

CY 2026 PBP Data Entry System Pages

16a – Medicare Dental Services – Page 1

**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 \*  
\$

Close Save and Close Save and Next

CY 2026 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 2026 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



CY 2026 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 2026 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 Save and Next

CY 2026 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

**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 2026 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**

CY 2026 PBP Data Entry System Pages

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 Save and Next

CY 2026 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

CY 2026 PBP Data Entry System Pages

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

Coinsurance	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 2026 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**

CY 2026 PBP Data Entry System Pages

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 2026 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

CY 2026 PBP Data Entry System Pages

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

Coinsurance	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 2026 PBP Data Entry System Pages

16b3 – Other Diagnostic Dental Services – Page 1

**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

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 2026 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

CY 2026 PBP Data Entry System Pages

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

Coinsurance	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](#)

16b4 - Prophylaxis (cleaning) - Page 1

**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

CY 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

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

CY 2026 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

Coinsurance	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](#)

Plan Characteristics

### Fluoride Treatment (16b5) - Non-Medicare

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

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 2026 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

- 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

Coinsurance	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 2026 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
- 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 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 2026 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 2026 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

CY 2026 PBP Data Entry System Pages

16b6 - Other Preventive Dental Services - Page 4

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

+ Add New POS Group

Other Preventive Dental Services (16b6) Non Medicare Service

Add to POS Group

POS Group

Coinsurance	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 2026 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 2026 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)? ⓘ \*

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? ⓘ \*

Notes

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

16c1 - Restorative Services - Page 1

**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**

CY 2026 PBP Data Entry System Pages

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 2026 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

CY 2026 PBP Data Entry System Pages

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

Coinsurance	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](#)

- 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**

CY 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

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](#)

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

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 2026 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

CY 2026 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

Coinsurance	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 2026 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

CY 2026 PBP Data Entry System Pages

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 2026 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

CY 2026 PBP Data Entry System Pages

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

Coinsurance	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 2026 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

CY 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

16c5 - Maxillofacial Prosthetics - Page 4

- Restorative Services(16c1) - Not Started
- Endodontics(16c2) - Not Started
- Periodontics(16c3) - Not Started
- Prostodontics, removable(16c4) - Not Started
- Maxillofacial Prosthetics(16c5) - Not Started**
- Implant Services(16c6) - Not Started
- Prostodontics, 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

Coinsurance	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 2026 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**

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 2026 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

CY 2026 PBP Data Entry System Pages

16c6 - Implant Services - Page 4

Comprehensive Dental(16c) - In Progress

Restorative Services(16c1) - Not Started

Endodontics(16c2) - Not Started

Periodontics(16c3) - Not Started

Prostodontics, removable(16c4) - Not Started

Maxillofacial Prosthetics(16c5) - Not Started

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

Prostodontics, 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

Coinsurance	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 2026 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? ⓘ \*

Indicate number of visits \*

Periodicity ⓘ \*



---

Is there a coinsurance? ⓘ \*

Minimum coinsurance ⓘ \*  Maximum coinsurance ⓘ \*

---

Is there a copayment? ⓘ \*

Minimum copayment ⓘ \*  Maximum copayment ⓘ \*

---

Authorization required for this benefit?

Referral required for this benefit?

CY 2026 PBP Data Entry System Pages

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 2026 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

CY 2026 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

Coinsurance	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 2026 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

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 2026 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

CY 2026 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
- Prostodontics, removable(16c4) - Not Started
- Maxillofacial Prosthetics(16c5) - Not Started
- Implant Services(16c6) - Not Started
- Prostodontics, 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

Coinsurance	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](#)

- 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**

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 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

16c9 - Orthodontics - Page 4

- Endodontics(16c2) - Not Started
- Periodontics(16c3) - Not Started
- Prostodontics, removable(16c4) - Not Started
- Maxillofacial Prosthetics(16c5) - Not Started
- Implant Services(16c6) - Not Started
- Prostodontics, 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

Coinsurance	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 2026 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

11/200 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

# CY 2026 PBP Data Entry System Pages

## 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 2026 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

CY 2026 PBP Data Entry System Pages

16c10 - Adjunctive General Services - Page 4

**Point-of-Service (POS) benefits**

Add to POS Group

POS Group  
**Group Name 1 - POS** + Add New POS Group

Coinsurance	Copayment	Deductible
<b>20%</b>	<b>\$20</b>	<b>\$200</b>

---

Authorization required for this benefit?  
**Yes**

Referral required for this benefit?  
**No**

---

+ Add Notes

Close Save and Close Save and Next

# CY 2026 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? \*

Yes  No

Close Save and Close Save and Next

CY 2026 PBP Data Entry System Pages

17a – Eye Exams– 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?

**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

CY 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

17a – Eye Exams– Page 5

**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 2026 PBP Data Entry System Pages

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

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

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

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 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

17a1 – Routine Eye Exams – Page 4

**Point-of-Service (POS) benefits**

Add to POS Group

POS Group **Group Name 1 - POS** **+ Add New POS Group**

Coinsurance	Copayment	Deductible
<b>20%</b>	<b>\$20</b>	<b>\$200</b>

Authorization required for this benefit?  
**Yes**

Referral required for this benefit?  
**No**

**+ Add Notes**

**Close** **Save and Close** **Save and Next**

CY 2026 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?

..

CY 2026 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 2026 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

CY 2026 PBP Data Entry System Pages

17a2 – Other Eye Exam Services – Page 4

**Point-of-Service (POS) benefits**

Add to POS Group

POS Group  
**Group Name 1 - POS** + Add New POS Group

Coinsurance	Copayment	Deductible
<b>20%</b>	<b>\$20</b>	<b>\$200</b>

---

Authorization required for this benefit?  
**Yes**

Referral required for this benefit?  
**No**

---

+ Add Notes

Close Save and Close Save and Next

CY 2026 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 \*

Periodicity \*

Description \*

0/300 characters

---

Is there a coinsurance? \*

Yes  Yes with a min & max  No

Minimum coinsurance \*

Maximum coinsurance \*

CY 2026 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

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 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

17b – Eyewear - Medicare - Page 5

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 2026 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 \*

Periodicity \*

Description \*  
Enter description

0/300 characters

---

Is there a deductible? ⓘ \*

Yes  No

CY 2026 PBP Data Entry System Pages

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 2026 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? \*

CY 2026 PBP Data Entry System Pages

17b1 – Contact 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

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

CY 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

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 2026 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? \*

# CY 2026 PBP Data Entry System Pages

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

0/300 characters

---

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

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

CY 2026 PBP Data Entry System Pages

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

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 2026 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 \*

CY 2026 PBP Data Entry System Pages

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

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 2026 PBP Data Entry System Pages

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

**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	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 2026 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?

CY 2026 PBP Data Entry System Pages

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

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 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

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 

Coinsurance	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](#)



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 2026 PBP Data Entry System Pages

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

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	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 2026 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?

CY 2026 PBP Data Entry System Pages

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

CY 2026 PBP Data Entry System Pages

18a – Hearing Exams– Page 3

Is there a copayment? ⓘ \*

Minimum copayment ⓘ \*  Maximum copayment ⓘ \*

---

Is there a deductible? ⓘ \*

Deductible amount ⓘ \*

---

Out-of-Network Notes \*

0/2000 characters

CY 2026 PBP Data Entry System Pages

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:

Coinsurance	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 2026 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

[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

[Close](#) [Save and Close](#) [Save and Next](#)

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

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

CY 2026 PBP Data Entry System Pages

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 2026 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

CY 2026 PBP Data Entry System Pages

18a1 – Routine Hearing Exams - Page 4

**Point-of-Service (POS) benefits**

Add to POS Group

POS Group  
**Group Name 1 - POS** + Add New POS Group

Coinsurance	Copayment	Deductible
<b>20%</b>	<b>\$20</b>	<b>\$200</b>

---

Authorization required for this benefit?  
**Yes**

Referral required for this benefit?  
**No**

+ Add Notes

Close Save and Close Save and Next

CY 2026 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? \*

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?

Yes

Referral required for this benefit?

No

CY 2026 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 2026 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

# CY 2026 PBP Data Entry System Pages

## 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 2026 PBP Data Entry System Pages

18b – Prescription Hearing Aids– Page 1

**Prescription Hearing Aids (18b) - 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 ⓘ \*

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): ⓘ \*

Yes  No

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

Covered under Hearing exams Category (18a)

Plan-specified amount per period

---

Is there a deductible? ⓘ \*

Yes  No

Deductible amount ⓘ \*

\$

Close Save and Close Save and Next

CY 2026 PBP Data Entry System Pages

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

0/200 characters

Close Save and Close Save and Next

CY 2026 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?  Yes  No

Indicate quantity for Hearing Aids \*

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 2026 PBP Data Entry System Pages

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 2026 PBP Data Entry System Pages

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

Is there a copayment? ⓘ \*

Minimum copayment ⓘ \*  Maximum copayment ⓘ \*

---

Is there a deductible? ⓘ \*

Deductible amount ⓘ \*

---

Out-of-Network Notes \*

0/2000 characters

CY 2026 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

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 2026 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 \*

Description \*

0/300 characters

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

Yes  No

Is there a deductible? ⓘ \*

CY 2026 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

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 2026 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

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

[+ Add New POS Group](#)

OTC Hearing Aids (18c) Non Medicare Service

Add to POS Group

POS Group

Coinsurance	Copayment	Deductible
No	No	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 2026 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:  
5

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

**Yes** No

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 \*  
\$ 4.00

Periodicity  
Every month

Is there a coinsurance? \*

Yes **Yes with a min & max** No

Close Save and Close Save and Next

CY 2026 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):

<input checked="" type="checkbox"/> Medicare Part B Insulin Drugs	Minimum coinsurance 1%	Maximum coinsurance 1%
<input checked="" type="checkbox"/> Medicare Part B Chemotherapy/Radiation Drugs	Minimum coinsurance 0%	Maximum coinsurance 1%
<input checked="" type="checkbox"/> 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):

<input checked="" type="checkbox"/> Medicare Part B Insulin Drugs	Minimum copayment \$ 1.00	Maximum copayment \$ 1.00
<input checked="" type="checkbox"/> Medicare Part B Chemotherapy/Radiation Drugs	Minimum copayment \$ 1.00	Maximum copayment \$ 1.00
<input checked="" type="checkbox"/> Other Medicare Part B Drugs	Minimum copayment \$ 1.00	Maximum copayment \$ 1.00

CY 2026 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 2026 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 2026 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

CY 2026 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

Monthly

Maximum amount

Other

Describe

Maximum amount

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

CY 2026 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

Semi-annually

Maximum amount

Quarterly

Maximum amount

Monthly

Maximum amount

Other

Describe

CY 2026 PBP Data Entry System Pages

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

<p>Eye Exams(17a) - Completed</p> <p>Hearing Exams/Hearing Aids(18) - Completed</p> <p>Prescription Drugs(20) - In Progress</p> <p><b>Prescription Drugs Non medicare (20) - In Progress</b></p> <p>Outpatient Drugs Groups(20) - Not Started</p>	<p>Describe <input type="text" value="Describing Other stuff"/></p> <p>Maximum amount <input type="text" value="\$400"/></p> <hr/> <p>Is a selected group unlimited after the combination maximum plan benefit coverage amount has been reached?</p> <p><input type="button" value="Yes"/> <input type="button" value="No"/></p> <p>Indicate the selected group(s) for which the maximum plan benefit coverage is waived (Select all that apply):</p> <ul style="list-style-type: none"><li><input checked="" type="checkbox"/> Group 1</li><li><input checked="" type="checkbox"/> Group 2</li><li><input type="checkbox"/> Group 3</li><li><input checked="" type="checkbox"/> Group 4</li><li><input checked="" type="checkbox"/> Group 5</li></ul> <hr/> <p>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?</p> <p><input type="button" value="Yes"/> <input type="button" value="No"/></p> <p><input type="button" value="+ Add Notes"/></p>
<p><input type="button" value="Close"/> <input type="button" value="Save and Close"/> <input type="button" value="Save and Next"/></p>	

CY 2026 PBP Data Entry System Pages

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 2026 PBP Data Entry System Pages

20 – Add New Outpatient Drug Group– Page 1

### 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

CY 2026 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

CY 2026 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:  Maximum percentage:

Is there copayment?

Yes  Yes with a min & max  No

Designated retail pharmacy

Minimum amount:  Maximum amount:

Enter the maximum day supply for Group 1 Designated Retail Pharmacy

Indicate day supply:

[+ Add Notes](#)

Plan Characteristics

#### Add New Outpatient Drugs Group

	Actions
Mail Order	<input type="checkbox"/>
Pharmacy	<input type="checkbox"/>
Pharmacy	<input type="checkbox"/>