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 *
$

Close | Save and Close | Save and Next

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

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

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) - Not Started
Diagnostic and Preventive Dental(16b) - Not Started
Comprehensive Dental(16c) - In Progress
Eye Exams/Eyewear(17) - In Progress

Point-of-Service (POS) Benefits

+ Add New POS Group

Medicare Dental Services (16a) 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 *

0/2000 characters

Close | Save and Close | Save and Next

16b – Diagnostic and Preventive Dental – Page 1

Outpatient Services(9) - Completed
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) - In Progress
Medicare Dental Services(16a) - Completed
Diagnostic and Preventive Dental(16b) - In Progress

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 *
$ 4000.00

Periodicity *
Every 3 Years

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group? *

Yes No

Select CSB group: *

CSB Group 2

N... U... and periodicity entered should match the maximum plan benefit coverage amount and periodicity for the CSB group selected.

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

Close | Save and Close | Save and Next

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

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

16b – Diagnostic and Preventive Dental – Page 4

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

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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 | Save and Next

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

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

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

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

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

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

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

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	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

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

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

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

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 Treatement - 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

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	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

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

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

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

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

16c - Comprehensive Dental - Page 1

- Outpatient Services(9) - Completed
- 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) - In Progress
  - Medicare Dental Services(16a) - Completed
  - Diagnostic and Preventive Dental(16b) - In Progress
  - Comprehensive Dental(16c) - In Progress
- Eye Exams/Eyewear(17) - Completed
- Hearing Exams/Hearing Aids(18) - Completed

Comprehensive Dental (16c) - Non-Medicare

Plan Characteristics

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

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 *: $ 1.00

Periodicity *: Other, Describe

Description *: Enter description

0/300 characters

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group? *

Yes | No

Select CSB group: *

Note: In most cases, the maximum plan benefit coverage amount and periodicity entered should match the maximum plan benefit coverage amount and periodicity for the CSB group selected. Users should review this data.

Close | Save and Close | Save and Next

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

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

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	Copayment	Deductible
No	No	No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes *

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Close | Save and Close | Save and Next

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

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

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

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

Coinsurance	Copayment	Deductible
No	No	No

Authorization required for this benefit?
No

Referral required for this benefit?
No

Notes *

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Close | Save and Close | Save and Next

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

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

Coinsurance	Copayment	Deductible
No	No	No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes *

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Close | Save and Close | Save and Next

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

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

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

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

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

Coinsurance	Copayment	Deductible
No	No	No

Authorization required for this benefit?
No

Referral required for this benefit?
No

Notes *

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Close | Save and Close | Save and Next

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

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

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

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

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

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

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

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

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

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

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

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

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
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– 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

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

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: 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

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
20%	$20	$200

Authorization required for this benefit?
Yes

Referral required for this benefit?
No

+ Add Notes

Close | Save and Close | Save and Next

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

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

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

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
20%	$20	$200

Authorization required for this benefit?
Yes

Referral required for this benefit?
No

+ Add Notes

Close | Save and Close | Save and Next

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

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

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

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

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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

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

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

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

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	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

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

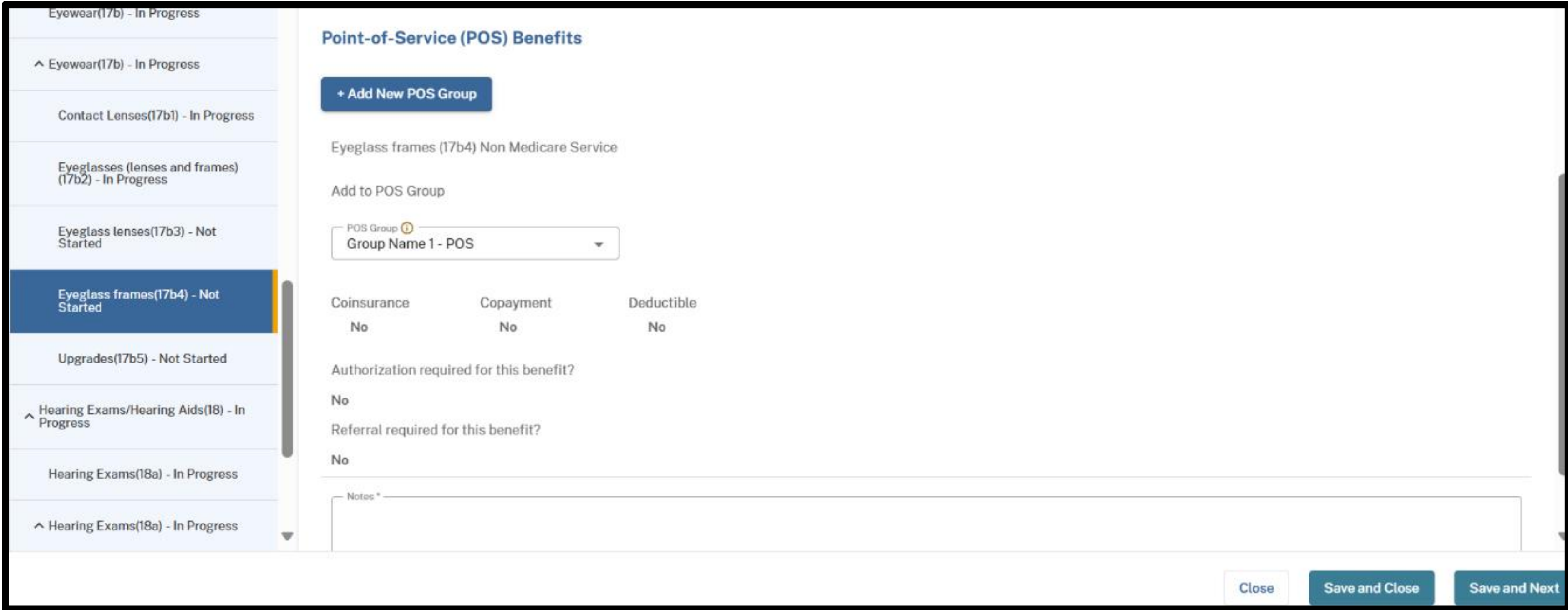
Deductible amount ⓘ *
$

Out-of-Network Notes *

0/2000 characters

Close | Save and Close | Save and Next

17b4 – Eyeglass frames– Page 5



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

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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

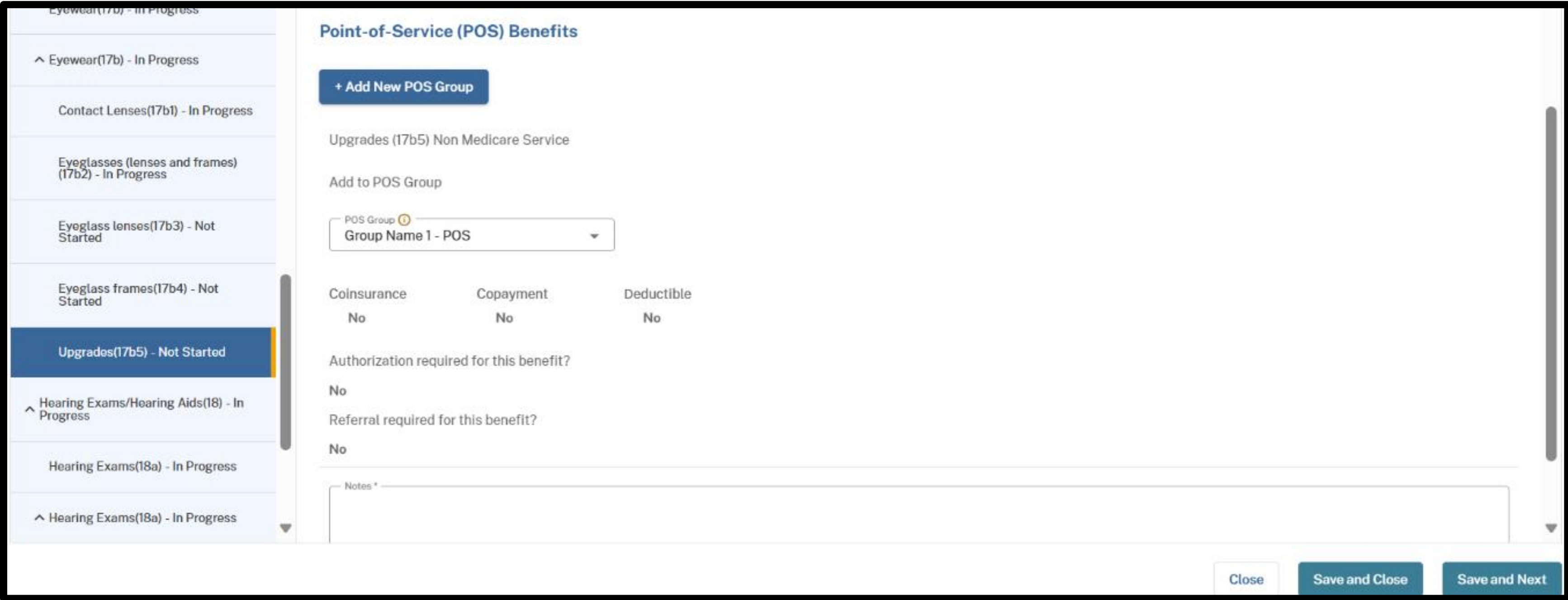
Deductible amount ⓘ *
$

Out-of-Network Notes *

0/2000 characters

Close | Save and Close | Save and Next

17b5 – Upgrades – Page 4



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	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

18a - Hearing Exams - Non-Medicare

Hearing Exams (18a) - Non-Medicare

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

18/300 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

0/300 characters

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

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

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
20%	$20	$200

Authorization required for this benefit?
Yes

Referral required for this benefit?
No

+ Add Notes

Close | Save and Close | Save and Next

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

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

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

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

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

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

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

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

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

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

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

18c - OTC Hearing Aids - Page 1

- 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
- Eye Exams/Eyewear(17) - In Progress
  - Eye Exams(17a) - In Progress
  - Eye Exams(17a) - In Progress
  - Eyewear(17b) - In Progress
  - Eyewear(17b) - 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) - Non-Medicare

Updated by Test TESTER on 1/6/2026 12:08:07 PM EST

Service maximum plan benefit coverage: *

Yes | No

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

Select Coverage *: Both ears combined

Select the maximum plan benefit coverage type *

- Covered under Hearing Exams Category (18a)
- Covered under Prescription Hearing Aids (18b)
- Plan-specified amount per period

Maximum amount *: $ 1000.00

Periodicity *: Every Year

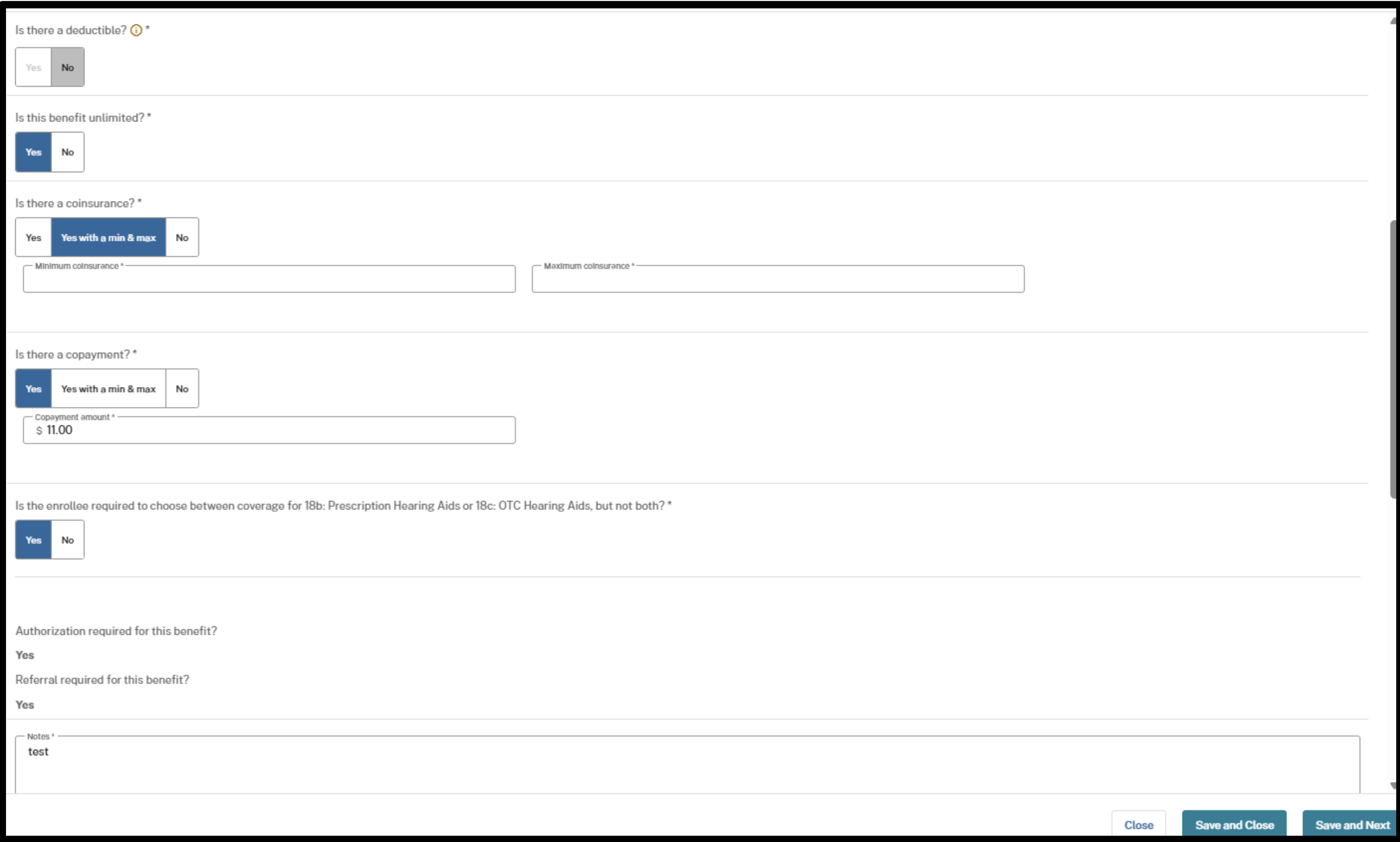
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)? *

Yes | No

Is there a deductible? *

Yes | No

18c - OTC Hearing Aids - Page 2



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

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

CMS SENSITIVE INFORMATION - REQUIRES SPECIAL HANDLING

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

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

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

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):

- [x] Medicare Part B Insulin Drugs
  - Minimum coinsurance: 1%
  - Maximum coinsurance: 1%
- [x] Medicare Part B Chemotherapy/Radiation Drugs
  - Minimum coinsurance: 0%
  - Maximum coinsurance: 1%
- [x] 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):

- [x] Medicare Part B Insulin Drugs
  - Minimum copayment: $ 1.00
  - Maximum copayment: $ 1.00
- [x] Medicare Part B Chemotherapy/Radiation Drugs
  - Minimum copayment: $ 1.00
  - Maximum copayment: $ 1.00
- [x] Other Medicare Part B Drugs
  - Minimum copayment: $ 1.00
  - Maximum copayment: $ 1.00

Close | Save and Close | Save and Next

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

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

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

- [x] 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

- [x] Annually

Maximum amount
$400

- [x] Semi-annually

Maximum amount
$400

Close | Save and Close | Save and Next

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

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

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?

Yes No

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

- [x] Group 1
- [x] Group 2
- [ ] Group 3
- [x] Group 4
- [x] 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?

Yes No

+ 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

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

- [x] 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):

- [x] Designated retail pharmacy
- [ ] HMO-Owned pharmacy
- [ ] Mail Order

Cancel | Save

Plan Characteristics

d New Outpatient Drugs Group

Actions

Mail Order

acy

acy

Close | Save and Close | Save and Next

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

HMO-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

Close | Save and Close | Save and Next

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

Close | Save and Close | Save and Next