**SECTION V: Response Forms**

**Exhibit I: Dental Plan Response Form – Please Complete Below Form**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  | | **Current** | | **Proposed (Please Fill out the Chart Below)** | |
| **Sample Procedures** | | | | | **Sun Life** | |  | |
| **Basic** | | | **Code** | | **Low DHMO** | |  | |
| Periodic Exam | | | D0120 | | $0 | |  | |
| Office Visit | | | D9430 | | $10 | |  | |
| Prophylaxis | | | D1110 | | $0 | |  | |
| Full Mouth X-rays | | | D0210 | | $0 | |  | |
| Pediatric Provider Age Limitation | | | | | No Limitation | |  | |
| **Extraction** | | |  | |  | |  | |
| Single Tooth | | | D7111 | | $20 | |  | |
| Partial Impaction | | | D7230 | | $75 | |  | |
| Boney Impaction | | | D7240 | | $100 | |  | |
| **Fillings** | | |  | |  | |  | |
| Amalgam - 1 surface | | | D2140 | | $10 | |  | |
| Resin - 1 surface | | | D2330 | | $35 | |  | |
| Sedative | | | D2940 | | $15 | |  | |
| **Root Canal Therapy** | | | | |  | |  | |
| Anterior | | | D3310 | | $135 | |  | |
| Bicuspid | | | D3320 | | $195 | |  | |
| Molar | | | D3330 | | $245 | |  | |
| **Periodontic Therapy** | | | | |  | |  | |
| Root Planning (1/4) | | | D4341 | | $50 | |  | |
| Gingivectomy (1/4) | | | D4210 | | $120 | |  | |
| **Crown & Bridge** | | | | |  | |  | |
| Full High Noble Metal | | | D2790 | | $265 | |  | |
| Porcelain fused to Metal | | | D2750 | | $265 | |  | |
| **Dentures** | | |  | |  | |  | |
| Partial Denture | | | D5213 | | $380 + Lab | |  | |
| Complete Denture | | | D5110 | | $295 + Lab | |  | |
| Denture Reline (chairside) | | | D5730 | | $60 | |  | |
| Denture Reline (lab) | | | D5750 | | $95 + Lab | |  | |
| **Orthodontia** | | |  | |  | |  | |
| Comprehensive Treatment | | | | | 25% Discount | |  | |
| Adult Orthodontia Covered? | | | | | Yes | |  | |
| **Rate Guarantee** | | | | | **12/31/2024** | |  | |
| EE Only | | |  | | $6.50 | |  | |
| EE + One | | |  | | $10.99 | |  | |
| EE + Two or More | | |  | | $17.34 | |  | |
|  |  | | | **Current** | | **Proposed (Please Fill out the Chart Below)** | |
| **Sample Procedures** |  | | | **Cigna** | |  | |
| **Basic** | | **Code** | | **Mid DHMO** | |  | |
| Periodic Exam | D0120 | | | $0 | |  | |
| Office Visit | D9430 | | | $5 | |  | |
| Prophylaxis | D1110 | | | $0 | |  | |
| Full Mouth X-rays | D0210 | | | $0 | |  | |
| Pediatric Provider Age Limitation | | | | 17 Years Old | |  | |
| **Extraction** |  | | |  | |  | |
| Single Tooth | D7111 | | | $5 | |  | |
| Partial Impaction | D7230 | | | $70 | |  | |
| Boney Impaction | D7240 | | | $90 | |  | |
| **Fillings** |  | | |  | |  | |
| Amalgam - 1 surface | D2140 | | | $0 | |  | |
| Resin - 1 surface | D2330 | | | $0 | |  | |
| Sedative | D2940 | | | $5 | |  | |
| **Root Canal Therapy** |  | | |  | |  | |
| Anterior | D3310 | | | $80 | |  | |
| Bicuspid | D3320 | | | $120 | |  | |
| Molar | D3330 | | | $250 | |  | |
| **Periodontic Therapy** |  | | |  | |  | |
| Root Planning (1/4) | D4341 | | | $40 | |  | |
| Gingivectomy (1/4) | D4210 | | | $130 | |  | |
| **Crown & Bridge** |  | | |  | |  | |
| Full High Noble Metal | D2790 | | | $185 | |  | |
| Porcelain fused to Metal | D2750 | | | $185 | |  | |
| **Dentures** |  | | |  | |  | |
| Partial Denture | D5213 | | | $160 | |  | |
| Complete Denture | D5110 | | | $150 | |  | |
| Denture Reline (chairside) | D5730 | | | $35 | |  | |
| Denture Reline (lab) | D5750 | | | $60 | |  | |
| **Orthodontia** |  | | |  | |  | |
| Comprehensive Treatment | | | | $1,344 Child; $1,944 Adult | |  | |
| Adult Orthodontia Covered? | | | | Yes | |  | |
| **Rate Guarantee** |  | | | **12/31/2024** | |  | |
| EE Only |  | | | $16.35 | |  | |
| EE + One |  | | | $30.42 | |  | |
| EE + Two or More |  | | | $39.59 | |  | |

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|  |  | **Current** | **Proposed (Please Fill out the Chart Below)** |
| **Sample Procedures** |  | **Cigna** |  |
| **Basic** |  | **High DHMO** |  |
| Periodic Exam | D0120 | $0 |  |
| Office Visit | D9430 | $0 |  |
| Prophylaxis | D1110 | $0 |  |
| Full Mouth X-rays | D0210 | $0 |  |
| Pediatric Provider Age Limitation | | 17 Years Old |  |
| **Extraction** |  |  |  |
| Single Tooth | D7111 | $12 |  |
| Partial Impaction | D7230 | $73 |  |
| Boney Impaction | D7240 | $120 |  |
| **Fillings** |  |  |  |
| Amalgam - 1 surface | D2140 | $0 |  |
| Resin - 1 surface | D2330 | $0 |  |
| Sedative | D2940 | $13 |  |
| **Root Canal Therapy** |  |  |  |
| Anterior | D3310 | $12 |  |
| Bicuspid | D3320 | $31 |  |
| Molar | D3330 | $280 |  |
| **Periodontic Therapy** |  |  |  |
| Root Planning (1/4) | D4341 | $96 |  |
| Gingivectomy (1/4) | D4210 | $220 |  |
| **Crown & Bridge** |  |  |  |
| Full High Noble Metal | D2790 | $390 |  |
| Porcelain fused to Metal | D2750 | $380 |  |
| **Dentures** |  |  |  |
| Partial Denture | D5213 | $575 |  |
| Complete Denture | D5110 | $500 |  |
| Denture Reline (chairside) | D5730 | $14 |  |
| Denture Reline (lab) | D5750 | $170 |  |
| **Orthodontia** |  |  |  |
| Comprehensive Treatment | | $2,184 Child; $2,904 Adult |  |
| Adult Orthodontia Covered? | | Yes |  |
| **Rate Guarantee** |  | **12/31/2024** |  |
| EE Only |  | $20.45 |  |
| EE + One |  | $38.08 |  |
| EE + Two or More |  | $49.57 |  |

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|  |  | **Current** | | **Proposed (Please Fill out the Chart Below)** | |
| **SCHEDULE OF BENEFITS** | | **Cigna DPPO** | |  | |
| **Plan Basics** |  | ***In Network*** | ***Non Network*** | ***In Network*** | ***Non Network*** |
| Calendar Year Maximum |  | $1,100 | |  | |
| **Deductibles** |  |  |  |  |  |
| Single |  | $50 | $50 |  |  |
| Family |  | $150 | $150 |  |  |
| Deductible Waived for Preventive + Ortho Services? |  | Yes | Yes |  |  |
| **Benefits** |  |  |  |  |  |
| Preventative |  | 100% | 100% |  |  |
| Basic |  | 80% | 80% |  |  |
| Major |  | 50% | 50% |  |  |
| Orthodontia (Child only) | | 50% | 50% |  |  |
| Implants |  | Not covered | |  |  |
| **Service Information** |  |  |  |  |  |
| Out of Network Benefits  Payable Level |  | 70th Percentile | |  | |
| Orthodontia Lifetime Max |  | $1,000 | |  | |
| **Rate Guarantee** |  | **12/31/2024** | |  | |
| EE Only |  | $37.68 | |  | |
| EE + One |  | $76.35 | |  | |
| EE + Two or More |  | $112.56 | |  | |

If the City were to raise the Out of Network Benefits payable level to 90th U&C, how much of an increase would that be to your proposed rates?

**SECTION V: Response Forms**

**Exhibit II: Vision Plan Response Form – Please Complete Below Form**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **Current** | | | **Proposed (Please Fill out the Chart Below)** | |
| **SCHEDULE OF BENEFITS** | | **Humana** | | |  | |
|  |  | ***In Network*** | | ***Non Network*** | ***In Network*** | ***Non Network*** |
| Exam Copay |  | $10 | Up to $30 | |  | |
| **Frequency** |  |  | |  |  |  |
| Exam Copay |  | 12 months | | |  | |
| Lenses |  | 12 months | | |  | |
| Frames |  | 24 months | | |  | |
| **Benefits Payable** |  | ***Copay*** | | ***Reimbursement*** |  |  |
| Eye Exam |  | $10 | | $30 |  |  |
| Single Lenses |  | $15 | | $25 |  |  |
| Bifocal Lenses |  | $15 | | $40 |  |  |
| Trifocal Lenses |  | $15 | | $60 |  |  |
| Lenticular Lenses |  | $15 | | $100 |  |  |
| **Lenses and Frames** |  | ***Reimbursement*** | | ***Reimbursement*** |  |  |
| Contact Lenses (Conventional) | | $130 + 15% discount above $130 | | Up to $104 |  |  |
| Contact Lenses (Disposable) | | $130 allowance | | Up to $104 |  |  |
| Contact Lenses (Medically Necessary) | | Paid in Full | | Up to $200 |  |  |
| Frames |  | $130 + 20% discount above $130 | | Up to $65 |  |  |
| **Rate Guarantee** |  | **Expires 12/31/2025** | | |  | |
| Employee | 738 | $5.12 | | |  | |
| Employee + One | 241 | $10.24 | | |  | |
| Employee + Family | 168 | $13.69 | | |  | |