

## CY 2027 PBP Data Entry System Pages

### 16a – Medicare Dental Services – Page 1

Outpatient Services(9) - In Progress

Ambulance/Transportation Services(10) - In Progress

DME, Prosthetics and Medical and Diabetic Supplies(11) - In Progress

Dialysis Services(12) - In Progress

Other Supplemental Services(13) - In Progress

Preventive and Other Defined Supplemental Services(14) - In Progress

Medicare Part B Rx Drugs(15) - In Progress

Dental(16) - In Progress

**Medicare Dental Services(16a) - In Progress**

Diagnostic and Preventive Dental(16b) - In Progress

Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Medicare Dental Services (16a) - Medicare ⓘ

Plan Characteristics

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? ⓘ \*

Yes

No

MOOP amount \*  
\$

Periodicity \*  
▼

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*  
Maximum coinsurance \*

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*  
\$

Maximum copayment \*  
\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount \*  
\$

CloseSave and CloseSave and Next

CY 2027 PBP Data Entry System Pages

16a – Medicare Dental Services – Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16a – Medicare Dental Services – Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## 16a – Medicare Dental Services – Page 4

***Softrams***

## CY 2027 PBP Data Entry System Pages

### 16b – Diagnostic and Preventive Dental – Page 1

Dental(16) - Completed

Medicare Dental Services(16a) - Completed

**Diagnostic and Preventive Dental(16b) - Completed**

Oral Exams(16b1) - Completed

Dental X-Rays(16b2) - Completed

Other Diagnostic Dental Services(16b3) - Completed

Prophylaxis (cleaning)(16b4) - Completed

Fluoride Treatment(16b5) - Completed

Other Preventive Dental Services(16b6) - Completed

Comprehensive Dental(16c) - Completed

Eye Exams/Eyewear(17) - Completed

Hearing Exams/Hearing Aids(18) - Completed

**Diagnostic and Preventive Dental (16b) - Non-Medicare ⓘ**

Plan Characteristics

Is there a maximum plan benefit coverage? ⓘ \*

Yes

No

Does the maximum plan benefit coverage amount apply to in-network services only or does it apply to both in-network and out-of-network services? \*

☐ In-network services only

☒ Both in-network and out-of-network services

Maximum amount \*  
\$ 4000

Periodicity \*  
Every Year

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? ⓘ \*

Yes

No

MOOP amount \*  
\$

Periodicity \*  
Other, Describe

Description \*  
Enter description

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16b – Diagnostic and Preventive Dental – Page 2

✓ Ambulance/Transportation Services(10) - Completed

✓ DME, Prosthetics and Medical and Diabetic Supplies(11) - Completed

Dialysis Services(12) - Completed

✓ Other Supplemental Services(13) - Completed

✓ Preventive and Other Defined Supplemental Services(14) - Completed

✓ Medicare Part B Rx Drugs(15) - Completed

^ Dental(16) - Completed

Medicare Dental Services(16a) - Completed

**^ Diagnostic and Preventive Dental(16b) - Completed**

Oral Exams(16b1) - Completed

Dental X-Rays(16b2) - Completed

Other Diagnostic Dental Services(16b3) - Completed

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? ⓘ \*

Yes

No

MOOP amount ⓘ \*

\$

Periodicity ⓘ \*

Other, Describe

Description ⓘ \*

Enter description

0/300 characters

Is there a Coinsurance for combination of services included in a single cost per office visit? ⓘ \*

Yes

Yes with a min & max

No

Select all that apply: \*

☐ Oral Exams ⓘ

☐ Dental X-Rays ⓘ

☐ Other Diagnostic Dental Services ⓘ

☐ Prophylaxis (cleaning) ⓘ

☐ Fluoride Treatment ⓘ

☐ Other Preventive Dental Services ⓘ

Close

Save and Close

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## CY 2027 PBP Data Entry System Pages

### 16b – Diagnostic and Preventive Dental – Page 3

Medicare Part B Rx Drugs(15) - In Progress

Dental(16) - In Progress

Medicare Dental Services(16a) - Not Started

**Diagnostic and Preventive Dental(16b) - Not Started**

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Is there a Copayment for combination of services included in a single cost per office visit? ⓘ \*

Yes

Yes with a min & max

No

Select all that apply: \*

☐ Oral Exams ⓘ

☐ Dental X-Rays ⓘ

☐ Other Diagnostic Dental Services ⓘ

☐ Prophylaxis (cleaning) ⓘ

☐ Fluoride Treatment ⓘ

☐ Other Preventive Dental Services ⓘ

Copayment amount ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next

Out-of-Network (OON) Benefits

Is there a maximum plan benefit coverage amount? \*

Yes

No

Maximum plan benefit coverage amount \*

\$

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Close

Save and Close

Save and Next



## CY 2027 PBP Data Entry System Pages

### 16b1 – Oral Exams – Page 1

Medicare Part B Rx Drugs(15) - In Progress

Dental(16) - In Progress

Medicare Dental Services(16a) - Not Started

Diagnostic and Preventive Dental(16b) - Not Started

**Oral Exams(16b1) - Not Started**

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

**Oral Exams (16b1) - Non-Medicare**

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \*

Maximum copayment ⓘ \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close Save and Close Save and Next

16b1 – Oral Exams – Page 2

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

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CY 2027 PBP Data Entry System Pages

16b1 – Oral Exams – Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

16b1 – Oral Exams – Page 4

Medicare Dental Services(16a) - Not Started

^ Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

✓ Comprehensive Dental(16c) - In Progress

✓ Eye Exams/Eyewear(17) - In Progress


✓ Hearing Exams/Hearing Aids(18) - In Progress

Point-of-Service (POS) Benefits

+ Add New POS Group

Oral Exams (16b1) Non Medicare Service

Add to POS Group

POS Group 

Group Name 1 - POS

Coinurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16b2 – Dental X-Rays – Page 1

Medicare Part B Rx Drugs(15) - In Progress

Dental(16) - In Progress

Medicare Dental Services(16a) - Not Started

Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

**Dental X-Rays(16b2) - Not Started**

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Dental X-Rays (16b2) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate the number of X-Rays \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \*

Maximum copayment ⓘ \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close Save and Close Save and Next

16b2 – Dental X-Rays – Page 2

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16b2 – Dental X-Rays – Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

16b2 – Dental X-Rays – Page 4

^ Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

^ Comprehensive Dental(16c) - In Progress

^ Eye Exams/Eyewear(17) - In Progress

^ Hearing Exams/Hearing Aids(18) - In Progress

Point-of-Service (POS) Benefits

+ Add New POS Group

Dental X-Rays (16b2) Non Medicare Service

Add to POS Group

POS Group Group Name 1 - POS

CoinuranceNo

CopaymentNo

DeductibleNo

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes \*

Close

Save and Close

Save and Next



## CY 2027 PBP Data Entry System Pages

### 16b3 – Other Diagnostic Dental Services – Page 1

Medicare Part B Rx Drugs(15) - In Progress

Dental(16) - In Progress

Medicare Dental Services(16a) - Not Started

Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Other Diagnostic Dental Services (16b3) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \*  
\$

Maximum copayment ⓘ \*  
\$

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Close Save and Close Save and Next

CY 2027 PBP Data Entry System Pages

16b3 – Other Diagnostic Dental Services – Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16b3 – Other Diagnostic Dental Services – Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

16b3 – Other Diagnostic Dental Services – Page 4

Medicare Dental Services(16a) - Not Started

Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Point-of-Service (POS) Benefits

+ Add New POS Group

Other Diagnostic Dental Services (16b3) Non Medicare Service

Add to POS Group

POS Group

Group Name 1 - POS

Coinsurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16b4 - Prophylaxis (cleaning) - Page 1

Medicare Part B Rx Drugs(15) - In Progress

Dental(16) - In Progress

Medicare Dental Services(16a) - Not Started

Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Prophylaxis (cleaning) (16b4) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \*

Maximum copayment ⓘ \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close Save and Close Save and Next

16b4 - Prophylaxis (cleaning) - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

16b4 - Prophylaxis (cleaning) - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16b4 - Prophylaxis (cleaning) - Page 4

^ Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

✓ Comprehensive Dental(16c) - In Progress

✓ Eye Exams/Eyewear(17) - In Progress

✓ Hearing Exams/Hearing Aids(18) - In Progress

#### Point-of-Service (POS) Benefits

+ Add New POS Group

Prophylaxis (cleaning) (16b4) Non Medicare Service

Add to POS Group

POS Group ⓘ  
Group Name 1 - POS

Coinurance	Copayment	Deductible
No	No	No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

CloseSave and CloseSave and Next



## CY 2027 PBP Data Entry System Pages

### 16b5 - Fluoride Treatment - Page 1

Medicare Part B Rx Drugs(15) - In Progress

Dental(16) - In Progress

Medicare Dental Services(16a) - Not Started

Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Fluoride Treatment (16b5) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \*

Maximum copayment ⓘ \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close Save and Close Save and Next

16b5 - Fluoride Treatment - Page 2

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16b5 - Fluoride Treatment - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

16b5 - Fluoride Treatment - Page 4

^ Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

✓ Comprehensive Dental(16c) - In Progress

✓ Eye Exams/Eyewear(17) - In Progress

✓ Hearing Exams/Hearing Aids(18) - In Progress

Point-of-Service (POS) Benefits

+ Add New POS Group

Fluoride Treatment (16b5) Non Medicare Service

Add to POS Group

POS Group Group Name 1 - POS

Coinsurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16b6 - Other Preventive Dental Services - Page 1

Medicare Part B Rx Drugs(15) - In Progress

Dental(16) - In Progress

Medicare Dental Services(16a) - Not Started

Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Other Preventive Dental Services (16b6) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \*  
\$

Maximum copayment ⓘ \*  
\$

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Close Save and Close Save and Next

CY 2027 PBP Data Entry System Pages

16b6 - Other Preventive Dental Services - Page 2

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16b6 - Other Preventive Dental Services - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

16b6 - Other Preventive Dental Services - Page 4

^ Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

✓ Comprehensive Dental(16c) - In Progress

✓ Eye Exams/Eyewear(17) - In Progress

✓ Hearing Exams/Hearing Aids(18) - In Progress

Point-of-Service (POS) Benefits

+ Add New POS Group

Other Preventive Dental Services (16b6) Non Medicare Service

Add to POS Group

POS Group

Group Name 1 - POS

Coinurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

Close

Save and Close

Save and Next



## CY 2027 PBP Data Entry System Pages

### 16c - Comprehensive Dental - Page 1

Other Preventive Dental Services(16b6) - Completed

Comprehensive Dental(16c) - Completed

Restorative Services(16c1) - Completed

Endodontics(16c2) - Completed

Periodontics(16c3) - Completed

Prosthodontics, removable(16c4) - Completed

Implant Services(16c6) - Completed

Prosthodontics, fixed(16c7) - Completed

Oral and Maxillofacial Surgery(16c8) - Completed

Adjunctive General Services(16c10) - Completed

Eye Exams/Eyewear(17) - Completed

Hearing Exams/Hearing Aids(18) - Completed

Comprehensive Dental (16c) - Non-Medicare ⓘ

Updated by Terri Terraferma on 6/26/2024 10:53:53 AM EDT

Service maximum plan benefit coverage: ⓘ \*

Yes No

Select the maximum plan benefit coverage type ⓘ

☐ Covered under Diagnostic and Preventive Dental (16b)

☒ Plan-specified amount per period

Maximum amount ⓘ \*

\$

Periodicity ⓘ \*

Other, Describe

Description ⓘ \*

Enter description

0/300 characters

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? ⓘ \*

Yes No

Select the maximum enrollee out-of-pocket cost type ⓘ \*

☐ Covered under Diagnostic and Preventive Dental (16b)

☒ Plan-specified amount per period

Plan Characteristics

Close Save and Close Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c - Comprehensive Dental - Page 2

Other Preventive Dental Services(16b6) - Completed

Comprehensive Dental(16c) - Completed

Restorative Services(16c1) - Completed

Endodontics(16c2) - Completed

Periodontics(16c3) - Completed

Prosthodontics, removable(16c4) - Completed

Implant Services(16c6) - Completed

Prosthodontics, fixed(16c7) - Completed

Oral and Maxillofacial Surgery(16c8) - Completed

Adjunctive General Services(16c10) - Completed

Eye Exams/Eyewear(17) - Completed

Hearing Exams/Hearing Aids(18) - Completed

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? ⓘ \*

Yes

No

Select the maximum enrollee out-of-pocket cost type ⓘ \*

☐ Covered under Diagnostic and Preventive Dental (16b)

☒ Plan-specified amount per period

MOOP amount ⓘ \*

\$

Periodicity ⓘ \*

Other, Describe

Description ⓘ \*

Enter description

0/300 characters

Is there a deductible? ⓘ \*

Yes

No

Notes

Close

Save and Close

Save and Next

16c - Comprehensive Dental - Page 3

Other Preventive Dental Services(16b6) - Completed

Comprehensive Dental(16c) - Completed

Restorative Services(16c1) - Completed

Endodontics(16c2) - Completed

Periodontics(16c3) - Completed

Prosthodontics, removable(16c4) - Completed

Maxillofacial Prosthetics(16c5) - Completed

Out-of-Network (OON) Benefits

Is there a maximum plan benefit coverage amount? \*

Yes

No

Maximum plan benefit coverage amount \*

\$

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c1 - Restorative Services - Page 1

Dental(16) - In Progress

Medicare Dental Services(16a) - Not Started

Diagnostic and Preventive Dental(16b) - Not Started

Oral Exams(16b1) - Not Started

Dental X-Rays(16b2) - Not Started

Other Diagnostic Dental Services(16b3) - Not Started

Prophylaxis (cleaning)(16b4) - Not Started

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

Comprehensive Dental(16c) - In Progress

**Restorative Services(16c1) - Not Started**

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Restorative Services (16c1) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \*

Maximum copayment ⓘ \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close Save and Close Save and Next

16c1 - Restorative Services - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16c1 - Restorative Services - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

16c1 - Restorative Services - Page 4

Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

Point-of-Service (POS) Benefits

+ Add New POS Group

Restorative Services (16c1) Non Medicare Service

Add to POS Group

POS Group 

Group Name 1 - POS

Coinsurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c2 - Endodontics - Page 1

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

^ Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

**Endodontics(16c2) - Not Started**

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

**Endodontics (16c2) - Non-Medicare**

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes

No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close

Save and Close

Save and Next



16c2 - Endodontics - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

16c2 - Endodontics - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

16c2 - Endodontics - Page 4

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started


Adjunctive General Services(16c10) - Not Started

Point-of-Service (POS) Benefits

+ Add New POS Group

Endodontics (16c2) Non Medicare Service

Add to POS Group

POS Group  Select a Group

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c3 - Periodontics - Page 1

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

^ Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

Periodontics (16c3) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \* \$

Maximum copayment ⓘ \* \$

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close Save and Close Save and Next

16c3 - Periodontics - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16c3 - Periodontics - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c3 - Periodontics - Page 4

^ Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

**Periodontics(16c3) - Not Started**

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

#### Point-of-Service (POS) Benefits

+ Add New POS Group

Periodontics (16c3) Non Medicare Service

Add to POS Group

POS Group ⓘ  
Group Name 1 - POS

Coinurance	Copayment	Deductible
No	No	No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*  

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c4 - Prosthodontics, removable - Page 1

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

^ Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

**Prosthodontics, removable(16c4) - Not Started**

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

**Prosthodontics, removable (16c4) - Non-Medicare**

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes

**No**

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes

**Yes with a min & max**

No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes

**Yes with a min & max**

No

Minimum copayment ⓘ \*  
\$

Maximum copayment ⓘ \*  
\$

Authorization required for this benefit?  
**No**

Referral required for this benefit?  
**No**

Close

Save and Close

Save and Next



16c4 - Prosthodontics, removable - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16c4 - Prosthodontics, removable - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

16c4 - Prosthodontics, removable - Page 4

Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

Point-of-Service (POS) Benefits

+ Add New POS Group

Prosthodontics, removable (16c4) Non Medicare Service

Add to POS Group

POS Group Group Name 1 - POS

Coinurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c5 - Maxillofacial Prosthetics - Page 1

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

^ Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

**Maxillofacial Prosthetics(16c5) - Not Started**

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

**Maxillofacial Prosthetics (16c5) - Non-Medicare**

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes

No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*  
\$

Maximum copayment ⓘ \*  
\$

Authorization required for this benefit?  
**No**

Referral required for this benefit?  
**No**

Close

Save and Close

Save and Next

16c5 - Maxillofacial Prosthetics - Page 2

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

16c5 - Maxillofacial Prosthetics - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c5 - Maxillofacial Prosthetics - Page 4

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

**Maxillofacial Prosthetics(16c5) - Not Started**

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started


Adjunctive General Services(16c10) - Not Started

#### Point-of-Service (POS) Benefits

+ Add New POS Group

Maxillofacial Prosthetics (16c5) Non Medicare Service

Add to POS Group

POS Group  Group Name 1 - POS

Coinurance	Copayment	Deductible
No	No	No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

CloseSave and CloseSave and Next

## CY 2027 PBP Data Entry System Pages

### 16c6 - Implant Services - Page 1

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

^ Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

**Implant Services(16c6) - Not Started**

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

**Implant Services (16c6) - Non-Medicare**

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes

No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*  
\$

Maximum copayment ⓘ \*  
\$

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Close

Save and Close

Save and Next



16c6 - Implant Services - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16c6 - Implant Services - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

16c6 - Implant Services - Page 4

Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

Point-of-Service (POS) Benefits

+ Add New POS Group

Implant Services (16c6) Non Medicare Service

Add to POS Group

POS Group Group Name 1 - POS

CoinsuranceNo

CopaymentNo

DeductibleNo

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c7 - Prosthodontics, fixed - Page 1

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

^ Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

Prosthodontics, fixed (16c7) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \*

Maximum copayment ⓘ \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close Save and Close Save and Next

16c7 - Prosthodontics, fixed - Page 2

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16c7 - Prosthodontics, fixed - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c7 - Prosthodontics, fixed - Page 4

^ Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

#### Point-of-Service (POS) Benefits

+ Add New POS Group

Prosthodontics, fixed (16c7) Non Medicare Service

Add to POS Group

POS Group ⓘ  
Group Name 1 - POS

Coinurance	Copayment	Deductible
No	No	No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*  

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c8 - Oral and Maxillofacial Surgery - Page 1

Fluoride Treatment(16b5) - Not Started

Other Preventive Dental Services(16b6) - Not Started

^ Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

Oral and Maxillofacial Surgery (16c8) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \*

Maximum copayment ⓘ \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close Save and Close Save and Next



16c8 - Oral and Maxillofacial Surgery - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

Softrams

CY2027 PBP – Benefit Service Categories 16-20  
09/05/2025  
CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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CY 2027 PBP Data Entry System Pages

16c8 - Oral and Maxillofacial Surgery - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c8 - Oral and Maxillofacial Surgery - Page 4

^ Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

**Oral and Maxillofacial Surgery(16c8) - Not Started**

Orthodontics(16c9) - Not Started


Adjunctive General Services(16c10) - Not Started

Point-of-Service (POS) Benefits

+ Add New POS Group

Oral and Maxillofacial Surgery (16c8) Non Medicare Service

Add to POS Group

POS Group  Group Name 1 - POS

Coinurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 16c9 - Orthodontics - Page 1

Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Orthodontics (16c9) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? ⓘ \*

Yes No

Indicate number of visits \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Yes Yes with a min & max No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes Yes with a min & max No

Minimum copayment ⓘ \*

Maximum copayment ⓘ \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close Save and Close Save and Next

16c9 - Orthodontics - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

16c9 - Orthodontics - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

16c9 - Orthodontics - Page 4

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prosthodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

Implant Services(16c6) - Not Started

Prosthodontics, fixed(16c7) - Not Started

Oral and Maxillofacial Surgery(16c8) - Not Started

Orthodontics(16c9) - Not Started

Adjunctive General Services(16c10) - Not Started

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Point-of-Service (POS) Benefits

+ Add New POS Group

Orthodontics (16c9) Non Medicare Service

Add to POS Group

POS Group

Group Name 1 - POS

Coinurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16c10 - Adjunctive General Services - Page 1

Adjunctive General Services (16c10) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? \*

Yes

No

Indicate number of visits \*

Periodicity \*

Other, Describe

Description \*

sample text

11/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*

\$

Maximum copayment \*

\$

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close

Save and Close

Save and Next



16c10 - Adjunctive General Services - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

16c10 - Adjunctive General Services - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

Point-of-Service (POS) benefits

Add to POS Group

POS Group

Group Name 1 - POS

+ Add New POS Group

Coinsurance

Copayment

Deductible

20%

\$20

\$200

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

+ Add Notes

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 17a – Eye Exams– Page 1

Home Health Services(6) - Not Started

✓ Health Care Professional Services(7) - Not Started

✓ Outpatient Procedures, Tests, Labs and Radiology Services(8) - Not Started

✓ Outpatient Services(9) - Not Started

✓ Ambulance/Transportation Services(10) - Not Started

✓ DME, Prosthetics and Medical and Diabetic Supplies(11) - Not Started

Dialysis Services(12) - Not Started

✓ Other Supplemental Services(13) - Not Started

✓ Preventive and Other Defined Supplemental Services(14) - In Progress

✓ Medicare Part B Rx Drugs(15) - Not Started

✓ Dental(16) - Not Started

**Eye Exams (17a) - Medicare** ⓘ

Plan Characteristics

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? ⓘ \*

Yes

No

MOOP amount \*  
\$

Periodicity \*  
Other, Describe

Description \*  
Enter description  
0/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*  
Maximum coinsurance \*

Is there a copayment? \*

Close

Save and Close

Save and Next

17a – Eye Exams– Page 2

Is there a coinsurance?

Yes

Yes with a min & max

No

Minimum coinsurance

4%

Maximum coinsurance

8%

Is there a copayment?

Yes

Yes with a min & max

No

Minimum copayment

\$400

Maximum copayment

\$400

Is there a deductible?

Yes

No

Deductible amount

\$400

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

17a – Eye Exams– Page 3

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

17a – Eye Exams– Page 4

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

Point-of-Service (POS) benefits

Add to POS Group

POS Group

Group Name 1 - POS

+ Add New POS Group

Coinsurance

Copayment

Deductible

20%

\$20

\$200

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

+ Add Notes

Close

Save and Close

Save and Next



17a – Eye Exams – Non-Medicare

Dialysis Services(12) - Not Started

Other Supplemental Services(13) - Not Started

Preventive and Other Defined Supplemental Services(14) - In Progress

Medicare Part B Rx Drugs(15) - Not Started

Dental(16) - Not Started

Eye Exams/Eyewear(17) - Not Started

Eye Exams(17a) - Not Started

Eye Exams(17a) - Not Started

Routine Eye Exams(17a1) - Not Started

Eyewear(17b) - Not Started

Eyewear(17b) - Not Started

Eye Exams (17a) - Non-Medicare ⓘ

Plan Characteristics

Is there a maximum plan benefit coverage? ⓘ \*

Yes

No

Maximum amount \*  
\$

Periodicity \*

Is there a deductible? ⓘ \*

Yes

No

Deductible amount \*  
\$

+ Add Notes

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 17a1 – Routine Eye Exams – Page 1

Medicare Part B Rx Drugs(15)-Completed

Dental(16)-Completed

Eye Exams(17a)- In Progress

**Routine Eye Exams(17a1)- In Progress**

Other Eye Exam Services(17a2)- Not Started

Eyewear(17b)- Not Started

Eyewear(17b) Non Medicare - Not Started

Contact Lenses(17b1)- Not Started

Eyeglasses (lenses and frames)(17b2)- Not Started

Eyeglass lenses(17b3)- Not Started

Eyeglass frames(17b4))- Not Started

Upgrades(17b5)- Not Started

Routine Eye Exams(17a1)

Plan Characteristics

Is this benefit unlimited?

Yes No

Indicate number of visits

10

Periodicity

6 Months

Is there a coinsurance?

Yes Yes with a min & max No

Minimum coinsurance

4%

Maximum coinsurance

8%

Is there a copayment?

Yes Yes with a min & max No

Minimum copayment

\$400

Maximum copayment

\$400

17a1 – Routine Eye Exams – Page 2

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

17a1 – Routine Eye Exams – Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

Point-of-Service (POS) benefits

Add to POS Group

POS Group

Group Name 1 - POS

+ Add New POS Group

Coinurance

Copayment

Deductible

20%

\$20

\$200

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

+ Add Notes

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

17a2 – Other Eye Exam Services – Page 1

Othr Eye Exam Services (17a2) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? \*

Yes

No

Indicate number of visits \*

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*

\$

Maximum copayment \*

\$

Authorization required for this benefit?

\*\*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

17a2 – Other Eye Exam Services – Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

17a2 – Other Eye Exam Services – Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next



Point-of-Service (POS) benefits

Add to POS Group

POS Group

Group Name 1 - POS

+ Add New POS Group

Coinurance

Copayment

Deductible

20%

\$20

\$200

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

+ Add Notes

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 17b – Eyewear - Medicare - Page 1

**Eyewear (17b) - Medicare** ⓘ

Plan Characteristics

Even if you do not offer enhanced benefits, you must complete this section for your Medicare-covered Benefits.

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? ⓘ \*

Yes

No

Select the maximum enrollee out-of-pocket cost type \*

☐ Covered under Eye exams Category (17a)

☒ Plan-specified amount per period

MOOP amount \*  
\$ 1000.00

Periodicity \*  
Other, Describe ▼

Description \*  
Enter description  

0/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

17b – Eyewear - Medicare – Page 2

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*

Maximum copayment \*

Is there a deductible? ⓘ \*

Yes

No

Deductible amount \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

17b – Eyewear - Medicare - Page 3

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

17b – Eyewear - Medicare - Page 4

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

Point-of-Service (POS) benefits

Add to POS Group

POS Group

Group Name 1 - POS

+ Add New POS Group

Coinurance

Copayment

Deductible

20%

\$20

\$200

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

+ Add Notes

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

17b – Eyewear - Non-Medicare - Page 1

Eyewear (17b) - Non-Medicare ⓘ

Plan Characteristics

Is there a maximum plan benefit coverage? ⓘ \*

Yes

No

Select the maximum plan benefit coverage type \*

☐ Covered under Eye exams Category (17a)

☒ Plan-specified amount per period

Does the maximum plan benefit coverage amount apply to in-network services only or does it apply to both in-network and out-of-network services

☐ In-network services only

☒ Both in-network and out-of-network services

Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear? \*

Yes

No

Combined maximum amount \*

\$ 400

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Is there a deductible? ⓘ \*

Yes

No

Close

Save and Close

Save and Next

17b – Eyewear - Non-Medicare - Page 2

Is there a deductible? ⓘ \*

Yes

No

Notes

Combined maximum allowance amount is \$50 less

72/2000 characters

Out-of-Network (OON) Benefits

Is there a maximum plan benefit coverage amount? ⓘ \*

Yes

No

Maximum plan benefit coverage amount \*

\$

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Close

Save and Close

Save and Next



## CY 2027 PBP Data Entry System Pages

### 17b1 – Contact Lenses– Page 1

#### Contact Lenses (17b1) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? \*

Yes

No

Indicate number of pairs \*

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

---

Is there a maximum plan benefit coverage amount? ⓘ \*

Yes

No

Maximum plan benefit coverage amount \*

\$

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

---

Is there a coinsurance? \*

Close

Save and Close

Save and Next

17b1 – Contact Lenses– Page 2

Preventive and Other Defined Supplemental Services(14) - In Progress

Medicare Part B Rx Drugs(15) - Not Started

Dental(16) - Not Started

Eye Exams/Eyewear(17) - In Progress

Eye Exams(17a) - Not Started

Eye Exams(17a) - In Progress

Eyewear(17b) - Not Started

Eyewear(17b) - In Progress

Contact Lenses(17b1) - Not Started

Eyeglasses (lenses and frames) (17b2) - Not Started

Hearing Exams/Hearing Aids(18) - In Progress

0/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*

Maximum copayment \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close

Save and Close

Save and Next

17b1 – Contact Lenses– Page 3

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

17b1 – Contact Lenses– Page 4

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

17b1 – Contact Lenses– Page 5

^ Eye Exams(17a) - In Progress

Routine Eye Exams(17a1) - In Progress

Eye Exam Services Specify(17a2) - Not Started

Eyewear(17b) - In Progress

^ Eyewear(17b) - In Progress

Contact Lenses(17b1) - In Progress

Eyeglasses (lenses and frames) (17b2) - In Progress

Eyeglass lenses(17b3) - Not Started

Eyeglass frames(17b4) - Not Started

Point-of-Service (POS) Benefits

+ Add New POS Group

Contact Lenses (17b1) Non Medicare Service

Add to POS Group

POS Group 

Group Name 1 - POS

Coinsurance

Copayment

Deductible

No

No

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

N/A

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 17b2 – Eyeglasses (lenses and frames)– Page 1

**Eyeglasses (lenses and frames) (17b2) - Non-Medicare**Plan Characteristics

Is this benefit unlimited? \*

Yes

No

Indicate number of eyeglasses \*

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Is there a maximum plan benefit coverage amount? ⓘ \*

Yes

No

Maximum amount \*

\$

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Is there a coinsurance? \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

17b2 – Eyeglasses (lenses and frames)– Page 2

0/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*

Maximum copayment \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

17b2 – Eyeglasses (lenses and frames)– Page 3

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next



17b2 – Eyeglasses (lenses and frames)– Page 4

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

17b2 – Eyeglasses (lenses and frames)– Page 5

^ Eye Exams(17a) - In Progress

Routine Eye Exams(17a1) - In Progress

Eye Exam Services Specify(17a2) - Not Started

Eyewear(17b) - In Progress

^ Eyewear(17b) - In Progress

Contact Lenses(17b1) - In Progress

**Eyeglasses (lenses and frames) (17b2) - In Progress**

Eyeglass lenses(17b3) - Not Started

Eyeglass frames(17b4) - Not Started

Point-of-Service (POS) Benefits

+ Add New POS Group

Eyeglasses (lenses and frames) (17b2) Non Medicare Service

Add to POS Group

POS Group ⓘ

Group Name 1 - POS

Coinsurance

Copayment

Deductible

No

No

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

N/A

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 17b3 – Eyeglass lenses– Page 1

#### Eyeglass lenses (17b3) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? \*

Yes

No

Indicate number of pairs of lenses \*

Periodicity \*

Is there a maximum plan benefit coverage amount? ⓘ \*

Yes

No

Maximum amount \*

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Close

Save and Close

Save and Next

17b3 – Eyeglass lenses– Page 2

0/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*

Maximum copayment \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close

Save and Close

Save and Next

17b3 – Eyeglass lenses– Page 3

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

17b3 – Eyeglass lenses– Page 4

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

17b3 – Eyeglass lenses– Page 5

^ Eyewear(17b) - In Progress

Contact Lenses(17b1) - In Progress

Eyeglasses (lenses and frames) (17b2) - In Progress

**Eyeglass lenses(17b3) - Not Started**

Eyeglass frames(17b4) - Not Started

Upgrades(17b5) - Not Started

^ Hearing Exams/Hearing Aids(18) - In Progress

Hearing Exams(18a) - In Progress


^ Hearing Exams(18a) - In Progress

Point-of-Service (POS) Benefits

+ Add New POS Group

Eyeglass lenses (17b3) Non Medicare Service

Add to POS Group

POS Group  Group Name 1 - POS

Coinsurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

CloseSave and CloseSave and Next

## CY 2027 PBP Data Entry System Pages

### 17b4 – Eyeglass frames– Page 1

#### Eyeglass frames (17b4) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? \*

Yes

No

Indicate number of eyeglass frames \*

Periodicity \*

Is there a maximum plan benefit coverage amount? ⓘ \*

Yes

No

Maximum amount \*

\$

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Close

Save and Close

Save and Next



17b4 – Eyeglass frames– Page 2

0/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*

Maximum copayment \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close

Save and Close

Save and Next

17b4 – Eyeglass frames– Page 3

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

17b4 – Eyeglass frames– Page 4

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

17b4 – Eyeglass frames– Page 5

Eyewear(17b) - In Progress

^ Eyewear(17b) - In Progress

Contact Lenses(17b1) - In Progress

Eyeglasses (lenses and frames) (17b2) - In Progress

Eyeglass lenses(17b3) - Not Started

Eyeglass frames(17b4) - Not Started

Upgrades(17b5) - Not Started

^ Hearing Exams/Hearing Aids(18) - In Progress

Hearing Exams(18a) - In Progress

^ Hearing Exams(18a) - In Progress

Point-of-Service (POS) Benefits

+ Add New POS Group

Eyeglass frames (17b4) Non Medicare Service

Add to POS Group

POS Group ⓘ

Group Name 1 - POS

Coinurance

Copayment

Deductible

No

No

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 17b5 – Upgrades – Page 1

#### Upgrades (17b5) - Non-Medicare

Plan Characteristics

Is there a maximum plan benefit coverage amount? ⓘ \*

Yes

No

Maximum amount \*  
\$

Periodicity \*  
Other, Describe ▾

Description \*  
Enter description  

0/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

Maximum coinsurance \*

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*  
\$

Maximum copayment \*  
\$

Authorization required for this benefit?

Close

Save and Close

Save and Next

17b5 – Upgrades – Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

17b5 – Upgrades – Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

17b5 – Upgrades – Page 4

Eyewear(17b) - In Progress

^ Eyewear(17b) - In Progress

Contact Lenses(17b1) - In Progress

Eyeglasses (lenses and frames) (17b2) - In Progress

Eyeglass lenses(17b3) - Not Started

Eyeglass frames(17b4) - Not Started

Upgrades(17b5) - Not Started

^ Hearing Exams/Hearing Aids(18) - In Progress

Hearing Exams(18a) - In Progress


^ Hearing Exams(18a) - In Progress

Point-of-Service (POS) Benefits

+ Add New POS Group

Upgrades (17b5) Non Medicare Service

Add to POS Group

POS Group  Group Name 1 - POS

Coinsurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

Close

Save and Close

Save and Next



## CY 2027 PBP Data Entry System Pages

### 18a – Hearing Exams – Page 1

#### Hearing Exams (18a) - Medicare ⓘ

Plan Characteristics

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? ⓘ \*

Yes

No

MOOP amount \*  
\$

Periodicity \*  
▼

---

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*  
Maximum coinsurance \*

---

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*  
\$

Maximum copayment \*  
\$

---

Is there a deductible? ⓘ \*

Yes

No

Deductible amount \*  
\$

---

Authorization required for this benefit?

Close

Save and Close

Save and Next

18a – Hearing Exams– Page 2

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

18a – Hearing Exams– Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

18a – Hearing Exams– Page 4

Dialysis Services(12) - Completed

Other Supplemental Services(13) - Not Started

Preventive and Other Defined Supplemental Services(14) - In Progress

Medicare Part B Rx Drugs(15) - In Progress

Dental(16) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

**Hearing Exams(18a) - In Progress**

Hearing Exams(18a) - In Progress

Prescription Hearing Aids(18b) - In Progress

OTC Hearing Aids(18c) - Not Started

Point-of-Service (POS) Benefits

+ Add New POS Group

Hearing Exams (18a) Medicare Service

Add to POS Group

POS Group  
Group Name 1 - POS

Coinsurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 18a - Hearing Exams - Non-Medicare

#### Hearing Exams (18a) - Non-Medicare

Plan Characteristics

Is there a deductible? \*

☐ Yes ☒ No

Is there a maximum plan benefit coverage? \*

☒ Yes ☐ No

Does the maximum plan benefit coverage amount apply to in-network services only or does it apply to both in-network and out-of-network services \*

☒ In-network services only ☐ Both in-network and out-of-network services

Maximum amount \*

\$ 1000.00

Periodicity \*

Other, Describe

Description \*

sample description

0/200 characters

Add Notes

#### Out-of-Network (OON) Benefits

Is there a maximum plan benefit coverage amount? \*

☒ Yes ☐ No

Maximum plan benefit coverage amount \*

\$ 1000.00

Periodicity \*

Other, Describe

Description \*

Enter description

0/200 characters

Close Save and Close Save and Next

## CY 2027 PBP Data Entry System Pages

### 18a1 – Routine Hearing Exams - Page 1

Eye Exams(17a) - Completed

Hearing Exams/Hearing Aids(18) - In Progress

Hearing Exams(18a) - Completed

**Routine Hearing Exams(18a1) - In Progress**

Fitting/Evaluation for Hearing Aid(18a2) - Not Started

Hearing Aids(18b) - Not Started

Hearing Aids (all types)(18b1) - Not Started

Hearing Aids -Inner Ear(18b2) - Not Started

Hearing Aids -Outer Ear(18b3) - Not Started

Hearing Aids -Over the Ear(18b4) - Not Started

**Routine Hearing Exams(18a1)**

Plan Characteristics

Is this benefit unlimited?

Yes No

Indicate number of visits  
10

Periodicity  
6 Months

Is there a coinsurance?

Yes Yes with a min & max No

Minimum coinsurance  
4%

Maximum coinsurance  
8%

Is there a copayment?

Yes Yes with a min & max No

Minimum copayment  
\$400

Maximum copayment  
\$400

18a1 – Routine Hearing Exams - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

18a1 – Routine Hearing Exams - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next



Point-of-Service (POS) benefits

Add to POS Group

POS Group

Group Name 1 - POS

+ Add New POS Group

Coinurance

Copayment

Deductible

20%

\$20

\$200

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

+ Add Notes

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 18a2 – Fitting/Evaluation for Hearing Aid– Page 1

#### Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Plan Characteristics

Is this benefit unlimited? \*

Indicate number of visits \*

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Is there a coinsurance? \*

Minimum coinsurance \*

Maximum coinsurance \*

Is there a copayment? \*

Minimum copayment \*

\$

Maximum copayment \*

\$

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

CY 2027 PBP Data Entry System Pages

18a2 – Fitting/Evaluation for Hearing Aid– Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

18a2 – Fitting/Evaluation for Hearing Aid– Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

18a2 – Fitting/Evaluation for Hearing Aid– Page 4

Fitting/Evaluation for Hearing Aid  
(18a2)- In Progress

^ Hearing Aids(18b) - Not Started

Hearing Aids (all types)(18b1) - Not Started

Hearing Aids - Inner Ear(18b2) - Not Started

Hearing Aids - Outer Ear(18b3) - Not Started

Hearing Aids - Over the Ear(18b4) - Not Started

Point-of-Service (POS) benefits

Add to POS Group

POS Group

Group Name 1 - POS

+ Add New POS Group

Coinsurance

Copayment

Deductible

20%

\$20

\$200

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

+ Add Notes

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 18b – Prescription Hearing Aids– Page 1

#### Prescription Hearing Aids (18b) - Non-Medicare ⓘ

[Plan Characteristics](#)

Service maximum plan benefit coverage: ⓘ \*

Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?

Select Coverage ⓘ \*

Select the maximum plan benefit coverage type ⓘ \*

☐ Covered under Hearing Exams Category (18a)

☐ Plan-specified amount per period

Service maximum enrollee out-of-pocket cost (MOOP): ⓘ \*

Select the maximum enrollee out-of-pocket cost type ⓘ \*

☐ Covered under Hearing exams Category (18a)

☐ Plan-specified amount per period

Is there a deductible? ⓘ \*

Deductible amount ⓘ \*

\$

Close

Save and Close

Save and Next

18b – Prescription Hearing Aids– Page 2

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a maximum plan benefit coverage amount? \*

Yes

No

Maximum plan benefit coverage amount \*

\$ 1000.00

Periodicity \*

Other, Describe

Description \*

Enter description

0/300 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 18b1 - Prescription Hearing Aids (all types) - Page 1

**Prescription Hearing Aids (all types) (18b1) - Non-Medicare**[Plan Characteristics](#)

Is this benefit unlimited? ⓘ \*

Indicate quantity for Hearing Aids \*

Periodicity ⓘ \*

Is there a coinsurance? ⓘ \*

Minimum coinsurance ⓘ \*  Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Minimum copayment ⓘ \*  \$ Maximum copayment ⓘ \*  \$

Authorization required for this benefit?

No

Referral required for this benefit?

No



18b1 - Prescription Hearing Aids (all types) - Page 2

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

2%

Maximum coinsurance ⓘ \*

3%

Is there a copayment? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

18b1 - Prescription Hearing Aids (all types) - Page 3

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

\$

Maximum copayment ⓘ \*

\$

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Out-of-Network Notes \*

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 18b1 - Prescription Hearing Aids (all types) - Page 4

Other Preventive Dental Services(16b6) - Not Started

Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Hearing Exams(18a) - In Progress

Hearing Exams(18a) - In Progress

Routine Hearing Exams(18a1) - In Progress

Fitting/Evaluation for Hearing Aid(18a2) - In Progress

Prescription Hearing Aids(18b) - In Progress

**Prescription Hearing Aids (all types)(18b1) - In Progress**


OTC Hearing Aids(18c) - Not Started

#### Point-of-Service (POS) Benefits

+ Add New POS Group

Prescription Hearing Aids (all types) (18b1) Non Medicare Service

Add to POS Group

POS Group  Group Name 1 - POS

Coinsurance	Copayment	Deductible
No	No	No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes \*

1/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 18c - OTC Hearing Aids - Page 1

OTC Hearing Aids (18c) - Non-Medicare ⓘ

Plan Characteristics

Service maximum plan benefit coverage: \*

Yes

No

Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?

Select Coverage \*  
▼

Does the maximum plan benefit coverage amount apply to in-network services only or does it apply to both in-network and out-of-network services

☐ In-network services only

☒ Both in-network and out-of-network services

Maximum amount \*

\$

Periodicity \*

Other, Describe  
▼

Description \*

Enter description

0/300 characters

The following will be added to the screen

Select the Maximum Plan Benefit Coverage type\*

☒ Covered under Hearing Exams Category(18a)

☐ Covered under Prescription Hearing Aids Category (18b)

☐ Plan-specified amount per period

Is the enrollee required to choose between coverage for 18b: Prescription Hearing Aids or 18c: Hearing Aids, but not both\*

Yes

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? ⓘ \*

Yes

No

Is there a deductible? ⓘ \*

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

18c - OTC Hearing Aids - Page 2

Is there a deductible? ⓘ \*

Yes

No

Deductible amount ⓘ \*

\$

Is this benefit unlimited? ⓘ \*

Yes

No

Is there a coinsurance? ⓘ \*

Yes

Yes with a min & max

No

Minimum coinsurance ⓘ \*

Maximum coinsurance ⓘ \*

Is there a copayment? ⓘ \*

Yes

Yes with a min & max

No

Minimum copayment ⓘ \*

Maximum copayment ⓘ \*

Authorization required for this benefit?

No

Referral required for this benefit?

No

Close

Save and Close

Save and Next

18c - OTC Hearing Aids - Page 3

Authorization required for this benefit?  
No

Referral required for this benefit?  
No

Notes

0/2000 characters

Out-of-Network (OON) Benefits

Is there a maximum plan benefit coverage amount? \*

Yes

No

Maximum plan benefit coverage amount \*

\$ 13.00

Periodicity \*

Other, Describe

Description \*

test

4/300 characters

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

18c - OTC Hearing Aids – Page 4

4/300 characters

Is there a coinsurance? \*

Yes

Yes with a min & max

No

Minimum coinsurance \*

2%

Maximum coinsurance \*

3%

Is there a copayment? \*

Yes

Yes with a min & max

No

Minimum copayment \*

\$ 4.00

Maximum copayment \*

\$ 5.00

Is there a deductible? \*

Yes

No

Deductible amount \*

\$ 34.00

Out-of-Network Notes \*

test

4/2000 characters

Close

Save and Close

Save and Next

18c - OTC Hearing Aids – Page 5

Other Preventive Dental Services(16b6) - Not Started

✓ Comprehensive Dental(16c) - In Progress

Eye Exams/Eyewear(17) - In Progress

Hearing Exams/Hearing Aids(18) - In Progress

Hearing Exams(18a) - In Progress

^ Hearing Exams(18a) - In Progress

Routine Hearing Exams(18a1) - In Progress

Fitting/Evaluation for Hearing Aid(18a2) - In Progress

^ Prescription Hearing Aids(18b) - In Progress

Prescription Hearing Aids (all types)(18b1) - In Progress

OTC Hearing Aids(18c) - Not Started

Point-of-Service (POS) Benefits

+ Add New POS Group

OTC Hearing Aids (18c) Non Medicare Service

Add to POS Group

POS Group ⓘ

Group Name 1 - POS

Coinurance

No

Copayment

No

Deductible

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes \*

0/2000 characters

Close

Save and Close

Save and Next



## CY 2027 PBP Data Entry System Pages

### 20 – Prescription Drugs– Page 1

#### Prescription Drugs (Cost Plans Only) (20) - Medicare ⓘ

Plan Characteristics

☒ I attest that the Section 1876 Cost Plan enrollee cost sharing for a Part B rebatable drug will not exceed the effective original Medicare coinsurance percentage for a Medicare Part B rebatable drug when such a drug is in the "Chemotherapy administration services to include chemotherapy/radiation drugs" category. \*

Indicate the number of drug groupings that are offered:

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? ⓘ \*

Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost: (Select all that apply): \*

☐ Group 1  
☐ Group 2  
☐ Group 3  
☐ Group 4  
☐ Group 5  
☐ Medicare Covered Benefits

MOOP amount \*

Periodicity

Is there a coinsurance? ⓘ \*

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 20 – Prescription Drugs– Page 2

Is there a coinsurance? ⓘ \*

☐ Yes ☒ Yes with a min & max ☐ No

Select which Medicare-covered Outpatient Drugs have a Coinsurance (Select all that apply):

☒ Medicare Part B Insulin Drugs

Minimum coinsurance  
1%

Maximum coinsurance  
1%

☒ Medicare Part B Chemotherapy/Radiation Drugs

Minimum coinsurance  
0%

Maximum coinsurance  
1%

☒ Other Medicare Part B Drugs

Minimum coinsurance  
1%

Maximum coinsurance  
1%

Is there a copayment? \*

☐ Yes ☒ Yes with a min & max ☐ No

Select which Medicare-covered Outpatient Drugs have a Copayment (Select all that apply):

☒ Medicare Part B Insulin Drugs

Minimum copayment  
\$ 1.00

Maximum copayment  
\$ 1.00

☒ Medicare Part B Chemotherapy/Radiation Drugs

Minimum copayment  
\$ 1.00

Maximum copayment  
\$ 1.00

☒ Other Medicare Part B Drugs

Minimum copayment  
\$ 1.00

Maximum copayment  
\$ 1.00

Close Save and Close Save and Next

CY 2027 PBP Data Entry System Pages

20 – Prescription Drugs– Page 3

☒ Medicare Part B Chemotherapy/Radiation Drugs

Minimum copayment

\$ 1.00

Maximum copayment

\$ 1.00

☒ Other Medicare Part B Drugs

Minimum copayment

\$ 1.00

Maximum copayment

\$ 1.00

Is there a deductible? ⓘ \*

Yes

No

Select what combination of drug groups applies for Deductible: (Select all that apply): \*

☐ Group 1

☐ Group 2

☐ Group 3

☐ Group 4

☐ Group 5

☐ Medicare Covered Benefits

Deductible amount \*

\$ 4.00

Authorization required for this benefit?

Yes

Notes \*

test

4/2000 characters

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

20 – Prescription Drugs - Non-Medicare

Prescription Drugs (Cost Plans Only) (20) - Non-Medicare

Plan Characteristics

Does the plan provide Part D home infusion drugs as part of a bundled service as a supplemental benefit? \*

Yes

No

Notes

0/2000 characters

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 20 – Prescription Drugs Supplemental - Non-Medicare - Page 1

Eye Exams(17a) - Completed

Hearing Exams/Hearing Aids(18) - Completed

Prescription Drugs(20) - In Progress

**Prescription Drugs Non medicare (20) - In Progress**

Outpatient Drugs Groups(20) - Not Started

Prescription Drugs Non medicare (20)

Plan Characteristics

Is there a maximum plan benefit coverage for drugs?  

Yes No

  
Indicate type of maximum plan benefit coverage  

☒ All drug groups covered by plan

☐ Combination of drug groups

☐ Individual drug groups

  
Is the maximum plan benefit coverage net of the enrollee copay?  

Yes No

  
Indicate maximum plan benefit coverage periodicity for drugs  

☒ Annually  
Maximum amount

☒ Semi-annually  
Maximum amount

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

20 – Prescription Drugs Supplemental - Non-Medicare– Page 2

Eye Exams(17a) -Completed

Hearing Exams/Hearing Aids(18) -Completed

Prescription Drugs(20) -In Progress

Prescription Drugs Non medicare (20) -In Progress

Outpatient Drugs Groups(20) -Not Started

☒ Quarterly

Maximum amount  
\$400

☒ Monthly

Maximum amount  
\$400

☒ Other

Describe  
Describing Other stuff

Maximum amount  
\$400

Can any unused amounts be carried forward to the next period within the contract period?

Yes

No

Select what combination of drug groups are included in the maximum plan benefit (Select all that apply):

☒ Group 1

☒ Group 2

☐ Group 3

☒ Group 4

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 20 – Prescription Drugs Supplemental - Non-Medicare– Page 3

▼ Eye Exams(17a) -Completed

▼ Hearing Exams/Hearing Aids(18) -Completed

▲ Prescription Drugs(20) -In Progress

Prescription Drugs Non medicare (20) -In Progress

Outpatient Drugs Groups(20) -Not Started

☒ Group 4

☒ Group 5

Indicate maximum plan benefit coverage periodicity for combination of drug groups (Select all that apply):

☒ Annually

Maximum amount  
\$400

☒ Semi-annually

Maximum amount  
\$400

☒ Quarterly

Maximum amount  
\$400

☒ Monthly

Maximum amount  
\$400

☒ Other

Describe  
Describing Other stuff

Close

Save and Close

Save and Next

CY 2027 PBP Data Entry System Pages

20 – Prescription Drugs Supplemental - Non-Medicare– Page 4

Eye Exams(17a) -Completed

Hearing Exams/Hearing Aids(18) -Completed

Prescription Drugs(20) -In Progress

Prescription Drugs Non medicare (20) -In Progress

Outpatient Drugs Groups(20) -Not Started

Describe

Describing Other stuff

Maximum amount

\$400

Is a selected group unlimited after the combination maximum plan benefit coverage amount has been reached?

YesNo

Indicate the selected group(s) for which the maximum plan benefit coverage is waived (Select all that apply):

☒ Group 1

☒ Group 2

☐ Group 3

☒ Group 4

☒ Group 5

Does the enrollee incur a cost in addition to the coinsurance or copay for selecting a higher priced drug when a less expensive drug is available?

YesNo

+ Add Notes

Close

Save and Close

Save and Next



20 – Outpatient Drug Groups

Eye Exams(17a) -Completed

Hearing Exams/Hearing Aids(18) -Completed

Prescription Drugs(20) -In Progress

Prescription Drugs Non medicare (20) -Completed

Outpatient Drugs Groups(20) -In Progress

Outpatient Drugs Groups(20)

Plan Characteristics

+ Add New Outpatient Drugs Group

Group Name	Copayment	Coinsurance	Max Coverage Amount	Aquisition Method	Actions
Group 1	\$20	5%-10%	\$200	HMO-Owned pharmacy, Mail Order	
Group 2	\$23	10%	\$230	Mail Order	
Group 3	\$25	5%-10%	\$250	Designated retail pharmacy	
Group 4	\$20	10%	\$200	Designated retail pharmacy	

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 20 – Add New Outpatient Drug Group– Page 1

Very long Plan Name

✓ Eye Exams(17a) -Completed

✓ Hearing Exams/Hearing Aids(18) -Completed

^ Prescription Drugs(20) -In Progress

Prescription Drugs Non medicare (20) -Completed

Outpatient Drugs Groups(20) -In Progress

Add New Outpatient Drugs Group

Group Name

Sample Group Name

Select the drug type(s) covered for Group

☒ Generic

☐ Preferred Brand

☐ Brand

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

Yes

No

Maximum plan benefit coverage amount

4

Periodicity

Every 6 Months

Select from where the Group Drugs can be acquired (Select all that apply):

☒ Designated retail pharmacy

☐ HMO-Owned pharmacy

☐ Mail Order

Cancel

Save

Plan Characteristics

Add New Outpatient Drugs Group

	Actions
Mail Order	
acy	
acy	

Close

Save and Close

Save and Next

## CY 2027 PBP Data Entry System Pages

### 20 – Add New Outpatient Drug Group– Page 2

very long Plan Name

▼ Eye Exams(17a) -Completed

▼ Hearing Exams/Hearing Aids(18) -Completed

▲ Prescription Drugs(20) -In Progress

Prescription Drugs Non medicare (20) -Completed

Outpatient Drugs Groups(20) -In Progress

Add New Outpatient Drugs Group

☐ Home-Owned pharmacy

☐ Mail Order

☐ Other, describe

Is there coinsurance?

Yes Yes with a min & max No

Designated retail pharmacy

Minimum percentage 4%

Maximum percentage 8%

Is there copayment?

Yes Yes with a min & max No

Designated retail pharmacy

Minimum amount \$400

Maximum amount \$800







Enter the maximum day supply for Group 1 Designated Retail Pharmacy

Indicate day supply 100

Cancel Save

Plan Characteristics

Add New Outpatient Drugs Group

	Actions
Mail Order	 
Pharmacy	 
Pharmacy	 

Close Save and Close Save and Next

## CY 2027 PBP Data Entry System Pages

### 20 – Add New Outpatient Drug Group– Page 3

Very long Plan Name

✓ Eye Exams(17a) -Completed

✓ Hearing Exams/Hearing Aids(18) -Completed

^ Prescription Drugs(20) -In Progress

Prescription Drugs Non medicare (20) -Completed

Outpatient Drugs Groups(20) -In Progress

Add New Outpatient Drugs Group

Is there coinsurance?

Yes

Yes with a min & max

No

Designated retail pharmacy

Minimum percentage

4%

Maximum percentage

8%

Is there copayment?

Yes

Yes with a min & max

No

Designated retail pharmacy

Minimum amount

\$400

Maximum amount

\$800

Enter the maximum day supply for Group 1 Designated Retail Pharmacy

Indicate day supply

100

+ Add Notes

Cancel

Save

Plan Characteristics

Add New Outpatient Drugs Group

	Actions
Mail Order	
armacy	
armacy	

Close

Save and Close

Save and Next

Softtrans

CY2027 PBP – Benefit Service Categories 16-20  
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