**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 |   |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **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 |   |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **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  |   |