
- Yes
- No

Indicate Minimum Coinsurance percentage per visit for Medicare Covered Benefits:
___

Indicate Maximum Coinsurance percentage per visit for Medicare Covered Benefits:
___

Select the Coinsurance Coverage Basis for Medicare Covered Benefits:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

Indicate the Minimum Coinsurance percentage per visit for Routine Care:
___

Indicate the Maximum Coinsurance percentage per visit for Routine Care:
___

Select the Coinsurance Coverage Basis for Routine Care:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

SECTION D – STEP-UP – 7B – CHIROPRACTIC SERVICES – BASE 3 SCREEN

PBP 2008 Data Entry System - Step Up #7b Chiropractic Services - Base 3

File

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- Yes
- No

Indicate Minimum Copayment amount for Medicare Covered Benefits:

Indicate Maximum Copayment amount for Medicare Covered Benefits:

Indicate Minimum Copayment amount per visit for Routine Care:

Indicate Maximum Copayment amount per visit for Routine Care:

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 Chiropractic Services?
- Yes
- No

Section D – Step-Up – 7b – Chiropractic Services – Base 4 Screen

PBP 2008 Data Entry System - Step Up #7b Chiropractic Services - Base 4

File

Chiropractic Services Notes

Notes (Optional):

Import Text

Section D – Step-Up – 7f – Podiatry Services – Base 1 Screen

PBP 2008 Data Entry System - Step Up #7f Podiatry Services - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
- Yes
- No

Select enhanced benefits:
- Routine Footcare

Select type of benefit for Routine Footcare:
- Mandatory
- Optional

Is this benefit unlimited for Routine Footcare?
- Yes
- No

Indicate number of Routine Footcare visits: ___

Select the Routine Footcare 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 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 D – STEP-UP – 7F – PODIATRY SERVICES – BASE 2 SCREEN

PBP 2008 Data Entry System - Step Up #7f Podiatry Services - Base 2

File

Is there an enrollee Coinsurance?
- Yes
- No

Indicate Minimum Coinsurance percentage for Medicare Covered Benefits: ___

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits: ___

Select the Coinsurance Coverage Basis for Medicare Covered Benefits:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

Indicate Minimum Coinsurance percentage for Routine Footcare: ___

Indicate Maximum Coinsurance percentage for Routine Footcare: ___

Select the Coinsurance Coverage Basis for Routine Footcare:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount: ______

Is there an enrollee Copayment?
- Yes
- No

Indicate Minimum Copayment amount per visit for Medicare Covered Benefits: ______

Indicate Maximum Copayment amount per visit for Medicare Covered Benefits: ______

Indicate Minimum Copayment amount per visit for Routine Footcare: ______

Indicate Maximum Copayment amount per visit for Routine Footcare: ______

SECTION D – STEP-UP – 7F – PODIATRY SERVICES – BASE 3 SCREEN

PBP 2008 Data Entry System - Step Up #7f Podiatry Services - Base 3

File

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 Podiatrist Services?

- ( ) Yes
- ( ) No

Notes (Optional):

Import Text

SECTION D – STEP-UP – 10B – TRANSPORTATION – BASE 1 SCREEN

PBP 2008 Data Entry System - Step Up #10b Transportation - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
- Yes
- No

Select enhanced benefit:
- Plan-approved Location
- Any Location

Select type of benefit for Plan-approved Location:
- Mandatory
- Optional

Is this benefit unlimited for number of trips for Plan-approved Location?
- Yes
- No

Indicate number of trips for Plan-approved Location:

Select Plan-approved Location Trips periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select Type of Transportation for Plan-approved Location:
- One-way
- Round Trip

Select Mode of Transportation for Plan-approved Location:
- Taxi
- Bus/Subway
- Van
- Other, describe

Select type of benefit for Any Location:
- Mandatory
- Optional

Is this benefit unlimited for number of trips for Any Location?
- Yes
- No

Indicate number of trips for Any Location:

Select Any Location Trips periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select Type of Transportation for Any Location:
- One-way
- Round Trip

Select Mode of Transportation for Any Location:
- Taxi
- Bus/Subway
- Van
- Other, describe

SECTION D – STEP-UP – 10B – TRANSPORTATION – BASE 2 SCREEN

PBP 2008 Data Entry System - Step Up #10b Transportation - Base 2

File

Is there a service-specific Maximum Plan Benefit Coverage amount?
- Yes
- No

Indicate Maximum Plan Benefit Coverage amount:

Select 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
- Other, describe

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
- Yes
- No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select 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 an enrollee Coinsurance?
- Yes
- No

Indicate Coinsurance percentage:

Select the Coinsurance Coverage Basis:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Other, describe

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

SECTION D – STEP-UP – 10B – TRANSPORTATION – BASE 3 SCREEN

PBP 2008 Data Entry System - Step Up #10b Transportation - Base 3

File

Is there an enrollee Copayment?
- Yes
- No

Indicate Copayment amount per trip:

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 Transportation Services?
- Yes
- No

Notes (Optional):

Import Text

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 1 SCREEN

PBP 2008 Data Entry System - Step Up #16a Preventive Dental - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
- Yes
- No

Select enhanced benefits:
- Oral Exams
- Prophylaxis (Cleaning)
- Fluoride Treatment
- Dental X-Rays

Select type of benefit for Oral Exams:
- Mandatory
- Optional

Is this benefit unlimited for Oral Exams?
- Yes
- No, indicate number

Indicate number of visits for Oral Exams: ___

Select the Oral Exams periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Prophylaxis (Cleaning):
- Mandatory
- Optional

Is this benefit unlimited for Prophylaxis (Cleaning)?
- Yes
- No, indicate number

Indicate number of visits for Prophylaxis (Cleaning): ___

Select the Prophylaxis (Cleaning) periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Fluoride Treatment:
- Mandatory
- Optional

Is this benefit unlimited for Fluoride Treatment?
- Yes
- No, indicate number

Indicate number of visits for Fluoride Treatment: ___

Select the Fluoride Treatment periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Section D – Step-Up – 16a – Preventive Dental – Base 2 Screen

PBP 2008 Data Entry System - Step Up #16a Preventive Dental - Base 2

File

Select type of benefit for Dental X-Rays:
- Mandatory
- Optional

Is this benefit unlimited for Dental X-Rays?
- Yes
- No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays 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
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 3 SCREEN

PBP 2008 Data Entry System - Step Up #16a Preventive Dental - Base 3

File

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

Is there an enrollee Coinsurance?
- Yes
- No

Is there a combination of services included in a single cost per Office Visit?
- Yes
- No

Select which combination of services are included in a single cost per Office Visit:
- Oral Exams
- Prophylaxis (Cleaning)
- Fluoride Treatment
- Dental X-Rays

Indicate Coinsurance percentage for Office Visit:

Select the Coinsurance Coverage Basis for combination of services included in a single cost per Office Visit:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 4 SCREEN

PBP 2008 Data Entry System - Step Up #16a Preventive Dental - Base 4

File

Indicate Minimum Coinsurance percentage for Oral Exams:

___

Indicate Maximum Coinsurance percentage for Oral Exams:

___

Select the Coinsurance Coverage Basis for Oral Exams:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):

___

Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):

___

Select the Coinsurance Coverage Basis for Prophylaxis (Cleaning):
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

Indicate Minimum Coinsurance percentage for Fluoride Treatment:

___

Indicate Maximum Coinsurance percentage for Fluoride Treatment:

___

Select the Coinsurance Coverage Basis for Fluoride Treatment:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 5 SCREEN

PBP 2008 Data Entry System - Step Up #16a Preventive Dental - Base 5

File

Indicate Minimum Coinsurance percentage for Dental X-Rays:

___

Indicate Maximum Coinsurance percentage for Dental X-Rays:

___

Select the Coinsurance Coverage Basis for Dental X-Rays:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

______

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 6 SCREEN

PBP 2008 Data Entry System - Step Up #16a Preventive Dental - Base 6

File

Is there an enrollee Copayment?
Yes
No

Is there a combination of services included in a single cost per Office Visit?
Yes
No

Select which combination of services are included in a single cost per Office Visit:
Oral Exams
Prophylaxis (Cleaning)
Fluoride Treatment
Dental X-Rays

Indicate Copayment amount for Office Visit:

Indicate Minimum Copayment amount for Oral Exams:

Indicate Maximum Copayment amount for Oral Exams:

Indicate Minimum Copayment amount for Prophylaxis (Cleaning):

Indicate Maximum Copayment amount for Prophylaxis (Cleaning):

Indicate Minimum Copayment amount for Fluoride Treatment:

Indicate Maximum Copayment amount for Fluoride Treatment:

Indicate Minimum Copayment amount for Dental X-Rays:

Indicate Maximum Copayment amount for Dental X-Rays:

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 7 SCREEN

PBP 2008 Data Entry System - Step Up #16a Preventive Dental - Base 7

File

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 Preventive Dental Services?

- ( ) Yes
- ( ) No

Notes (Optional):

Import Text

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 1 SCREEN

PBP 2008 Data Entry System - Step Up #16b Comp Dental - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
- Yes
- No

Select enhanced benefits:
- Emergency Services
- Diagnostic Services
- Restorative Services
- Endodontics/Periodontics/Extractions
- Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Emergency Services:
- Mandatory
- Optional

Is this benefit unlimited for Emergency Services?
- Yes
- No, indicate number

Indicate number of visits for Emergency Services:

Select the Emergency Services periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Diagnostic Services:
- Mandatory
- Optional

Is this benefit unlimited for Diagnostic Services?
- Yes
- No, indicate number

Indicate number of visits for Diagnostic Services:

Select the Diagnostic Services periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Section D – Step-Up – 16b – Comprehensive Dental – Base 2 Screen

PBP 2008 Data Entry System - Step Up #16b Comp Dental - Base 2

File

Select type of benefit for Restorative Services:
- Mandatory
- Optional

Is this benefit unlimited for Restorative Services?
- Yes
- No, indicate number

Indicate number of visits for Restorative Services:
___

Select the Restorative Services periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Endodontics/Periodontics/Extractions:
- Mandatory
- Optional

Is this benefit unlimited for Endodontics/Periodontics/Extractions?
- Yes
- No, indicate number

Indicate number of visits for Endodontics/Peridontics/Extractions:
___

Select the Endodontics/Periodontics/Extractions periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:
- Mandatory
- Optional

Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?
- Yes
- No, indicate number

Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:
___

Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 3 SCREEN

PBP 2008 Data Entry System - Step Up #16b Comp Dental - Base 3

File

Is there a service-specific Maximum Plan Benefit Coverage amount?
- Yes
- No

Select the Maximum Plan Benefit Coverage type:
- Covered under Preventive Dental Category 16a
- Plan-specified amount per period

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

Select the Maximum Enrollee Out-of-Pocket Cost type:
- Covered under Preventive Dental Category 16a
- Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Section D – Step-Up – 16b – Comprehensive Dental – Base 4 Screen

PBP 2008 Data Entry System - Step Up #16b Comp Dental - Base 4

File

Is there an enrollee Coinsurance?
- Yes
- No

Indicate the Minimum Coinsurance percentage for Medicare Covered Benefits:

___

Indicate the Maximum Coinsurance percentage for Medicare Covered Benefits:

___

Select the Coinsurance Coverage Basis for Medicare Covered Benefits:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

Indicate Minimum Coinsurance percentage for Emergency Services:

___

Indicate Maximum Coinsurance percentage for Emergency Services:

___

Select the Coinsurance Coverage Basis for Emergency Services:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 5 SCREEN

PBP 2008 Data Entry System - Step Up #16b Comp Dental - Base 5

File

Indicate Minimum Coinsurance percentage for Diagnostic Services:

Indicate Maximum Coinsurance percentage for Diagnostic Services:

Select the Coinsurance Coverage Basis for Diagnostic Services:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

Indicate Minimum Coinsurance percentage for Restorative Services:

Indicate Maximum Coinsurance percentage for Restorative Services:

Select the Coinsurance Coverage Basis for Restorative Services:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

Section D – Step-Up – 16b – Comprehensive Dental – Base 6 Screen

PBP 2008 Data Entry System - Step Up #16b Comp Dental - Base 6

File

Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions:

___

Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:

___

Select the Coinsurance Coverage Basis for Endodontics/Periodontics/Extractions:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

___

Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

___

Select the Coinsurance Coverage Basis for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

______

Section D – Step-Up – 16b – Comprehensive Dental – Base 7 Screen

PBP 2008 Data Entry System - Step Up #16b Comp Dental - Base 7

File

Is there an enrollee Copayment?
- Yes
- No

Indicate Minimum Copayment amount for Medicare Covered Benefits:

Indicate Maximum Copayment amount for Medicare Covered Benefits:

Indicate Minimum Copayment amount for Emergency Services:

Indicate Maximum Copayment amount for Emergency Services:

Indicate Minimum Copayment amount for Diagnostic Services:

Indicate Maximum Copayment amount for Diagnostic Services:

Indicate Minimum Copayment amount for Restorative Services:

Indicate Maximum Copayment amount for Restorative Services:

Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions:

Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions:

Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 8 SCREEN

PBP 2008 Data Entry System - Step Up #16b Comp Dental - Base 8

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 Comprehensive Dental Services?
- ( ) Yes
- ( ) No

Notes (Optional):

Import Text

SECTION D – STEP-UP – 17A – EYE EXAMS – BASE 1 SCREEN

PBP 2008 Data Entry System - Step Up #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 D – STEP-UP – 17A – EYE EXAMS – BASE 2 SCREEN

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

File

Is there an enrollee Coinsurance?
- Yes
- No

Indicate Minimum Coinsurance percentage for Medicare Covered Benefits: ___

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits: ___

Select the Coverage Basis for Coinsurance for Medicare Covered Benefits:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

Indicate Minimum Coinsurance percentage for Routine Eye Exams: ___

Indicate Maximum Coinsurance percentage for Routine Eye Exams: ___

Select the Coverage Basis for Coinsurance for Routine Eye Exams:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount: ______

Is there an enrollee Copayment?
- Yes
- No

Indicate Minimum Copayment amount for Medicare Covered Benefits: ______

Indicate Maximum Copayment amount for Medicare Covered Benefits: ______

Indicate Minimum Copayment amount per Routine Eye Exam: ______

Indicate Maximum Copayment amount per Routine Eye Exam: ______

SECTION D – STEP-UP – 17A – EYE EXAMS – BASE 3 SCREEN

PBP 2008 Data Entry System - Step Up #17a Eye Exams - Base 3

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 D – Step-Up – 17b – Eye Wear – Base 1 Screen

PBP 2008 Data Entry System - Step Up #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 D – STEP-UP – 17B – EYE WEAR – BASE 2 SCREEN

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

File

Select type of benefit for Eye Glass Lenses:
- Mandatory
- Optional

Is this benefit unlimited for Eye Glass Lenses?
- Yes
- No, indicate number

Indicate quantity (number of pairs) for Eye Glass Lenses:

Select Eye Glass Lenses periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Eye Glass Frames:
- Mandatory
- Optional

Is this benefit unlimited for Eye Glass Frames?
- Yes
- No, indicate number

Indicate quantity for Eye Glass Frames:

Select Eye Glass Frames periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Upgrades:
- Mandatory
- Optional

SECTION D – STEP-UP – 17B – EYE WEAR – BASE 3 SCREEN

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

File

Is there a service-specific Maximum Plan Benefit Coverage amount?
- Yes
- No

Select the Maximum Plan Benefit Coverage type:
- Covered under Eye Exams Category 17a
- Plan-specified amount per period

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 Maximum Plan Benefit Coverage Basis:
- Discount (__%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Other, describe

Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage: __

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
- Yes
- No

Select the Maximum Enrollee Out-of-Pocket Cost type:
- Covered under Eye Exams Category 17a
- Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount: ________

Select Maximum Enrollee Out-of-Pocket Cost periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Section D – Step-Up – 17b – Eye Wear – Base 4 Screen

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

File

Is there an enrollee Coinsurance?
- Yes
- No

Indicate Coinsurance percentage for Medicare Covered Benefits:

___

Select the Coinsurance Coverage Basis for Medicare Covered Benefits:
- Published Retail Price
- Published Wholesale Price
- MA Organization Developed Cost Structure
- Other, describe

Indicate Coinsurance percentage for Contact Lenses:

___

Select the Coinsurance Coverage Basis for Contact Lenses:
- Published Retail Price
- Published Wholesale Price
- MA Organization Developed Cost Structure
- Other, describe

Indicate Coinsurance percentage for Eye Glasses (Lenses and Frames):

___

Select the Coinsurance Coverage Basis for Eye Glasses (Lenses and Frames):
- Published Retail Price
- Published Wholesale Price
- MA Organization Developed Cost Structure
- Other, describe

Indicate Coinsurance percentage for Eye Glass Lenses:

___

Select the Coinsurance Coverage Basis for Eye Glass Lenses:
- Published Retail Price
- Published Wholesale Price
- MA Organization Developed Cost Structure
- Other, describe

Indicate Coinsurance percentage for Eye Glass Frames:

___

Select the Coinsurance Coverage Basis for Eye Glass Frames:
- Published Retail Price
- Published Wholesale Price
- MA Organization Developed Cost Structure
- Other, describe

Indicate Coinsurance percentage for Upgrades:

___

Select the Coinsurance Coverage Basis for Upgrades:
- Published Retail Price
- Published Wholesale Price
- MA Organization Developed Cost Structure
- Other, describe

SECTION D – STEP-UP – 17B – EYE WEAR – BASE 5 SCREEN

PBP 2008 Data Entry System - Step Up #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 D – STEP-UP – 17B – EYE WEAR – BASE 6 SCREEN

PBP 2008 Data Entry System - Step Up #17b Eye Wear - Base 6

File

Eye Wear Notes

Notes (Optional):

Import Text

SECTION D – STEP-UP – 18A – HEARING EXAMS – BASE 1 SCREEN

PBP 2008 Data Entry System - Step Up #18a Hearing Exams - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
- Yes
- No

Select enhanced benefits:
- Routine Hearing Tests
- Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Tests:
- Mandatory
- Optional

Is this benefit unlimited for Routine Hearing Tests?
- Yes
- No, indicate number

Indicate number for Routine Hearing Tests:

Select Routine Hearing Tests periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Fitting/Evaluation for Hearing Aid:
- Mandatory
- Optional

Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?
- Yes
- No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

SECTION D – STEP-UP – 18A – HEARING EXAMS – BASE 2 SCREEN

PBP 2008 Data Entry System - Step Up #18a Hearing Exams - Base 2

File

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 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 an enrollee Coinsurance?
- Yes
- No

Indicate the Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare Covered Benefits:

Select the Coinsurance Coverage Basis for Medicare Covered Benefits:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

SECTION D – STEP-UP – 18A – HEARING EXAMS – BASE 3 SCREEN

PBP 2008 Data Entry System - Step Up #18a Hearing Exams - Base 3

File

Indicate Minimum Coinsurance percentage for Routine Hearing Tests:

Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

Is there an enrollee Deductible?
- Yes
- No

Indicate Maximum Coinsurance percentage for Routine Hearing Tests:

Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

Indicate Deductible Amount:

Select the Coinsurance Coverage Basis for Routine Hearing Tests:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

Select the Coinsurance Coverage Basis for Fitting/Evaluation for Hearing Aid:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

SECTION D – STEP-UP – 18A – HEARING EXAMS – BASE 4 SCREEN

PBP 2008 Data Entry System - Step Up #18a Hearing Exams - Base 4

File

Is there an enrollee Copayment?
- Yes
- No

Indicate Minimum Copayment amount for Medicare Covered Benefits:

Indicate Maximum Copayment amount for Medicare Covered Benefits:

Indicate Minimum Copayment amount for Routine Hearing Tests:

Indicate Maximum Copayment amount for Routine Hearing Tests:

Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:

Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:

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 Hearing Exams?
- Yes
- No

SECTION D – STEP-UP – 18A – HEARING EXAMS – BASE 5 SCREEN

PBP 2008 Data Entry System - Step Up #18a Hearing Exams - Base 5

File

Hearing Exams Notes

Notes (Optional):

Import Text

SECTION D – STEP-UP – 18B – HEARING AIDS – BASE 1 SCREEN

PBP 2008 Data Entry System - Step Up #18b Hearing Aids - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
- Yes
- No

Select enhanced benefits:
- Hearing Aids (all types)
- Hearing Aids - Inner Ear
- Hearing Aids - Outer Ear
- Hearing Aids - Over the Ear

Select type of benefit for Hearing Aids (all types):
- Mandatory
- Optional

Is this benefit unlimited for Hearing Aids (all types)?
- Yes
- No, indicate number

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Hearing Aids - Inner Ear:
- Mandatory
- Optional

Is this benefit unlimited for Hearing Aids - Inner Ear?
- Yes
- No, indicate number

Indicate quantity for Hearing Aids - Inner Ear:

Select Hearing Aids - Inner Ear periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Hearing Aids - Outer Ear:
- Mandatory
- Optional

Is this benefit unlimited for Hearing Aids - Outer Ear?
- Yes
- No, indicate number

Indicate quantity for Hearing Aids - Outer Ear:

Select Hearing Aids - Outer Ear periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

SECTION D – STEP-UP – 18B – HEARING AIDS – BASE 2 SCREEN

PBP 2008 Data Entry System - Step Up #18b Hearing Aids - Base 2

File

Select type of benefit for Hearing Aids - Over the Ear:
- Mandatory
- Optional

Is this benefit unlimited for Hearing Aids - Over the Ear?
- Yes
- No, indicate number

Indicate quantity for Hearing Aids - Over the Ear: ___

Select Hearing Aids - Over the Ear 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

Select the Maximum Plan Benefit Coverage type:
- Covered under Hearing Exams Category - 18a
- Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage amount: ________

Indicate 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:
- Discount (__%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Other, describe

Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage: __

SECTION D – STEP-UP – 18B – HEARING AIDS – BASE 3 SCREEN

PBP 2008 Data Entry System - Step Up #18b Hearing Aids - Base 3

File

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
- Yes
- No

Select the Maximum Enrollee Out-of-Pocket Cost type:
- Covered under Hearing Exams Category - 18a
- Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select 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 an enrollee Coinsurance?
- Yes
- No

Indicate Coinsurance percentage for Hearing Aids (all types):

Select the Coinsurance Coverage Basis for Hearing Aids (all types):
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Other, describe

Indicate Coinsurance percentage for Hearing Aids - Inner Ear:

Select the Coinsurance Coverage Basis for Hearing Aids - Inner Ear:
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Other, describe

Indicate Coinsurance percentage for Hearing Aids - Outer Ear:

Select the Coinsurance Coverage Basis for Hearing Aids - Outer Ear:
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Other, describe

SECTION D – STEP-UP – 18B – HEARING AIDS – BASE 4 SCREEN

PBP 2008 Data Entry System - Step Up #18b Hearing Aids - Base 4

File

Indicate Coinsurance percentage for Hearing Aids - Over the Ear:

Select the Coinsurance Coverage Basis for Hearing Aids - Over the Ear:
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Other, describe

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- Yes
- No

Indicate Minimum Copayment amount per Hearing Aid (all types):

Indicate Maximum Copayment amount per Hearing Aid (all types):

Indicate Copayment amount per Hearing Aid - Inner Ear:

Indicate Copayment amount per two Hearing Aids - Inner Ear:

Indicate Copayment amount per Hearing Aid - Outer Ear:

Indicate Copayment amount per two Hearing Aids - Outer Ear:

Indicate Copayment amount per Hearing Aid - Over the Ear:

Indicate Copayment amount per two Hearing Aids - Over the Ear:

SECTION D – STEP-UP – 18B – HEARING AIDS – BASE 5 SCREEN

PBP 2008 Data Entry System - Step Up #18b Hearing Aids - Base 5

File

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 Hearing Aids?

- ○ Yes
- ○ No

Notes (Optional):

Import Text