Department of MANAGEMENT SERVICES

2021

# OPEN ENROLLMENT PRE-TAX BENEFITS PACKET

*STATE OF FLORIDA & UNIVERSITY EMPLOYEES*

50 YEARS 1970-2020

Capital Insurance Agency, Inc.

# *KNOW YOUR*
# PRE-TAX BENEFITS

Aflac

### *CANCER & HOSPITAL INTENSIVE CARE* (CODE 102)

**Cancer | HIC**

- **Personal Cancer Indemnity Plan** offers benefits for cancer related treatments. Two optional Riders to this plan are the *Building Benefit Rider* and *Specified-Disease Benefit Rider*.
- **Personal Hospital Intensive Care Plan** pays if you or any covered person incurs a charge for confinement in a hospital ICU.

Cigna

### *HOSPITAL SUPPLEMENT* (CODE 101)

**30/20+ | PPP | 365+ | SIS**

- **Supplemental Hospital** coverage is additional coverage designed especially to help take care of some of the out-of-pocket hospital facility costs that may not be covered by your primary plan.

### *DENTAL* (CODE 103)

- Cigna Dental Care's Prepaid Patient Charge Schedule (PCS) reflects a fixed co-payment amount that allows you to plan and budget for you and your family's dental care needs with confidence.

MetLife

### *DENTAL* (CODE 103)

**Indemnity PPO | Standard PPO | Preventative PPO**

- MetLife's Preferred Dentist Program is a Dental PPO plan. You can visit any licensed dentist, in or out of the network, and receive benefits.

Humana

### *DENTAL* (CODE 103)

**HD205 Prepaid | Schedule B Indemnity**

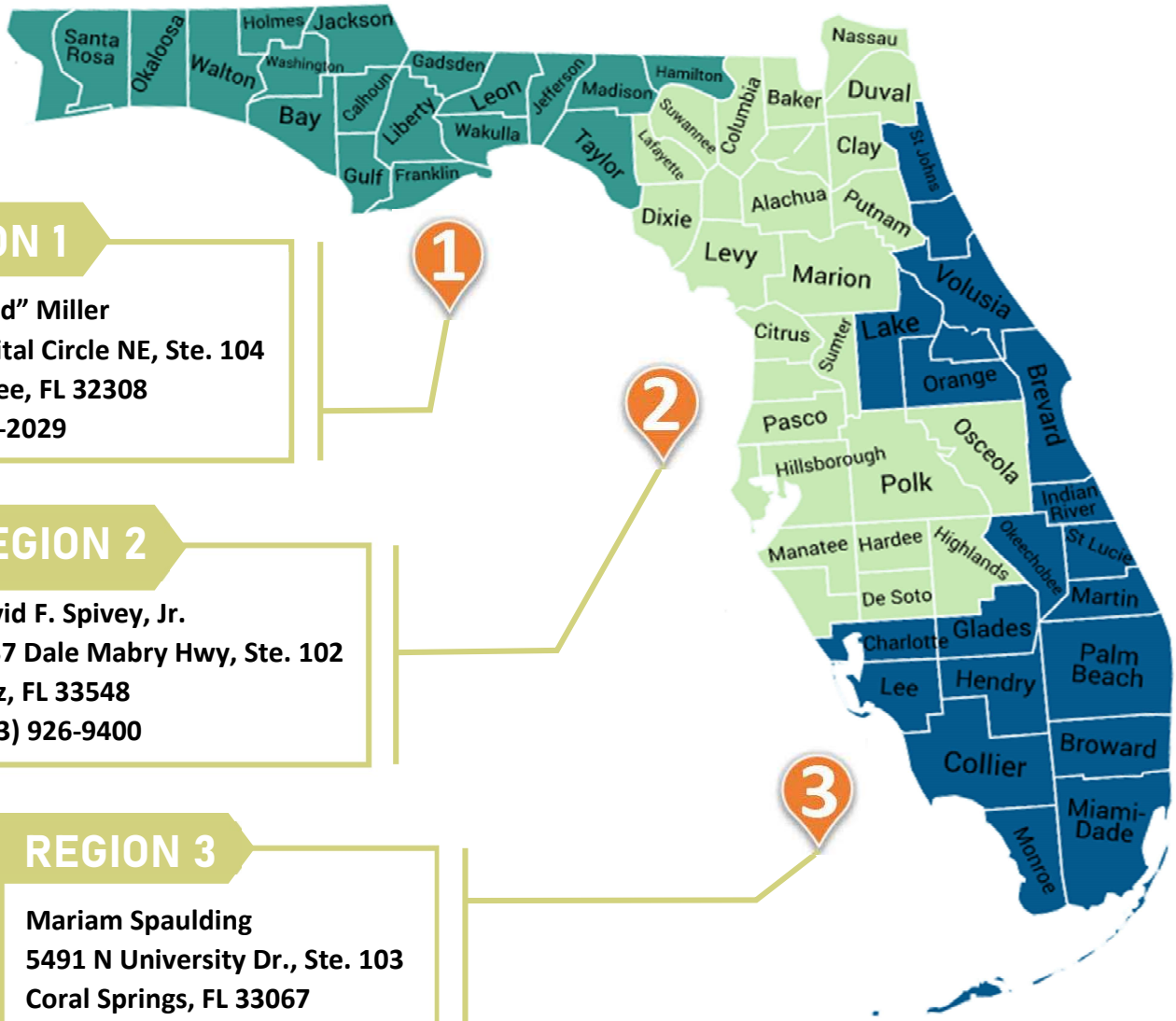
- **HD205 Prepaid** (managed care plan) covers preventive care and other dental procedures as listed when you're treated by your selected primary care dentist.
- **Schedule B Indemnity** covers preventive care and other dental procedures as listed when you're treated by any dentist you choose.

### *VISION* (CODE 107)

- An extensive network of optometrists and ophthalmologists provides you and your family with a benefit option that covers all routine eye care, exams, eyeglasses or contact lenses.

# CAPITAL INSURANCE AGENCY

## *Contact Your Regional Representative*

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**(850) 671-2029**

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### REGION 3

**Mariam Spaulding**
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**(954) 341-8705**

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50 YEARS 1970-2020

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## Ed Miller, Regional Director

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### Counties

| | |
|---|---|
| Bay | Leon |
| Calhoun | Liberty |
| Escambia | Madison |
| Franklin | Okaloosa |
| Gadsden | Santa Rosa |
| Gulf | Taylor |
| Hamilton | Wakulla |
| Holmes | Walton |
| Jackson | Washington |
| Jefferson | |

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## David Spivey, Regional Director

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### Counties

| | | |
|---|---|---|
| Alachua | Hardee | Pasco |
| Baker | Hernando | Pinellas |
| Bradford | Highlands | Polk |
| Citrus | Hillsborough | Putnam |
| Clay | Lafayette | Sarasota |
| Columbia | Levy | Sumter |
| DeSoto | Manatee | Suwanee |
| Dixie | Marion | Union |
| Duval | Nassau | |
| Gilchrist | Osceola | |

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## Mariam Spaulding, Regional Director

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### Counties

| | |
|---|---|
| Brevard | Lee |
| Broward | Martin |
| Charlotte | Monroe |
| Collier | Okeechobee |
| Dade | Orange |
| Flagler | Palm Beach |
| Glades | Seminole |
| Hendry | St. Johns |
| Indian River | St. Lucie |
| Lake | Volusia |

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# Peace of Mind *and* Real Cash Benefits

## PERSONAL CANCER INDEMNITY/ PERSONAL HOSPITAL INTENSIVE CARE INSURANCE

# PCI

Prepared for:
*State of Florida Employees*

Department of MANAGEMENT SERVICES
Division of State Group Insurance

Aflac®

Marketed & Serviced by:
Capital Insurance Agency, Inc.
1-800-780-3100

# Added Protection for You and Your Family

Chances are you know someone who's been affected, directly or indirectly, by cancer. You also know the toll it's taken on them–physically, emotionally, and financially. That's why we've developed the Aflac Personal Cancer Indemnity insurance policy. The plan pays a cash benefit upon initial diagnosis of a covered cancer, with a variety of other benefits payable throughout cancer treatment. You can use these cash benefits to help pay out-of-pocket medical expenses, the rent or mortgage, groceries, or utility bills–the choice is yours.

And while you can't always predict the future, here at Aflac we believe it's good to be prepared. The Aflac Personal Cancer Indemnity plan is here to help you and your family better cope financially if a positive diagnosis of cancer ever occurs. That way you can worry less about what may be ahead.

### The Personal Cancer Indemnity insurance policy has:

- No lifetime limit–policy won't terminate based on number or dollar amount of claims paid.
- No network restrictions–you choose your own medical treatment provider.
- No coordination of benefits–we pay regardless of any other insurance.

## TAKE A LOOK AT THE PROTECTION OFFERED BY AFLAC ...

### CANCER PLAN:

**POLICY A-75100-FL (LEVEL 1)**
**(PEOPLE FIRST PLAN CODE NO. 6500)**

**POLICY A-75300-FL (LEVEL 3)**
**(PEOPLE FIRST PLAN CODE NO. 6510)**

### OPTIONAL RIDERS TO THE CANCER PLAN:

**BUILDING BENEFIT RIDER**
**SPECIFIED-DISEASE BENEFIT RIDER**

### HOSPITAL INTENSIVE CARE PLAN

## AFLAC'S PERSONAL CANCER INDEMNITY PLAN POLICY SUMMARIES

| BENEFIT | (People First Plan Code No. 6500) A-75100-FL (LEVEL 1) | (People First Plan Code No. 6510) A-75300-FL (LEVEL 3) |
|---|---|---|
| Wellness | $40/calendar year, per covered person | $75/calendar year, per covered person |
| First-Occurrence | $1,500 Insured & Spouse<br>$2,250 (child) | $5,000 Insured & Spouse<br>$7,500 (child) |
| Hospital Confinement | $200/day (Days 1–30)<br>$400/day (Days 31+) | $300/day (Days 1–30)<br>$600/day (Days 31+) |
| Medical Imaging | $100 1x per year, per covered person | $200 1x per year, per covered person |
| Radiation/Chemotherapy | $200/daily treatment<br>Monthly Max = $1,600 self-injected<br>Max = $800 pump & oral | $300/daily treatment<br>Monthly Max = $2,400 self-injected<br>Max = $1,200 pump & oral |
| Experimental Treatment | $200/daily treatment<br>Monthly Max = $1,600 self-injected<br>Max = $800 pump & oral | $300/daily treatment<br>Monthly Max = $2,400 self-injected<br>Max = $1,200 pump & oral |
| Immunotherapy | $300/month<br>Lifetime Max $1,500 per covered person | $500/month<br>Lifetime Max $2,500 per covered person |
| Antinausea | $100/month | $150/month |
| Nursing Services – Inpatient | $100/day | $150/day |
| Skin Cancer Surgery | $100–$600 | $100–$600 |
| Surgical/Anesthesia | $95–$3,000<br>25 percent of Surgical Benefit | $100–$5,000<br>25 percent of Surgical Benefit |
| Outpatient Hospital Surgical | $200 (in addition to Surgical Benefit) | $300 (in addition to Surgical Benefit) |
| Prosthesis | | |
| • Surgical | $2,500<br>Lifetime Maximum: $5,000 per covered person | $3,000<br>Lifetime Maximum: $6,000 per covered person |
| • Nonsurgical | $200 per occurrence<br>Lifetime Maximum: $400 per covered person | $250 per occurrence<br>Lifetime Maximum: $500 per covered person |
| Reconstructive Surgery | $325–$2,500/procedure, Anesthesia = 25 percent of surgical benefit payable<br>No max on number of operations | $350–$3,000/procedure, Anesthesia = 25 percent of surgical benefit payable<br>No max on number of operations |
| Blood & Plasma | | |
| • In-Hospital | $50 times the number of days of covered hospital confinement | $150 times the number of days of covered hospital confinement |
| • Outpatient | $200/day | $250/day |
| Second Surgical Opinion | $200 | $300 |
| NCI Evaluation/ Consultation | Consultation $500 (once per covered person)<br>Travel & Lodging $250 (over 50 miles) | Consultation $500 (once per covered person)<br>Travel & Lodging $250 (over 50 miles) |
| Ambulance | $200 Ground<br>$1,000 Air | $200 Ground<br>$1,000 Air |
| Transportation | (Over 50 miles)<br>$.40/mile<br>Limit $1,200/round trip | (Over 50 miles)<br>$.50/mile<br>Limit $1,500/round trip |
| • Dependent Child | Pays benefit for up to two adults to accompany dependent child if commercial travel is necessary | Pays benefit for up to two adults to accompany dependent child if commercial travel is necessary |
| Lodging | $50/day<br>Limit 90 days/calendar year<br>(must be more than 50 miles from insured's residence) | $60/day<br>Limit 90 days/calendar year<br>(must be more than 50 miles from insured's residence) |
| Bone Marrow Transplantation | $10,000<br>Lifetime Maximum: $10,000 per covered person | $10,000<br>Lifetime Maximum: $10,000 per covered person |
| • Bone Marrow Donor | $1,000 | $1,000 |
| Stem Cell Transplantation | $2,500<br>Lifetime Maximum: $2,500 per covered person | $5,000<br>Lifetime Maximum: $5,000 per covered person |
| Extended-Care Facility | $100/day<br>Lifetime Maximum: 365 days per covered person | $100/day<br>Lifetime Maximum: 365 days per covered person |
| Hospice | $500 for first day<br>$50/day thereafter<br>Lifetime Maximum: $12,000 per covered person | $1,000 for first day<br>$50/day thereafter<br>Lifetime Maximum: $12,000 per covered person |
| Home Health Care | $50/day<br>(limited to 10 visits per hospitalization; limited to 30 visits per calendar year, per covered person) | $50/day<br>(limited to 10 visits per hospitalization; limited to 30 visits per calendar year, per covered person) |
| Waiver of Premium | Yes | Yes |
| Optional Specified-Disease Rider | Covers 32 diseases | Covers 32 diseases |
| Optional Building Benefit Rider | $300/year build | $500/year build |

# AFLAC'S PERSONAL CANCER INDEMNITY

## CANCER INDEMNITY INSURANCE

Policies A-75100-FL and A-75300-FL

# PCI

## PEACE *of* MIND. CASH BENEFITS.

### OUR INSURANCE POLICIES HELP PROVIDE BOTH.

*This is a preventive benefit; a diagnosis of cancer is not required for this benefit to be payable.*

**CANCER SCREENING WELLNESS BENEFIT:** *Aflac will pay $40 (A-75100-FL) or $75 (A-75300-FL)* per calendar year when a charge is incurred for one of the following: mammogram, breast ultrasound, Pap smear, ThinPrep, biopsy, flexible sigmoidoscopy, hemocult stool specimen, chest X-ray, CEA (blood test for colon cancer), CA 125 (blood test for ovarian cancer), PSA (blood test for prostate cancer), thermography, colonoscopy, or virtual colonoscopy. These tests must be performed to determine whether cancer exists in a covered person. This benefit is limited to one payment per calendar year, per covered person.

**FIRST-OCCURRENCE BENEFIT:** *Aflac will pay $1,500 (A-75100-FL) or $5,000 (A-75300-FL) for the insured, $1,500 (A-75100-FL) or $5,000 (A-75300-FL) for the spouse, or $2,250 (A-75100-FL) or $7,500 (A-75300-FL) for children* when a covered person is diagnosed with internal cancer. This benefit is payable only once for each covered person and will be paid in addition to any other benefit in the policy. Internal cancer includes melanomas classified as Clark's Level III and higher, or a Breslow level greater than 1.5 mm. In addition to the pathological or clinical diagnosis required by the policy, we may require additional information from the attending physician and hospital. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under the policy for a recurrence, extension, or metastatic spread of that same cancer.

**HOSPITAL CONFINEMENT BENEFIT:** *Aflac will pay $200 (A-75100-FL) or $300 (A-75300-FL) per day* when a covered person is confined to a hospital for treatment of cancer and is charged for a room as an inpatient. *Benefits increase to $400 (A-75100-FL) or $600 (A-75300-FL) per day* beginning with the 31st day of continuous confinement.

A person confined to a U.S. government hospital does not need to be charged for the Hospital Confinement Benefit to be payable.

When cancer treatment is received in a U.S. government hospital, the remaining benefits (except the Cancer Screening Wellness Benefit) are not payable unless the covered person is actually charged and is legally required to pay for such services.

**MEDICAL IMAGING BENEFIT:** *Aflac will pay $100 (A-75100-FL) or $200 (A-75300-FL) per calendar year* when a charge is incurred for each covered person who receives an initial diagnosis or follow-up evaluation of internal cancer using one of the following medical imaging exams: CT scans, MRIs, bone scans, multiple gated acquisition (MUGA) scans, positron emission tomography (PET) scans, or transrectal ultrasounds. These exams must be performed in a hospital, an ambulatory surgical center, or a physician's office. This benefit is payable once per calendar year, per covered person.

**RADIATION AND CHEMOTHERAPY BENEFIT:** *Aflac will pay $200 (A-75100-FL) or $300 (A-75300-FL) per day* as follows when a charge is incurred for a covered person who receives one or more of the following cancer treatments for the purpose of modification or destruction of abnormal tissue:

1. Cytotoxic chemical substances and their administration in the treatment of cancer:

THIS BROCHURE IS FOR ILLUSTRATION PURPOSES ONLY.

a. Injection by medical personnel in a physician's office, clinic, or hospital.

b. Self-injected medications [limited to $200 (A-75100-FL) or $300 (A-75300-FL) per daily treatment, subject to a monthly maximum of $1,600 (A-75100-FL) or $2,400 (A-75300-FL) for all medications].

c. Medications dispensed by a pump or implant [limited to $200 (A-75100-FL) or $300 (A-75300-FL) for the initial prescription and $200 (A-75100-FL) or $300 (A-75300-FL) for each pump refill, subject to a monthly maximum of $800 (A-75100-FL) or $1,200 (A-75300-FL) for all medications].

d. Oral chemotherapy, regardless of where administered [limited to $200 (A-75100-FL) or $300 (A-75300-FL) per prescription, subject to a monthly maximum of $800 (A-75100-FL) or $1,200 (A-75300-FL) for all prescriptions].

2. Radiation therapy.

3. The insertion of interstitial or intracavitary application of radium or radioisotopes.

If delivery of radiation or chemotherapy is other than listed above, benefits will be subject to a monthly maximum of $800 (A-75100-FL) or $1,200 (A-75300-FL). Treatments must be FDA- or NCI-approved for the treatment of cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, simulations, dosimetries, treatment plannings, or other procedures related to these therapy treatments. Benefits will not be paid for each day the radium or radioisotope remains in the body or for each day of continuous infusion of medications dispensed by a pump or implant. No lifetime maximum. This benefit is not payable the same day the Experimental Treatment Benefit is paid.

**EXPERIMENTAL TREATMENT BENEFIT** *Aflac will pay $200 (A-75100-FL) or $300 (A-75300-FL) per day* when a charge is incurred for a covered person who receives one or more of the following experimental cancer treatments, prescribed by a physician, for the purpose of modification or destruction of abnormal tissue:

- Treatment administered by medical personnel in a physician's office, clinic, or hospital.
- Self-injected medications [limited to $200 (A-75100-FL) or $300 (A-75300-FL) per daily treatment, subject to a monthly maximum of $1,600 (A-75100-FL) or $2,400 (A-75300-FL)].
- Medications dispensed by a pump [limited to $200 (A-75100-FL) or $300 (A-75300-FL) for the initial prescription and $200 (A-75100-FL) or $300 (A-75300-FL) for each refill, subject to a monthly maximum of $800 (A-75100-FL) or $1,200 (A-75300-FL)].
- Oral medications, regardless of where administered [limited to $200 (A-75100-FL) or $300 (A-75300-FL) per prescription, subject to a monthly maximum of $800 (A-75100-FL) or $1,200 (A-75300-FL) for all prescriptions].

Treatments must be approved by the National Cancer Institute (NCI) as viable experimental treatments for cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, or other procedures related to these therapy treatments. Benefits will not be paid for each day of continuous infusion of medications dispensed by a pump or implant. No lifetime maximum. This benefit is not payable the same day the Radiation and Chemotherapy Benefit is paid.

**IMMUNOTHERAPY BENEFIT:** *Aflac will pay $300 (A-75100-FL) or $500 (A-75300-FL) per calendar month* during which a charge is incurred for a covered person who receives immunoglobulins or colony-stimulating factors as prescribed by a physician as part of a treatment regimen for internal cancer. Any medications paid under the Radiation and Chemotherapy Benefit or the Experimental Treatment Benefit will not be paid under the Immunotherapy Benefit. Lifetime maximum of $1,500 (A-75100-FL) or $2,500 (A-75300-FL) per covered person.

**ANTINAUSEA BENEFIT:** *Aflac will pay $100 (A-75100-FL) or $150 (A-75300-FL) per calendar* month during which a charge is incurred for a covered person who receives antinausea drugs that are prescribed while receiving radiation or chemotherapy treatments.

**NURSING SERVICES BENEFIT:** *Aflac will pay $100 (A-75100-FL) or $150 (A-75300-FL) per 24-hour day* if, while confined in a hospital, a covered person requires and is charged for private nursing services other than those regularly furnished by the hospital. Services must be required and authorized by the attending physician. This benefit is not payable for private nurses who are members of your immediate family. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable.

**SURGICAL/ANESTHESIA BENEFIT:** *Aflac will pay the indemnity ($95 to $3,000 – A-75100-FL or $100 to $5,000 – A-75300-FL)* listed in the Schedule of Operations when a surgical operation is performed on a covered person for a diagnosed internal cancer and a charge is incurred. If any operation for the treatment of cancer is performed other than those listed, Aflac will pay an amount comparable to the amount shown for the operation most similar in severity and gravity. (Exceptions: Surgery for skin cancer will be payable under the Skin Cancer Surgery Benefit. Reconstructive surgery will be paid under the Reconstructive Surgery Benefit.) Two or more surgical procedures performed through the same incision will be considered one operation, and the highest eligible benefit will be paid.

*Aflac will pay an indemnity benefit equal to 25 percent* of the amount shown in the Schedule of Operations for the administration of anesthesia during a covered surgical operation. The combined benefits payable in the Surgical/

Anesthesia Benefit for any one operation will not exceed $3,750 (A-75100-FL) or $6,250 (A-75300-FL).

**OUTPATIENT HOSPITAL SURGICAL BENEFIT** *Aflac will pay $200 (A-75100-FL) or $300 (A-75300-FL)* when a surgical operation is performed on a covered person for a diagnosed internal cancer and an operating room charge is incurred. Surgeries must be performed on an outpatient basis in a hospital, to include an ambulatory surgical center. This benefit is not payable for surgery performed in a physician's office or for skin cancer surgery. This benefit is payable in addition to the Surgical/Anesthesia Benefit, is payable once per day, and is not payable on the same day as the Hospital Confinement Benefit.

**PROSTHESIS BENEFIT:** *Aflac will pay $2,500 (A-75100-FL) or $3,000 (A-75300-FL)* when a charge is incurred for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for cancer treatment. Lifetime maximum of $5,000 (A-75100-FL) or $6,000 (A-75300-FL) per covered person.

*Aflac will pay $200 (A-75100-FL) or $250 (A-75300-FL)* when a charge is incurred for nonsurgically implanted prosthetic devices that are prescribed as a direct result of cancer treatment. Lifetime maximum of $400 (A-75100-FL) or $500 (A-75300-FL) per covered person.

The Prosthesis Benefit does not include coverage for a breast transverse rectus abdominus myocutaneous (TRAM) flap procedure listed under the Reconstructive Surgery Benefit.

**RECONSTRUCTIVE SURGERY BENEFIT:** *Aflac will pay the indemnity ($325 to $2,500 – A-75100-FL or $350 to $3,000 – A-75300-FL)* listed when a surgical operation is performed on a covered person for reconstructive surgery for the treatment of cancer and a charge is incurred for the specific procedure. Aflac will pay an indemnity benefit equal to 25 percent of the amount shown in the policy for the administration of anesthesia during a covered reconstructive surgical operation. If any reconstructive surgery is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the policy for the operation most similar in severity and gravity.

**IN-HOSPITAL BLOOD AND PLASMA BENEFIT:** *Aflac will pay $50 (A-75100-FL) or $150 (A-75300-FL)* times the number of days paid under the Hospital Confinement Benefit if a covered person receives blood and/or plasma during a covered hospital confinement and a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors.

**OUTPATIENT BLOOD AND PLASMA BENEFIT:** *Aflac will pay $200 (A-75100-FL) or $250 (A-75300-FL)* for each day a covered person receives blood and/or plasma transfusions for the treatment of cancer as an outpatient in a physician's office, clinic, hospital, or ambulatory surgical center, and a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors.

**SECOND SURGICAL OPINION BENEFIT:** *Aflac will pay $200 (A-75100-FL) or $300 (A-75300-FL)* when a charge is incurred for a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician. This benefit is not payable the same day the NCI Evaluation/ Consultation Benefit is payable.

**TRANSPORTATION BENEFIT:** *Aflac will pay 40 cents per mile (A-75100-FL) or 50 cents per mile (A-75300-FL)* for round-trip transportation between the hospital or medical facility and the residence of the covered person when a covered person requires cancer treatment that has been prescribed by the local attending physician. Benefits are limited to $1,200 (A-75100-FL) or $1,500 (A-75300-FL) per round trip. This benefit will be paid only for the covered person for whom the treatment is prescribed. If the treatment is for a dependent child and commercial travel (coach-class plane, train, or bus fare) is necessary, Aflac will pay this benefit for up to two adults to accompany the dependent child. This benefit is not payable for transportation to any hospital/facility located within a 50-mile radius of the residence of the covered person or for transportation by ambulance to or from any hospital.

**LODGING BENEFIT:** *Aflac will pay $50 (A-75100-FL) or $60 (A-75300-FL)* per day when a charge is incurred for lodging for you or any one adult family member when a covered person receives cancer treatment at a hospital or medical facility more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 90 days per calendar year.

**STEM CELL TRANSPLANTATION BENEFIT:** *Aflac will pay $2,500 (A-75100-FL) or $5,000 (A-75300-FL)* when a charge is incurred if a covered person receives a peripheral stem cell transplantation for the treatment of cancer. This benefit does not include the harvesting, storage, and subsequent reinfusion of bone marrow from the recipient or a matched donor under general anesthesia. This benefit is payable once per covered person. Lifetime maximum of $2,500 (A-75100-FL) or $5,000 (A-75300-FL) per covered person.

**HOSPICE BENEFIT:** *Aflac will pay a one-time benefit of $500 (A-75100-FL) or $1,000 (A-75300-FL)* for the first day and $50 per day thereafter for hospice care when a covered person is diagnosed with cancer, therapeutic intervention directed toward the cure of the disease is medically determined no longer appropriate, and the covered person's prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer. This benefit is not payable the same day the Home Health Care Benefit is payable. Lifetime maximum of $12,000 per covered person.

*All of the following benefits are the same for A-75100-FL and A-75300-FL.*

**SKIN CANCER SURGERY BENEFIT:** *Aflac will pay the indemnity ($100 to $600)* listed when a surgical operation is performed on a covered person for a diagnosed skin cancer and a charge is incurred for the specific procedure. The benefit listed in the policy includes anesthesia services.

Exception: If skin cancer is diagnosed during hospitalization, benefits shall be limited to the day(s) the covered person actually received treatment for skin cancer [such as a malignant tumor, ulcer, pimple, or mole that may arise on the surface of the body (skin), including melanomas classified as Clark's Levels I and II, or a Breslow level less than or equal to 1.5 mm]. No benefits will be payable for expenses incurred prior to the 30th day after the effective date shown in the Policy Schedule.

**NATIONAL CANCER INSTITUTE (NCI) EVALUATION/ CONSULTATION BENEFIT:** *Aflac will pay $500* when a covered person seeks evaluation or consultation at an NCI-designated cancer center as a result of receiving a prior diagnosis of internal cancer. The purpose of the evaluation/ consultation must be to determine the appropriate course of cancer treatment. If the NCI-designated cancer center is more than 50 miles from the covered person's residence, Aflac will pay $250 for the transportation and lodging of the covered person receiving the evaluation/ consultation.

This benefit is also payable at the Aflac Cancer Center & Blood Disorders Service of Children's Healthcare of Atlanta. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable only once under the policy per covered person.

**AMBULANCE BENEFIT:** *Aflac will pay $200 for ground ambulance transportation or $1,000 for air ambulance transportation* when a charge is incurred for ambulance transportation of a covered person to or from a hospital where the covered person is confined overnight for cancer treatment. The ambulance service must be performed by a licensed professional ambulance company. This benefit is limited to two trips per confinement.

**BONE MARROW TRANSPLANTATION BENEFIT:** *Aflac will pay $10,000* when a covered person incurs a charge for a bone marrow transplantation for the treatment of cancer. This does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion. *Aflac will pay the covered person's bone marrow donor the greater of $1,000 or medical costs,* to the same extent and limitations as costs associated with the covered person for a covered bone marrow transplant. Lifetime maximum of $10,000 per covered person.

**EXTENDED-CARE FACILITY BENEFIT:** *Aflac will pay $100 per day* when a charge is incurred if a covered person receives Hospital Confinement Benefits and, within 30 days of hospital confinement, is confined to an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit or any bed designated as a swing bed, or to a section of the hospital used as such. This benefit is limited to the same number of days that the covered person received Hospital Confinement Benefits. For each day this benefit is payable, Hospital Confinement Benefits are not payable. If more than 30 days separates a stay in an extended-care facility, benefits are not payable for the second confinement unless the covered person was again confined to a hospital prior to the second such confinement. Lifetime maximum of 365 days per covered person.

**HOME HEALTH CARE BENEFIT:** *Aflac will pay $50 per day* when a charge is incurred for home health care or health supportive services when provided on a covered person's behalf within seven days of release from the hospital for the treatment of cancer. The attending physician must prescribe such services to be performed in the home of the covered person and certify that, if these services were not available, the covered person would have to be hospitalized to receive the necessary care, treatment, and services. These services must be performed by a person who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility. This benefit is not payable the same day the Hospice Benefit is payable. This benefit is limited to ten visits per hospitalization and 30 visits in any calendar year for each covered person.

*The following benefits have no lifetime maximum: Hospital Confinement, Medical Imaging, Radiation and Chemotherapy, Experimental Treatment, Antinausea, Nursing Services, Surgical/Anesthesia, Outpatient Hospital Surgical, Skin Cancer Surgery, Reconstructive Surgery, In-Hospital Blood and Plasma, Outpatient Blood and Plasma, Second Surgical Opinion, Ambulance, Transportation, Lodging, Home Health Care, and Cancer Screening Wellness.*

**WAIVER OF PREMIUM BENEFIT:** If you, due to having internal cancer, are completely unable to do all of the usual and customary duties of your occupation [or, if you are not employed: are completely unable to perform two or more of the activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a physician's statement of your inability to perform said duties or activities, and may each month thereafter require a physician's statement that total inability continues. Aflac may ask for and use an independent consultant to determine whether you can perform an ADL without assistance.

Aflac will also waive, from month to month, any premiums falling due while you are receiving hospice benefits under the Hospice Benefit.

## LIMITATIONS AND EXCLUSIONS

Aflac pays only for treatment of cancer, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions; conditions with malignant potential; complications of cancer; or any other disease, sickness, or incapacity. Pathological proof of diagnosis must be submitted. Clinical diagnosis will be accepted when a pathological diagnosis cannot be made, provided medical evidence sustains the diagnosis and the covered person receives treatment for cancer.

The policy contains a 30-day waiting period. If a covered person has cancer diagnosed before coverage has been in force 30 days from the effective date of coverage shown in the Policy Schedule, benefits for treatment of that cancer will apply only to treatment occurring after two years from the effective date of the policy. Or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium.

The First-Occurrence Benefit is not payable for: (1) any internal cancer diagnosed or treated before the effective date of the policy and the subsequent recurrence, extension, or metastatic spread of such internal cancer that is diagnosed prior to the effective date of the policy; (2) cancer diagnosed during the policy's 30-day waiting period; or (3) the diagnosis of skin cancer or melanomas classified as Clark's Levels I and II, or a Breslow level less than or equal to 1.5 mm. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under the policy for a recurrence, extension, or metastatic spread of that same cancer.

An ambulatory surgical center does not include a physician's or dentist's office, a clinic, or any other such location.

A bone marrow transplantation does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion.

A hospital does not include any institution, or part thereof, used as a hospice unit, including any bed designated as a hospice bed; a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; a rehabilitation unit or facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental diseases or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

A stem cell transplantation does not include the harvesting, storage, and subsequent reinfusion of bone marrow from the recipient or a matched donor under general anesthesia.

If skin cancer is diagnosed during hospitalization, benefits will be limited to the day(s) the covered person actually received treatment for skin cancer [such as a malignant tumor, ulcer, pimple, or mole that may arise on the surface of the body (skin) including melanomas classified as Clark's Levels I and II, or a Breslow level less than or equal to 1.5 mm]. No benefits will be payable for expenses incurred prior to the 30th day after the effective date shown in the Policy Schedule.

## TERMS YOU NEED TO KNOW

**ACTIVITIES OF DAILY LIVING (ADLS): MAINTAINING CONTINENCE:** controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters; TRANSFERRING: moving between a bed and a chair, or a bed and a wheelchair; DRESSING: putting on and taking off all necessary items of clothing; TOILETING: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; EATING: performing all major tasks of getting food into your body.

**CANCER:** A disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Cancer also includes leukemia and Hodgkin's disease. Premalignant conditions or conditions with malignant potential, including myelodysplastic and myeloproliferative disorders, will not be considered cancer.

**COVERED PERSON:** Any person insured under the coverage type you applied for: individual (named insured listed in the Policy Schedule), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Newborn children are automatically insured from the moment of birth. If coverage is for individual only and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 60 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage provided under any one-parent family or two-parent family will continue to include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, or legally adopted children who are under age 26.

**EFFECTIVE DATE:** The date(s) shown in the Policy Schedule. The effective date of the policy is not the date you signed the application for coverage, but the date recorded by Aflac in the Policy Schedule. The policy is available through age 70 on payroll deduction.

**GUARANTEED-RENEWABLE:** The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

**PHYSICIAN:** A legally qualified person, other than a member of your immediate family, who is licensed as a physician by the state to treat the type of condition for which a claim is made.

BENEFITS AND/OR PREMIUMS MAY VARY BASED ON STATE AND BENEFIT OPTION SELECTED. RIDERS ARE AVAILABLE FOR AN ADDITIONAL PREMIUM. THE POLICY HAS LIMITATIONS AND EXCLUSIONS THAT MAY AFFECT BENEFITS PAYABLE. THE POLICY MAY CONTAIN A WAITING PERIOD. THIS BROCHURE IS FOR ILLUSTRATIVE PURPOSES ONLY. REFER TO THE POLICY FOR COMPLETE BENEFIT DETAILS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

# OPTIONAL RIDER BENEFITS TO THE CANCER PLAN
# FIRST-OCCURRENCE BUILDING BENEFIT RIDER

Rider A-75050

*Riders become a part of the policy and are subject to all policy provisions, unless otherwise stated.*

**FIRST-OCCURRENCE BUILDING BENEFIT:** This benefit can be purchased in units of $100 each, up to a maximum of five units or $500. All amounts cited in the rider are for one unit of coverage. If more than one unit has been purchased, then the amounts listed must be multiplied by the number of units in force.

The First-Occurrence Benefit will be increased by $100 for each unit purchased on each rider anniversary date while the rider remains in force. This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of the rider following the covered person's 65th birthday or at the time internal cancer is diagnosed for that covered person, whichever occurs first. However, regardless of the age of the covered person on the effective date of the rider, this benefit will accrue for a period of at least five years unless internal cancer is diagnosed prior to the fifth year of coverage.

Note: For State of Florida Employees:

Policy A-75100-FL (Level 1) is sold with three units only.

Policy A-75300-FL (Level 3) is sold with five units only.

**TERMINATION:** The rider will terminate if the policy to which it is attached terminates, when the benefit has been paid for all covered persons, or if the premium for the rider is not paid.

**EFFECTIVE DATE:** The effective date of the rider is the effective date of the policy to which it is attached or the effective date of the rider, as stated in the Policy Schedule, if later.

# OPTIONAL RIDER BENEFITS TO THE CANCER PLAN
# SPECIFIED-DISEASE BENEFIT RIDER

Rider A-75052

*Riders become part of the policy and are subject to all policy provisions, unless otherwise stated.*

## SPECIFIED-DISEASE BENEFITS

While coverage is in force, if an insured is first diagnosed with one or more of the covered specified diseases and is hospitalized for the definitive treatment of any of the covered specified diseases, Aflac will pay the amounts listed below.

## INITIAL HOSPITALIZATION BENEFIT: $1,000

The covered person must be confined to a hospital for 12 or more hours as a result of receiving treatment for a specified disease. This benefit is payable only once per period of confinement and once per calendar year for each covered person.

A period of confinement is a hospital confinement that starts while the policy is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless it is the result of an entirely different sickness or injury, or unless the confinements are separated by 30 days or more.

## HOSPITAL CONFINEMENT BENEFIT

$200 per day for Days 1–30 (continuous confinement)

$500 per day for Days 31+ (continuous confinement)

## DEFINITION OF COVERED DISEASES

*Specified disease* is defined as one or more of the diseases listed below:

1. Adrenal hypofunction (Addison's disease)
2. Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
3. Botulism
4. Bubonic plague
5. Cerebral palsy
6. Cholera
7. Cystic fibrosis
8. Diphtheria
9. Encephalitis (including encephalitis contracted from West Nile virus)
10. Huntington's chorea
11. Legionnaires' disease
12. Malaria
13. Meningitis (bacterial)
14. Multiple sclerosis
15. Muscular dystrophy
16. Myasthenia gravis
17. Necrotizing fasciitis
18. Osteomyelitis
19. Polio
20. Rabies
21. Reye's syndrome
22. Scarlet fever
23. Scleroderma
24. Sickle cell anemia
25. Systemic lupus
26. Tetanus
27. Toxic shock syndrome
28. Tuberculosis
29. Tularemia
30. Typhoid fever
31. Variant Creutzfeldt-Jakob disease (mad cow disease)
32. Yellow fever

For benefits to be paid, these diseases must be first diagnosed by a physician 30 days following the effective date of the rider. The diagnosis must be made by and upon a tissue specimen, culture, and/or titer. If any of these diseases is diagnosed before the rider has been in effect for 30 days, benefits for that disease will be paid only for loss incurred after the rider has been in force two years.

## TERMINATION

The rider will terminate if the policy to which it is attached terminates or if the premium for the rider is not paid.

## EFFECTIVE DATE

The effective date of the rider is the effective date of the policy or the effective date of the rider, as stated in the Policy Schedule, if later.

# AFLAC'S PERSONAL HOSPITAL INTENSIVE CARE

## HOSPITAL INTENSIVE CARE INSURANCE

Policy A-1820B-FL

### DAILY HOSPITAL INTENSIVE CARE UNIT BENEFIT

Benefits will be paid if you or any covered person incurs a charge for confinement in a hospital intensive care unit (ICU). This benefit is limited to 15 days per period of confinement. No lifetime maximum.

$600 per day (Days 1–7)

$1,000 per day (Days 8–15)

Exception: During the first ten months the policy is in force, if a covered child is confined in a hospital intensive care unit within the first 28 days after birth, we will pay $250 per day for hospital intensive care unit confinement of Days 1 through 15.

### DAILY SUBACUTE INTENSIVE CARE UNIT BENEFIT

Benefits will be paid for up to a total of 15 days when a covered person incurs a charge for the following: (1) confinement in a subacute intensive care unit (step-down unit) or (2) confinement in a hospital intensive care unit (ICU) after exhaustion of benefits payable under the Daily Hospital Intensive Care Unit Benefit above.

$250 per day

Benefits payable for the Daily Subacute Intensive Care Unit/ Hospital Intensive Care Unit Benefit (combination of 1 and 2) are limited to a total of 15 days per covered period of confinement. No lifetime maximum.

Note: Benefits payable under the Daily Hospital Intensive Care Unit Benefit or Daily Subacute Intensive Care Unit/ Hospital Intensive Care Unit Benefit are not payable on the same day.

If a covered person is charged for both on the same day, Aflac will pay only the highest eligible benefit. Confinements not separated by 30 days or more from a previously covered confinement are considered a continuation of the previous period of confinement.

### HUMAN ORGAN TRANSPLANT BENEFIT

A benefit will be paid as a result of a human organ transplant procedure when a covered person is confined in a hospital and receives one or more of the following: kidney, liver, heart, heart-lung, lung, or pancreas transplant.

$25,000 per occurrence

Transplant procedures involving more than one organ will be considered to be one organ transplant procedure. This benefit is not payable for transplants involving mechanical or animal organs and is limited to one procedure per 180-day period. No lifetime maximum.

### AMBULANCE BENEFIT

Benefits will be paid for the actual charges incurred for ground ambulance transportation of a covered person to and from a hospital where the covered person is confined in a hospital intensive care unit or subacute intensive care unit.

Up to $250

Benefits will be paid for the actual charges incurred for air ambulance transportation of a covered person to and from a hospital where the covered person is confined in a hospital intensive care unit or subacute intensive care unit.

Up to $2,000

This benefit is limited to two trips per confinement. The ambulance service must be performed by a licensed professional or licensed volunteer ambulance company. No lifetime maximum.

### CONTINUATION OF COVERAGE BENEFIT

If you are paying your premiums through payroll deduction and you leave your employer for any reason after your policy has been in force for six months and Aflac has received premiums for six consecutive months, Aflac will waive all monthly premiums due for the policy and riders, if any, up to the date your premium payments are re-established. You or your employer must notify us in writing within 30 days of the date your premium payments cease due to your leaving employment. For you to take advantage of this benefit, you must re-establish premium payments within two months from the date you left the employer who was remitting your premiums. You can re-establish your premium payments through your new employer's payroll deduction process or direct payment to Aflac.

This benefit will again become available once you have re-established your premium payments through an employer's payroll deduction process for a period of six months and Aflac has received premiums for six consecutive months. Payroll deduction means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

REFER TO THE POLICY FOR COMPLETE DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS. FOR ILLUSTRATION PURPOSES ONLY.

## LIMITATIONS AND EXCLUSIONS

All benefits payable under the policy will be reduced by one-half for losses that start on or after the policy anniversary date following the 70th birthday of a covered person. Benefits are not payable for losses that begin before the policy effective date shown in the Policy Schedule. The policy will not cover any person who has attained age 65 prior to the effective date of the policy unless the policy is issued on a payroll deduction basis. If issued on a payroll deduction basis, the policy will not cover any person who has attained age 70 prior to the effective date of the policy.

No benefits will be payable for losses caused by or resulting from: intentionally self-inflicted bodily injury or attempted suicide; participation in or the attempt to participate in any illegal activity that is classified as a felony, whether charged or not (the term *felony* is as defined by the law of the jurisdiction in which the activity takes place); exposure to war or any act of war, declared or undeclared, or service in the armed forces; the treatment of mental or nervous disorder or disease; alcoholism or drug dependency; any loss sustained or contracted due to a covered person's being intoxicated or under the influence of alcohol, drugs or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term *intoxicated* refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred); confinement in units such as surgical recovery rooms, privately monitored rooms, observation units, labor or delivery rooms, or other facilities that do not meet the standards for a hospital intensive care unit or subacute intensive care unit (step-down unit). Newborn children will not be covered for routine nursing or routine well-baby care, but we will pay the policy benefits because of their sickness or injury, including congenital anomaly.

The term *hospital* is defined as a legally licensed hospital which is accredited by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities. The term *hospital* includes ambulatory surgical centers. Provided that medical or rehabilitative treatment for the disease covered by the policy is actually being received by an insured, we will not deny any claim for payment when the treatment is provided in any hospital meeting the above definitions. No claim will be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of a physical disability.

The Daily Hospital Intensive Care Unit Benefit does not provide benefits for confinement in units such as surgical recovery rooms, progressive care, intermediate care, private monitored rooms, observation units, telemetry units; subacute intensive care units* (step-down units), or other facilities that do not meet the standards for a hospital intensive care unit.

A subacute intensive care unit (step-down unit) does not include an observation unit; a bed, ward, or semiprivate room with or without monitoring equipment; an emergency room; a surgical recovery room; or a labor or delivery room.

## GUARANTEED-RENEWABLE FOR YOUR LIFETIME WITH BENEFITS REDUCED AT AGE 70

The policy is guaranteed-renewable for your lifetime with benefits reduced at age 70. It is subject to Aflac's right to change the applicable table of premium rates by class upon any renewal date.

## COVERED PERSON

Any person insured under the coverage type you applied for: individual (named insured listed in the Policy Schedule), family (named insured, spouse, and dependent children). Newborn children are automatically insured from the moment of birth. The coverage under any family policy shall continue to include any dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated while covered and prior to age 26. Dependent children are your natural children, stepchildren, or legally adopted children who are under age 26. You must notify us, in writing, of the birth of a child within 60 days after the birth. If timely notice is given, we will not charge an additional premium for coverage of the newborn child for the duration of the notice period. If timely notice is not given, we will change the applicable additional premium from the date of birth. We will not deny coverage for a child due to your failure to notify us within the 60-day period.

## EFFECTIVE DATE

The effective date of the policy is the date shown in the Policy Schedule, not the date the application is signed. The payroll rate may be retained after one month's premium payment on payroll deduction.

*Benefits for confinement in a subacute care facility are paid under the Daily Subacute Intensive Care Unit Benefit.

BENEFITS AND/OR PREMIUMS MAY VARY BASED ON STATE AND BENEFIT OPTION SELECTED. THE POLICY HAS LIMITATIONS AND EXCLUSIONS THAT MAY AFFECT BENEFITS PAYABLE. THIS BROCHURE IS FOR ILLUSTRATIVE PURPOSES ONLY. REFER TO THE POLICY FOR COMPLETE BENEFIT DETAILS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

**American Family Life Assurance Company of Columbus**
**(herein referred to as Aflac)**
**Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999**

## STATEMENT OF UNDERSTANDING AND AGREEMENT

I, the undersigned, understand and agree that the: (check all that apply)

- ❑ Cancer/Specified Disease
- ❑ Hospital Intensive Care

policy (policies) that I am applying for or if already issued, will not be effective until _____ _____. No benefits will be due to me or any family members, if applicable, and Aflac will not be liable for any claims for loss incurred prior to the effective date of the policy (policies) listed above.

**Reissues only**
_____(policyholder's initials) I certify my medical condition has not changed from the time I originally applied for coverage and I understand that any pre-existing condition clauses and applicable waiting periods will begin as of the newly selected effective date above.

Applicant's/Policyholder's Printed Name: _____

Address: _____

Policy Number: _____

Signature of Applicant/Policyholder: _____

Date Signed: _____

Signature of Associate: _____

**American Family Life Assurance Company of Columbus**
**(herein referred to as Aflac)**
**Worldwide Headquarters • Columbus, GA 31999**
**For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).**

# Suitability Notice

I, _____, have reviewed the benefits and premium of the insurance
Proposed Insured's Name

policy(ies) and/or riders that I am applying for and agree to the following.

- I understand the impact that the premium for this coverage has on my paycheck/income;
- I understand the impact that the total Aflac premium for this coverage and any other Aflac coverage has on my paycheck/income and believe it to be appropriate for me; and
- I have considered all of my existing health insurance coverage, with Aflac and/or with other carriers, and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

Proposed Insured's Signature _____ Date _____

I certify that I have advised the applicant to consider the impact that this Aflac coverage has on his or her paycheck/income, and I agree with the applicant's decision that it is appropriate for purchase.

Associate's/Agent's Signature _____ Date _____
Licensed Associate/Agent

# AUTHORIZATION TO OBTAIN INFORMATION

**MAIL TO:** American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999-0001

| **Primary Policyholder's Name:** | **SSN**(optional): | **Date of Birth:** |
|---|---|---|
| **Policy Number(s):** | | |
| **Address:** | | |
| **Name of Individual Subject to Disclosure** (if not the primary policyholder): | | **Date of Birth:** |
| **Relationship to Primary Policyholder:** □ Self □ Spouse □ Domestic Partner | | |

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, pharmacy-related service organizations, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc. (formerly known as the Medical Information Bureau), consumer reporting agency, or employer.

"Information" includes facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Policy Service, 1932 Wynnton Road, Columbus, Georgia 31999.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

Signature of Individual Subject to Disclosure _____ Date Signed _____

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Printed Name of Legal/Personal Representative _____ Legal Relationship *(e.g. Power of Attorney)* _____

Payroll

**Application for Cancer Indemnity Insurance (A-75000 Series)**
Application to: American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

❑ New
❑ Conversion
Policy Number:

**To Be Completed by Applicant: Please Print in Black Ink**

Applicant's Name _____ (Last / First / MI) DOB _____ (Month/Day/Year) Sex _____

Applicant's SSN _____ - _____ - _____ Dependent Children ❑ Yes ❑ No

**(Write spouse's name below if you are applying for Two-Parent Family coverage; if no spouse or spouse is not to be covered, write "N/A" or "None" in the space below.)**

Spouse's Name _____ (Last / First / MI) DOB _____ (Month/Day/Year) Sex _____

Address _____ (Street or Post Office Box) (Apt. No.)

City _____ State _____ ZIP Code _____

Home Telephone ( ) _____

Policyowner's Name _____ (if other than applicant) Relationship to Applicant _____

Address _____ (Street or Post Office Box) (Apt. No.) Owner's SSN _____ - _____ - _____

City _____ State _____ ZIP Code _____

Payroll Account Name State of Florida Payroll Account Number 0B217

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No

If yes, please read and sign the Replacement Notice provided by your agent and provide policy number and company name here: _____

**TO BE COMPLETED BY AFLAC AGENT**

| **Check Coverage Desired:** | ❑ Individual ❑ Two-Parent Family | ❑ One-Parent Family | |
|---|---|---|---|
| Level 1: Policy (Series A-75100) | ❑ CCAIPA | ❑ CCAIPD | ☒ Pre-tax |
| Level 3: Policy (Series A-75300) | ❑ CCAIPC | ❑ CCAIPF | ❑ After-tax |

**Optional Rider:**

| | | |
|---|---|---|
| **Building Benefit Rider (Series A-75050)** Units ____ ❑ No rider ❑ New rider ❑ Retain current rider | ❑ CCAIPG | ❑ CCAIPK |
| | | |
| **Specified-Disease Rider (Series A-75052)** ❑ No rider ❑ New rider ❑ Retain current rider | ❑ CCAIPJ | ❑ CCAIPM |

**Billing Method:** ☒ Payroll Deduction

**Mode:**
❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 28-Day Biweekly
❑ 01 Semimonthly
☒ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Employee No. _____ Dept. No. _____ Agent's No. _____

Billable Premium $ _____ Premium Collected $ PR Sit. Code C

**PLEASE COMPLETE THE FOLLOWING QUESTIONS:**

1. Have you or has anyone to be covered under this policy ever been diagnosed with or treated for Cancer of any type or form? ❑ Yes ❑ No

   If no, skip to number 7 or number 5 if this is a conversion. If yes, please complete numbers 2 and 3.

2. Was any Cancer referred to in number 1 an internal Cancer (which includes melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm):

   (a) diagnosed or treated within the last five years (two years for breast cancer) or for which preventive Hormonal Therapy has been received within the last 12 months? ❑ Yes ❑ No

   If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

   _____

   **Any individual(s) indicated above will not be covered under the policy.**

   (b) last diagnosed or treated over five years (two years for breast cancer) ago? ❑ Yes ❑ No

   If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

   _____

   **Please complete a Cancer History Form provided by your agent on any individual(s) listed.**

3. Was any Cancer referred to in number 1 a Skin Cancer (which includes melanoma of Clark's Level I or II, or a Breslow level less than or equal to 1.5 mm):

   (a) diagnosed or treated within the last five years? ❑ Yes ❑ No

   If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

   _____

   **Any individual(s) indicated above will be issued a Skin Cancer Exclusion Rider. Benefits will not be payable under this policy for the indicated individual for the treatment of Skin Cancer.**

   (b) last diagnosed or treated over five years ago? ❑ Yes ❑ No

   If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

   _____

   **Any individual(s) indicated above will not be issued a Skin Cancer Exclusion Rider. Benefits will be payable under this policy for the indicated individual for the treatment of Skin Cancer.**

If you answered yes to number 1 and this is a conversion, please complete the conversion section below.

**YOU MUST COMPLETE THIS SECTION IF THIS IS A CONVERSION.**

**IF** your answer to number 1 above was "yes," complete number 4 below. If no, skip to number 5.

4. Have you or any person to be covered under this policy received benefits, other than Wellness Benefits, under your existing AFLAC Cancer policy in the last five years(two years for breast cancer)? ❑ Yes ❑ No
   If yes, was it ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

   _____

   **Any individual(s) indicated above will not be covered under the policy.**

5. If this is an application for a conversion, the following conditions apply: (a) If Cancer is diagnosed between the date this application is signed and the Effective Date of the policy shown in the Policy Schedule, the policy for which this application is made will be void and coverage will continue under the terms of the previous policy, which may remain in force. Any benefits that may be due will be paid under the previous policy. (b) The waiting period provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. Any premium paid on the original policy that is unearned as of the Effective Date of the new policy will be applied to the new policy.
6. I acknowledge that I was offered the Building Benefit Rider and declined it. I understand that by not applying for the Building Benefit Rider that I will lose the building benefit amount accrued in my previous policy, if any.
   ❑ Yes
   Applicant's Initials _____
   ❑ N/A

7. I understand that the Effective Date of this policy will be the date recorded on the Policy Schedule by AFLAC**. It is not the date the application is signed.** This policy contains a 30-day waiting period. If a covered person has Cancer diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that Cancer will apply only to treatment occurring after two years from the Effective Date of the policy or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium.
8. I acknowledge receipt of, if applicable:
   - ❑ Fair Credit Reporting Notice
   - ❑ *Guide to Health Insurance for People with Medicare*
   - ❑ Replacement Notice
   - ❑ Outline of Coverage
9. I understand that: (a) the policy of insurance I am now applying for will be issued based upon the written answers to questions and information asked for in this application and any other pertinent information AFLAC may require for proper underwriting; (b) AFLAC is not bound by any statement made by me, or any agent of AFLAC, unless written herein; (c) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (d) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; (e) no change to the policy will be valid until approved by AFLAC's secretary and president and noted in or attached to the policy; and (f) all statements in this application are representations and not warranties.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, AFLAC may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by AFLAC may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon and Virginia.

**Complete this section if applicant is applying for Specified-Disease Rider Series A-75052.**

**American Family Life Assurance Company of Columbus (AFLAC)**
**Worldwide Headquarters: 1932 Wynnton Road, Columbus, Georgia 31999**

SUPPLEMENTAL MEDICAL INFORMATION QUESTIONNAIRE FOR SPECIFIED-DISEASE RIDER

Have you or has anyone to be covered under this policy ever had adrenal hypofunction (Addison's disease), ALS (amyotrophic lateral sclerosis) or Lou Gehrig's disease, botulism, bubonic plague, cerebral palsy, cholera, cystic fibrosis, diphtheria, encephalitis (including Encephalitis contracted from West Nile virus), Huntington's chorea, Legionnaires' disease, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, Reye's syndrome, scarlet fever, scleroderma, sickle-cell anemia, systemic lupus, tetanus, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, Variant Creutzfeldt-Jakob disease (mad cow disease), or yellow fever in any form? ❑ Yes ❑ No

If yes, was it the: ❑ Named Insured ❑ Spouse ❑ Child?

If "child," please list the name of the child(ren) _____.

Any person(s) named will not be covered under Specified-Disease Rider Form Series A-75052.

**I understand that the premium amount listed on this application represents the premium amount that my employer will remit to AFLAC on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my agent.**

**I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage. I also understand that if I am receiving any Medicaid benefits, the purchase of this supplemental coverage is not necessary.**

If I am applying to convert my current policy to another AFLAC policy, I acknowledge that I have been advised that the policies have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am giving up my current policy and its benefits for the benefits provided in the new policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. I realize that any false statement or misrepresentation hereon may result in loss of coverage under the policy.

**Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.**

Applicant's Signature _____ Date _____

Agent's Signature _____ Date _____
Licensed Resident Agent

Typed or Printed Name of Agent: _____

Agent Telephone Number: _____

Agent Address: _____

Agent Florida License Number: _____

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

## IMPORTANT NOTICE TO PERSONS ON MEDICARE
## THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

### Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Payroll

**Application for Hospital Intensive Care Unit Insurance (A-18200 Series)**
Application to American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

☐ New
☐ Conversion
Policy Number:

**Please Print In Black Ink - To Be Completed by Applicant**

Applicant's Name _____ (Last / First / MI) DOB _____ (Month/Day/Year) Sex _____

Applicant's SS# _____ - _____ - _____ Dependent Children ☐ Yes ☐ No

**(Complete spouse's name below if you are applying for Family coverage; if no spouse or spouse is not to be covered, put N/A in space below.)**

Spouse's Name _____ (Last / First / MI) DOB _____ (Month/Day/Year) Sex _____

Address _____ (Street or Post Office Box) (Apt. #)

City _____ State _____ ZIP Code _____

Home Telephone ( ) _____ Work Telephone ( ) _____

Policy owner's Name _____ **(if other than applicant)** Relationship to Applicant _____

Address _____ (Street or Post Office Box) (Apt. #) Owner's SS# _____ - _____ - _____

City _____ State _____ ZIP Code _____

Name of Employer State of Florida EEID **(Client SSN)**

Do you have any other hospital intensive care coverage with AFLAC? ☐ Yes ☐ No If yes, this must be an upgrade of that coverage. If yes, give current policy number and see Item #11.
Policy Number: _____
Is this insurance intended to replace any other hospital intensive care insurance now in force? ☐ Yes ☐ No
Name of company and policy number to be replaced _____
If yes, please read and sign the Replacement Notice provided by your agent, if applicable.

**TO BE COMPLETED BY AFLAC AGENT**

**Check Coverage Desired:** ☐ Individual ☐ Family

☒ Pre-tax
☐ After-tax

| Policy (Series A-18200) | **EHIC70** |
|---|---|

**Billing Method:**
☒ Payroll Deduction
☐ Share Deductions/Credit Union

**Mode:**
☐ 01 Weekly
☐ 01 Biweekly
☐ 01 Semimonthly
☒ 01 Monthly
☐ 03 Quarterly
☐ 06 Semiannual
☐ 12 Annual

Employee No.: _____ Dept. No.: _____ Agent's No.: _____

Billable Premium: $ _____ Premium Collected: $ **PR** Sit. Code: **0**

**ALL OF THE FOLLOWING MUST BE COMPLETED:**

1. Has anyone to be covered been diagnosed with or treated by a member of the medical profession in the last five years for: angina, congestive heart failure, heart attack or stroke? ☐ Yes ☐ No
2. Has anyone to be covered had or been advised of the need to have coronary angioplasty, coronary atherectomy, coronary bypass surgery, heart valve surgery or surgery for congenital heart defects within the last five years? ☐ Yes ☐ No
3. Has anyone to be covered ever been treated or diagnosed by a member of the medical profession with chronic liver disease, chronic kidney disease or impaired kidney function (not including kidney stones) or been treated with dialysis by a member of the medical profession? ☐ Yes ☐ No
4. Has anyone to be covered tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No
5. Within the last five years, has anyone to be covered ever had or been advised to have an organ transplant or consulted with a member of the medical profession about the need to have an organ transplant? ☐ Yes ☐ No
6. If any one of Questions 1 through 5 is answered "yes," the name and the relationship of the person(s) must be shown in the following space. Any person(s) so named will not be covered under the policy. _____

_____

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

7. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters. **Benefits of this policy reduce to half at age 70.**
8. I understand that the policy I am applying for will not cover any person who has attained age 70 prior to the Effective Date of the policy.
9. I acknowledge receipt of, if applicable:
   - ☐ Fair Credit Reporting Notice
   - ☐ Replacement Notice
   - ☐ Outline of Coverage
   - ☐ Guide To Health Insurance for People with Medicare
10. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application; statements in this application are representations and not warranties; AFLAC is not bound by any statement made by me, the applicant, or any agent of AFLAC unless written herein; the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; the policy together with this application, endorsements, benefit agreements and riders, if any, is the entire contract of insurance; and no change to the policy will be valid until approved by AFLAC's secretary and president, which must be noted in or attached to the policy.
11. If this is an application for an upgrade of coverage, the following conditions shall apply: (a) If Question 1, 2, 3, 4 or 5 is answered "yes," the policy for which this application is made for the person(s) identified in Item 6 above shall be void, and coverage shall continue under the terms of the previous policy, which may remain in force. Benefits that may be due any person(s) listed in Item 6 above will be paid under the previous policy. (b) Any person(s) not listed in Item 6 above, if eligible, will be covered under the new policy. (c) The Time Limit on Certain Defenses provision shall run from the Effective Date of the original policy. Any premium paid on the original policy that is unearned as of the Effective Date of the new policy shall be applied to the new policy.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, AFLAC may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by AFLAC may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This Notice only applies in Arizona, California, Georgia, Illinois, Maine, Minnesota, Montana, Nevada, North Carolina, Oregon and Virginia.

I have read, or had read to me, the completed application, and I realize policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief. I realize that any false statement or misrepresentation hereon may result in loss of coverage under the policy.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Applicant's Signature _____ Date _____

I certify I personally saw the applicant when the application was completed and each question was asked of the applicant and answered as recorded. All answers are correct to the best of my knowledge.

Agent's Signature _____ Date _____
Licensed Agent

Agent's Writing Number _____ Sit. Code _____

Typed or Printed Name of Agent _____ Agent's Telephone No. _____

Agent's Address _____ Agent's Florida License No. _____

**Make check or money order payable to AFLAC. For information, call toll-free 1-800-99-AFLAC (1-800-992-3522).**

## IMPORTANT NOTICE TO PERSONS ON MEDICARE
## THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

### Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

# DISCLOSURE STATEMENT

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS**
**(herein referred to as Aflac)**
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
For information, call 1.800.99.AFLAC (1.800.992.3522).
Visit our website at aflac.com

A Stock Company

Applicant's Name:_____

Policy Number:_____

## THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

### MINIMUM ESSENTIAL COVERAGE DEFINITION

The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

I certify, by signing below, that I am covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act.

_____ _____

Applicant's Signature Date


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**American Family Life Assurance Company of Columbus**
**(herein referred to as Aflac)**
**Worldwide Headquarters • Columbus, GA 31999**
**For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).**

# Replacement Notice

I, _____, have reviewed the benefits, limitations, exclusions, and costs of
Proposed Insured's Name

the insurance policy(ies) and/or riders that I am applying for and agree to the following.

- If I am applying to replace existing Aflac coverage or coverage with another carrier with this policy, I acknowledge that the policies and/or rider(s) may have different benefits, limitations, exclusions, and costs and that I should compare them to determine which is best for me. If I am replacing existing Aflac coverage, I understand and agree that I am terminating my current Aflac policy and/or rider(s) for this Aflac policy.

Proposed Insured's Signature _____ Date _____

## HOW TO FILE A CLAIM:

Completing the claims process is fast and easy. Most claims are paid in just one day* when you submit online using Aflac SmartClaim® and four days when claims are received through other submission channels.

**To Submit Claims Online**

1. Log in to Aflac Policyholder Services and access Aflac SmartClaim®:
2. Click Start a SmartClaim to begin the process of filing an online claim.
3. Electronically submit (upload) all requested supporting documentation.
4. Click *Submit*.

For claims that cannot be submitted online, Aflac SmartClaim® will also provide the correct form you need.

**To Use Other Submission Channels**

If you choose not to submit your claim online, you can access a claim form at www.aflac.com/claimforms.

1. Complete the form
2. Attach all required supporting documents.
3. Include your policy number, policyholder name, and date of birth or mailing address.

Claims may be faxed to 877.44.AFLAC (877.442.3522).
Claims may be mailed to:
American Family Life Assurance Company of Columbus
ATTN: Claims Department
1932 Wynnton Road
Columbus, GA 31999

*One Day Pay℠ is available for certain individual claims submitted online through the Aflac SmartClaim® process. Claims may be eligible for One Day Pay processing if submitted online through Aflac SmartClaim, including all required documentation, by 3 p.m. ET. Documentation requirements vary by type of claim; please review requirements for your claim(s) carefully. Aflac SmartClaim is available for claims on most individual Accident, Cancer, Hospital, Specified Health, and Intensive Care policies. Processing time is based on business days after all required documentation needed to render a decision is received and no further validation and/or research is required. Individual Company Statistic, 2019.

## HOW TO APPLY:

1. Contact your regional Capital Insurance representative (listed on the back cover of this brochure) to complete the enclosed Aflac application. Aflac's application is in addition to the online state enrollment process. To obtain information about Aflac insurance, contact your regional Capital Insurance representative or call Capital Insurance Agency toll-free at 1-800-780-3100.
2. To complete the state enrollment process, contact the People First Service Center toll-free at 1-866-663-4735, or visit their website at https://peoplefirst.myflorida.com.

***Note:*** You may apply for this coverage during the first 60 days of employment or during the annual open enrollment period. Enrollment will not be complete unless both the state enrollment process and an Aflac application are completed.

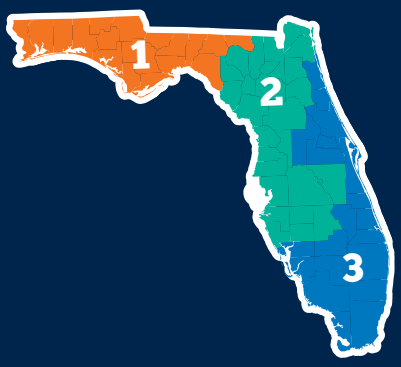
***Please return the Aflac application to:***
***Capital Insurance Agency, Inc.***
***P.O. Box 15949***
***Tallahassee, FL 32317***

| Plan | Benefit Plan Code | Monthly Payroll Premiums Individual | One-Parent Family | Two-Parent Family |
|---|---|---|---|---|
| Cancer | | | | |
| A-75100-FL Only (Level 1) | 6500 | $18.70 | $21.70 | $30.50 |
| A-75100-FL (Level 1)<br>SDR** | | $18.70<br>$ 1.00 | $21.70<br>$ 1.50 | $30.50<br>$ 2.00 |
| A-75100-FL + SDR | 6501 | $19.70 | $23.20 | $32.50 |
| A-75100-FL (Level 1)<br>BBR* (3 units) | | $18.70<br>$ 1.80 | $21.70<br>$ 2.70 | $30.50<br>$ 3.90 |
| A-75100-FL + BBR (3 units) | 6502 | $20.50 | $24.40 | $34.40 |
| A-75100-FL (Level 1)<br>BBR* (3 units)<br>SDR** | | $18.70<br>$ 1.80<br>$ 1.00 | $21.70<br>$ 2.70<br>$ 1.50 | $30.50<br>$ 3.90<br>$ 2.00 |
| A-75100-FL + BBR + SDR | 6503 | $21.50 | $25.90 | $36.40 |
| | | | | |
| A-75300-FL Only (Level 3) | 6510 | $33.50 | $40.20 | $55.90 |
| A-75300-FL (Level 3)<br>SDR** | | $33.50<br>$ 1.00 | $40.20<br>$ 1.50 | $55.90<br>$ 2.00 |
| A-75300-FL + SDR | 6511 | $34.50 | $41.70 | $57.90 |
| A-75300-FL (Level 3)<br>BBR* (5 units) | | $33.50<br>$ 3.00 | $40.20<br>$ 4.50 | $55.90<br>$ 6.50 |
| A-75300-FL + BBR (5 units) | 6512 | $36.50 | $44.70 | $62.40 |
| A-75300-FL (Level 3)<br>BBR* (5 units)<br>SDR** | | $33.50<br>$ 3.00<br>$ 1.00 | $40.20<br>$ 4.50<br>$ 1.50 | $55.90<br>$ 6.50<br>$ 2.00 |
| A-75300-FL + BBR + SDR | 6513 | $37.50 | $46.20 | $64.40 |
| *BBR – Building Benefit Rider<br>**SDR – Specified-Disease Rider | | | | |
| Hospital Intensive Care | 7000 | $ 8.70 | $16.64 | $16.64 |
| A-1820B-FL | | | | |

# CAPITAL INSURANCE AGENCY, INC.

***"We're Here To Help You!"***

Contact the Capital Insurance Agency




## Home Office

1425 E. Piedmont Dr.
Suite 301
Tallahassee, FL 32308

P.O. Box 15949
Tallahassee, FL 32317-5949

800.780.3100
850.386.3100
850.386.7116 fax
groupdepartment@capitalins.com

**www.capitalins.com**

## Regional Locations

### Region 1

**Robert E. "Ed" Miller**
**Regional Director**
2236 Capital Circle NE
Suite 104
Tallahassee, FL 32308

### Region 2

**David F. Spivey Jr., MDRT®**
**Regional Director**
1537 Dale Mabry Highway,
Suite 102
Lutz, FL 33548

### Region 3

**Mariam Spaulding, LUTCF**
**Regional Director**
5491 University Drive
Suite 103
Coral Springs, FL 33067

aflac || **1.800.99.AFLAC** (1.800.992.3522)

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

FSC MIX Paper FSC® C007639

STATE OF FLORIDA & UNIVERSITY EMPLOYEES

# HOW TO APPLY

1. Enroll during Open Enrollment or as a New Employee (within the first 60 days of employment). Contact the People First Service Center, toll-free 866.663.4735, or access their web site at https://peoplefirst.myflorida.com to make your election.

2. Complete the Enrollment Form(s) and return it by mail to Capital Insurance Agency's Group Benefits Dept., P.O. Box 15949 Tallahassee, Florida 32317.

3. Contact your local Capital Representative with any questions and for assistance with completing the enclosed application.

***Your enrollment is not complete until you have notified People First of your election and the completed enrollment application(s) are submitted.*

**Enroll Now**

For more information on how to enroll, please contact the Group Benefits Dept. by phone at 800.780.3100 or email at groupdepartment@capitalins.com.

# Supplemental Hospital Plans

**FRANCHISE INSURANCE POLICIES**

**FOR EMPLOYEES OF THE STATE OF FLORIDA**

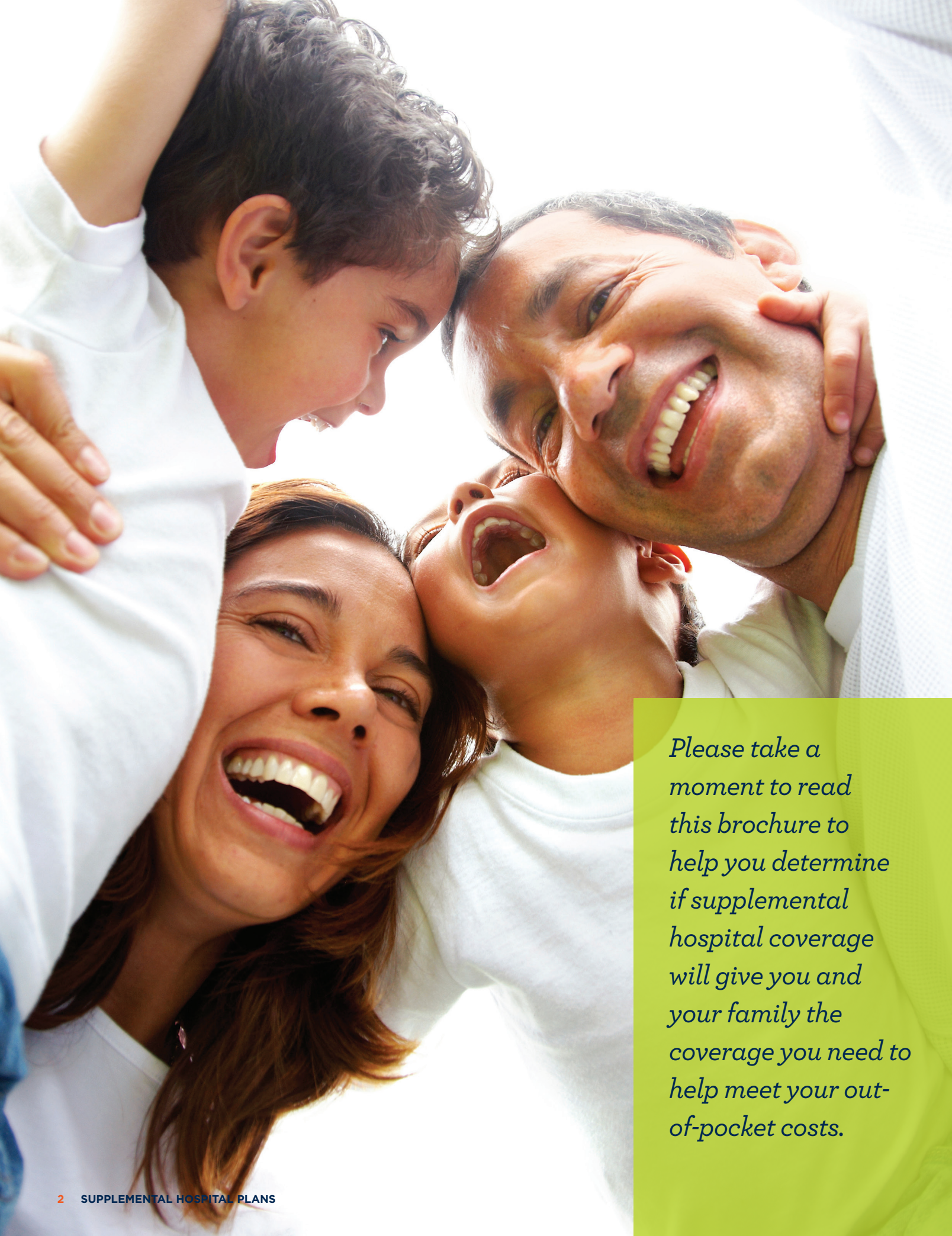
## Help Protect Your Family From Out-of-Pocket Hospital Facility Costs for:

- In-Hospital Confinement
- Out Patient Surgical Center

Department of MANAGEMENT SERVICES
Division of State Group Insurance

Capital Insurance Agency, Inc.

This plan marketed & serviced by Capital Insurance Agency, Inc.



*Please take a moment to read this brochure to help you determine if supplemental hospital coverage will give you and your family the coverage you need to help meet your out-of-pocket costs.*

# What is it?
# Why do I need it?
# Doesn't my medical plan cover all my expenses?

**Supplemental Hospital** coverage is additional coverage designed especially to help take care of some of the hospital facility costs that may not be covered by your primary plan.

Although it depends on your unique circumstances, there could be some amount of money that you are responsible for when you or someone in your family is hospitalized. These costs and obligations are called out-of-pocket costs. These charges can include hospital deductible, room and board, co-payments and any special fees.

All plans also include various levels of coverage for outpatient surgery at licensed Ambulatory Surgical Centers. The level of supplemental coverage is based upon the plan you select; it's your choice.

As an employee of the State of Florida, you can help protect your family against those extra out-of-pocket costs with Supplemental Hospital Expense Insurance from Cigna Health and Life Insurance Company (CHLIC).

Please remember, you do not have to have dependents to qualify for this additional coverage. If you are single, you may want to consider buying this insurance for yourself.

We offer you a choice of four different plans. Your primary health insurance coverage should be reviewed before considering whether or not to enroll in a Supplemental Hospital plan(s).

For example... If you have selected the State Employees' PPO Plan you may want to enroll in our **30/20 Plus** plan, **OR** our **Preferred Provider Plus** plan which are designed to help you with your network hospital admission deductibles and special in-hospital facility charges.

If you have elected a State HMO plan, you may want to choose one of the **365 Plus** plans which has been designed for use with the HMO or you can even use it with one of the other plans.

**The benefits are paid directly to you or to the hospital; it's your choice.**

# What Are My Options?

You can choose any one of the supplemental hospital plans from the list below. (Options 5-8 allow you to have more than one supplemental hospital plan)

**1**

**30/20 Plus**

People First
Benefit Code 8110

**2**

**Preferred Provider Plus (PPP)**

People First
Benefit Code 8100

**3**

**365+ $100 Daily**

People First Benefit Code 8130

**4**

**365+ $200 Daily**

People First
Benefit Code 8140

**5**

**30/20 Plus (8110)**
AND
**365+ $100 (8130)**

**6**

**30/20 Plus (8110)**
AND
**365+ $200 Daily (8140)**

**7**

**Preferred Provider Plus (8100)**
AND
**365+ $100 Daily (8130)**

**8**

**Preferred Provider Plus (8100)**
AND
**365+ $200 Daily (8140)**

**THESE POLICIES PROVIDE LIMITED HOSPITAL FACILITY COVERAGE ONLY.**

# 365+

**PEOPLE FIRST BENEFIT PLAN CODE, $100/DAY: 8130**
**PEOPLE FIRST BENEFIT PLAN CODE, $200/DAY: 8140**

## OUTLINE OF COVERAGE

**For policy Form Number 60065**
**365 Plus Hospital Confinement Indemnity Policy**

The purpose of the Policy is to provide a fixed daily benefit while you or your dependents are confined as an inpatient. The benefits of this policy will be in addition to those you may receive from your group health plan or any individual health plan that you may have.

You are eligible for benefits with each hospital confinement due to sickness, injury or pregnancy (including complications of pregnancy), but only if the confinement has been recommended or approved by an attending physician and you or your dependents have not exhausted the benefits of the policy.

If you choose to purchase this policy, you may elect to have your eligible dependents insured under your policy. "Eligible dependents" means: (a) your spouse; and (b) your child from birth until his or her 19th birthday. It does not mean anyone who lives outside the United States or Canada.

The term "child" includes your adopted child, stepchild, foster child or other child in court-ordered temporary or other custody, or a child under legal guardianship, but only if this child depends on the insured for support and maintenance. A child who is 19 years old will be considered an eligible dependent until the end of the calendar year in which the child reaches age 25, if: (a) the child depends on the insured for support; and (b) the child lives in the insured's household or is a full-time or part-time student.

## BENEFIT AMOUNTS

| BENEFIT | AMOUNT WE PAY |
|---|---|
| **FIXED DAILY BENEFIT (PER DAY OF CONFINEMENT)** | |
| Option I | $100 |
| Option II | $200 |
| Option III | $300 |

These benefits apply when you or your insured dependents are hospital-confined due to sickness, injury or certain complications of pregnancy. "Sickness" means illness or disease. With respect to you or your insured spouse, "sickness" also means pregnancy and resulting childbirth.

## EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for any hospital confinement when confinement is on account of or in connection with:

- Injury due to participation in a riot or insurrection;
- War or any act of war, if declared or not;
- The normal pregnancy of a dependent daughter;
- Routine care or treatment of an infant not due to the child's Sickness or Injury;
- Intentionally self-inflicted injury or attempted suicide, whether sane or insane.

Benefits will not be paid for confinement in a Hospital owned or operated by the United States Government or any of its agencies, subject to the right, if any, of the United States Government to recover reasonable and customary charges for inpatient care provided through a military or veteran's hospital.

Benefits in connection with Ambulatory Surgical Centers, Convalescent or Skilled Nursing Centers, or Home Health Care Services are covered only as outlined in the Schedule of Benefits.

Alcohol, drug and mental/nervous confinements are limited to 31 days per person per calendar year.

## PREMIUM CHANGES

Cigna can make premium and benefit changes as claims experience dictates, but only if: (a) these changes are made to all policies of the same form issued to employees of the sponsoring employer; and (b) 45 days advance notice is given to the sponsoring employer.

## TERMINATION

You may cancel your Policy during an open enrollment period or within 31 days of a qualifying event. Your Policy will terminate on the date you stop active work with the sponsoring employer. If your spouse is insured under the policy, his or her coverage will terminate on the date he or she becomes legally separated or divorced from you. If your children are insured under the policy, each child's coverage will terminate on the date he or she is no longer an eligible dependent. Coverage for all of your dependents will automatically terminate on the date your coverage terminates.

***This Outline of Coverage is only a brief summary of the policy and is not the contract of insurance. The policy itself sets forth the rights and obligations of the insured and Cigna.***

# 365+

**PEOPLE FIRST BENEFIT PLAN CODE, $100/DAY: 8130**
**PEOPLE FIRST BENEFIT PLAN CODE, $200/DAY: 8140**

## FRANCHISE INSURANCE POLICY

Offering you coverage 365 days a year for covered hospital stays, and additional coverage (see Schedule of Benefits below) for you and your eligible family members. The amount of supplementary coverage is $100 or $200 per day.

## SCHEDULE OF BENEFITS

**DAILY OPTION AMOUNT:**
Options $100 or $200 :
- $100 daily
- $200 daily

**IN HOSPITAL STAY:**
365 days per year coverage of the daily benefit (when charged room and board).

**OTHER BENEFITS:**
- 31 days per calendar year for alcohol/drug/mental or nervous disorders for inpatient confinement,
- One day benefit for single day surgery/ambulatory surgical centers,
- 100% daily benefit provided for up to a maximum of 20 days when transferred directly from a hospital to a convalescent or skilled nursing facility,
- 60% of your daily benefit for convalescent or skilled nursing care if confinement is in lieu of inpatient hospitalization (20-day limit per confinement),
- 50% of your daily benefit for home health care (7-day limit per confinement).

### 365+ $100 DAILY PLAN:

**This will pay up to the limits of the plan even if confined due to workers' compensation injury.**

**EXAMPLE:** In-patient hospital stay

| | |
|---|---|
| Day 1: | $100 benefit |
| Day 2 | $100 benefit |
| Day 3 | $100 benefit |

*Patient incurs three nights of hospital room and board charges; patient would receive $300 to help offset out of pocket expenses.*

## 365+ $100 Daily • Monthly Rate *To calculate BI-WEEKLY PAYROLL DEDUCTION, divide by 2*

| AGE | SINGLE | FAMILY | AGE | SINGLE | FAMILY | AGE | SINGLE | FAMILY |
|---|---|---|---|---|---|---|---|---|
| 18 | $4.68 | $11.10 | 39 | $7.80 | $19.18 | 60 | $16.94 | $35.02 |
| 19 | $4.70 | $11.18 | 40 | $8.06 | $19.64 | 61 | $17.48 | $35.84 |
| 20 | $4.72 | $11.34 | 41 | $8.30 | $20.04 | 62 | $17.80 | $36.18 |
| 21 | $4.76 | $11.50 | 42 | $8.62 | $20.56 | 63 | $18.10 | $36.56 |
| 22 | $4.80 | $11.66 | 43 | $8.92 | $21.14 | 64 | $18.56 | $37.26 |
| 23 | $4.82 | $11.84 | 44 | $9.38 | $21.98 | 65 | $19.02 | $38.04 |
| 24 | $4.94 | $12.14 | 45 | $9.84 | $22.88 | 66 | $19.48 | $39.00 |
| 25 | $5.06 | $12.58 | 46 | $10.20 | $23.44 | 67 | $20.00 | $40.00 |
| 26 | $5.18 | $12.98 | 47 | $10.50 | $24.00 | 68 | $20.48 | $40.96 |
| 27 | $5.34 | $13.44 | 48 | $10.88 | $24.62 | 69 | $21.00 | $41.98 |
| 28 | $5.52 | $14.04 | 49 | $11.42 | $25.62 | 70 | $21.48 | $42.98 |
| 29 | $5.72 | $14.60 | 50 | $11.96 | $26.60 | 71 | $22.02 | $44.06 |
| 30 | $5.92 | $15.22 | 51 | $12.40 | $27.34 | 72 | $22.56 | $45.14 |
| 31 | $6.10 | $15.86 | 52 | $12.78 | $27.98 | 73 | $23.12 | $46.20 |
| 32 | $6.28 | $16.42 | 53 | $13.24 | $28.74 | 74 | $23.68 | $47.36 |
| 33 | $6.46 | $16.98 | 54 | $13.82 | $29.78 | 75 | $24.24 | $48.50 |
| 34 | $6.66 | $17.40 | 55 | $14.42 | $30.82 | 76 | $24.86 | $49.70 |
| 35 | $6.90 | $17.76 | 56 | $14.88 | $31.58 | 77 | $25.46 | $50.94 |
| 36 | $7.08 | $18.02 | 57 | $15.36 | $32.36 | 78 | $26.06 | $52.12 |
| 37 | $7.26 | $18.28 | 58 | $15.82 | $33.08 | 79 | $26.08 | $52.14 |
| 38 | $7.48 | $18.66 | 59 | $16.38 | $34.06 | | | |

**Any eligible employee may purchase a policy during the allowable enrollment periods without restriction due to their age on the 365+ and SIS plans. PPP and 30/20 plans have an age restriction at 70.*

## 365+ $200 Daily • Monthly Rate *To calculate BI-WEEKLY PAYROLL DEDUCTION, divide by 2*

| AGE | SINGLE | FAMILY | AGE | SINGLE | FAMILY | AGE | SINGLE | FAMILY |
|---|---|---|---|---|---|---|---|---|
| 18 | $13.50 | $31.86 | 39 | $22.36 | $55.10 | 60 | $48.78 | $100.56 |
| 19 | $13.52 | $32.12 | 40 | $23.06 | $56.36 | 61 | $50.24 | $102.88 |
| 20 | $13.58 | $32.56 | 41 | $23.86 | $57.58 | 62 | $51.08 | $103.82 |
| 21 | $13.68 | $33.02 | 42 | $24.68 | $59.04 | 63 | $51.94 | $104.98 |
| 22 | $13.78 | $33.50 | 43 | $25.64 | $60.68 | 64 | $53.26 | $106.94 |
| 23 | $13.88 | $33.96 | 44 | $26.94 | $63.14 | 65 | $54.60 | $109.22 |
| 24 | $14.12 | $34.86 | 45 | $28.28 | $65.66 | 66 | $55.96 | $111.92 |
| 25 | $14.48 | $36.06 | 46 | $29.28 | $67.36 | 67 | $57.38 | $114.78 |
| 26 | $14.92 | $37.32 | 47 | $30.20 | $68.92 | 68 | $58.78 | $117.56 |
| 27 | $15.32 | $38.58 | 48 | $31.26 | $70.68 | 69 | $60.24 | $120.48 |
| 28 | $15.88 | $40.28 | 49 | $32.80 | $73.54 | 70 | $61.70 | $123.38 |
| 29 | $16.40 | $41.94 | 50 | $34.36 | $76.36 | 71 | $63.20 | $126.44 |
| 30 | $17.00 | $43.72 | 51 | $35.58 | $78.46 | 72 | $64.76 | $129.52 |
| 31 | $17.58 | $45.48 | 52 | $36.72 | $80.32 | 73 | $66.32 | $132.66 |
| 32 | $18.08 | $47.12 | 53 | $38.02 | $82.46 | 74 | $67.96 | $135.90 |
| 33 | $18.60 | $48.76 | 54 | $39.70 | $85.46 | 75 | $69.62 | $139.26 |
| 34 | $19.20 | $49.98 | 55 | $41.36 | $88.42 | 76 | $71.34 | $142.66 |
| 35 | $19.84 | $51.04 | 56 | $42.72 | $90.64 | 77 | $73.10 | $146.20 |
| 36 | $20.34 | $51.70 | 57 | $44.12 | $92.90 | 78 | $74.80 | $149.72 |
| 37 | $20.86 | $52.46 | 58 | $45.42 | $94.96 | 79 | $74.86 | $149.74 |
| 38 | $21.52 | $53.56 | 59 | $47.08 | $97.76 | | | |

** Any eligible employee may purchase a policy during the allowable enrollment periods without restriction due to their age on the 365+ and SIS plans. PPP and 30/20 plans have an age restriction at 70.*

# 30/20 Plus

**PEOPLE FIRST BENEFIT PLAN CODE 8110 | FRANCHISE SUPPLEMENTAL HOSPITAL INSURANCE POLICY**

Designed for participants in the State Employees' PPO Plan, the 30/20 Plus plan will provide benefits paid directly to you or your hospital for a covered in-hospital confinement or surgery at licensed Ambulatory Surgical Centers.

## OUTLINE OF COVERAGE

**For Policy Form Number 60055**

## HOSPITAL CONFINEMENT INDEMNITY POLICY

The purpose of the Policy is to provide reimbursement for specified hospital expenses that are incurred while you or your dependents are confined as an inpatient. The benefits of this policy will be in addition to those you may receive from your group health plan or any individual health plan that you may have.

Since this is a franchise policy, no other insurance carrier may coordinate with the benefits that are payable under this policy. You are eligible for benefits with each hospital confinement due to sickness, injury, or pregnancy (including complications of pregnancy), but only if confinement has been recommended by an attending physician, and you or your dependents have not exhausted the benefits of the policy.

**This Policy does not meet the minimum standards for Basic Hospital Expense Insurance. It is intended to be a supplement to any Basic Hospital Insurance or group coverage.**

*Supplemental Hospital coverage is additional coverage designed especially to help take care of some of the out-of-pocket hospital facility costs not covered by your primary plan.*

## BENEFIT AMOUNTS

| BENEFIT | AMOUNT WE PAY |
|---|---|
| Daily room and board benefit | $30 |
| Additional intensive care unit benefit, if applicable | $30 |
| Maximum daily hospital benefit for one period of confinement applicable | $3,600 |
| **INPATIENT HOSPITAL SPECIAL CHARGES BENEFIT** | |
| First $250 of eligible hospital expenses per admission, incurred by individual or family member | 100% |
| Next $12,500 | 20%* |
| **AMBULATORY SURGICAL CENTER BENEFIT** | |
| First $12,500 of eligible expenses incurred by individual or family member. | 20%* |

***Benefits paid at 20% will be subject to a maximum payment of $2,500 during one continuous period of inpatient confinement.***

***"One continuous period of inpatient confinement" means all periods of confinement of an insured person as an inpatient or for outpatient surgery which arise out of sickness or injury due to the same or related causes and are not separated by at least three consecutive months.***

## EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for any hospital confinement when confinement is on account of or in connection with:

- Injury due to participation in a riot or insurrection;
- War or any act of war, if declared or not;
- The Normal Pregnancy of a dependent daughter;
- Routine care or treatment of an infant not due to the child's Sickness or Injury.

Benefits will not be paid for confinement in a hospital owned or operated by the United States Government or any of its agencies, subject to the right, if any, of the United States Government to recover reasonable and customary charges for inpatient care provided through a military or veteran's hospital.

## PREMIUM CHANGES

Cigna can make premium and benefit changes as claims experience dictates, but only if: (a) these changes are made to all policies issued to employees within your Agency or Department; and (b) 45 days advance notice is given to the sponsoring employer.

## TERMINATION

You may cancel your Policy during any open enrollment. Your Policy will terminate on the earliest of: (a) the date you stop active work with the sponsoring employer; or (b) the effective date of your Medicare coverage; or (c) the date you reach age 70. If your spouse is insured under the policy, his or her coverage will terminate on the earliest of: (a) the effective date of his or her Medicare coverage; (b) the date he or she reaches age 70; or (c) the date he or she becomes legally separated or divorced from you. If your children are insured under the policy, each child's coverage will terminate on the date he or she is no longer an eligible dependent. Coverage for all of your dependents will automatically terminate on the date your coverage terminates.

If coverage for any person terminates for any reason other than non-payment of premium, and termination occurs prior to attainment of age 65 or eligibility for Medicare, the conversion privilege in your policy would give that person the right to obtain an individual policy similar to the terminated policy.

**The Outline of Coverage is only a brief summary of the Policy and is not the Contract of Insurance. The Policy itself sets forth the rights and obligations of the Insured and Cigna.**

## SCHEDULE OF BENEFITS

### PAYS $250 PER ADMISSION

Pays the first $250 of Inpatient (charged room and board) hospital "special charges" at 100% for each employee or family member per hospital admission, in order to help offset hospital deductibles.

### PLUS...PAYS $30

Pays $30 per day for each day you are charged room and board by the Hospital. An additional $30 per day is payable for confinement in a hospital intensive care unit making a total of $60 per day. The maximum payable for all hospital daily room and board benefits during One Continuous Period of Inpatient Confinement is $3,600 per person.

### PLUS...PAYS 20%

After deducting the $250 paid to you for admission, and the room and board charges from your hospital bill, the plan then pays 20% of the next $12,500 inpatient hospital "special charges" for each person.*

### OR...PAYS 20% FOR OUT PATIENT SURGERY

Pays 20% of the first $12,500 facility charges for Out Patient surgery performed at a hospital or licensed ambulatory Surgical Center.*

***Subject to a maximum of $2,500 for "One Continuous Period of Inpatient Confinement or subsequent surgeries for the same or related conditions".***

## 30/20 Plus Plan • Monthly Rate *To calculate BI-WEEKLY PAYROLL DEDUCTION, divide by 2*

| AGE | SINGLE | FAMILY | AGE | SINGLE | FAMILY | AGE | SINGLE | FAMILY |
|---|---|---|---|---|---|---|---|---|
| 18 | $31.04 | $73.20 | 39 | $51.40 | $126.58 | 60 | $112.06 | $231.00 |
| 19 | $31.06 | $73.80 | 40 | $53.16 | $129.56 | 61 | $115.46 | $236.44 |
| 20 | $31.24 | $74.84 | 41 | $54.88 | $132.34 | 62 | $117.34 | $238.64 |
| 21 | $31.48 | $75.92 | 42 | $56.80 | $135.64 | 63 | $119.38 | $241.18 |
| 22 | $31.70 | $76.98 | 43 | $58.94 | $139.46 | 64 | $122.40 | $245.68 |
| 23 | $31.90 | $78.06 | 44 | $61.94 | $145.10 | 65 | $125.48 | $250.94 |
| 24 | $32.50 | $80.10 | 45 | $65.00 | $150.90 | 66 | $128.58 | $257.16 |
| 25 | $33.42 | $82.92 | 46 | $67.26 | $154.76 | 67 | $131.86 | $263.72 |
| 26 | $34.28 | $85.76 | 47 | $69.44 | $158.34 | 68 | $135.06 | $270.16 |
| 27 | $35.22 | $88.68 | 48 | $71.84 | $162.44 | 69 | $138.44 | $276.88 |
| 28 | $36.52 | $92.56 | 49 | $75.36 | $168.94 | | | |
| 29 | $37.76 | $96.36 | 50 | $78.94 | $175.48 | | | |
| 30 | $39.10 | $100.46 | 51 | $81.78 | $180.28 | | | |
| 31 | $40.38 | $104.54 | 52 | $84.38 | $184.56 | | | |
| 32 | $41.56 | $108.28 | 53 | $87.36 | $189.54 | | | |
| 33 | $42.70 | $112.04 | 54 | $91.24 | $196.44 | | | |
| 34 | $44.10 | $114.86 | 55 | $95.06 | $203.18 | | | |
| 35 | $45.56 | $117.24 | 56 | $98.20 | $208.30 | | | |
| 36 | $46.70 | $118.84 | 57 | $101.38 | $213.48 | | | |
| 37 | $47.92 | $120.60 | 58 | $104.38 | $218.20 | | | |
| 38 | $49.48 | $123.08 | 59 | $108.20 | $224.64 | | | |

**Any eligible employee may purchase a policy during the allowable enrollment periods without restriction due to their age on the 365+ and SIS plans. PPP and 30/20 plans have an age restriction at 70.*

# Preferred Provider Plus/PPP

**PEOPLE FIRST BENEFIT PLAN CODE 8100 | FRANCHISE SUPPLEMENTAL HOSPITAL INSURANCE POLICY**

Preferred Provider Plus plan (PPP) is a supplemental hospital plan especially created to help offset your out-of-pocket deductible and in-hospital special charges when you or your covered dependents have a covered hospital confinement or surgery in a licensed Ambulatory Surgical Center.

The benefits are paid directly to you or your hospital. This is in addition to any other group or individual hospital insurance plan you may have.

## OUTLINE OF COVERAGE

**For Policy Form Number 60053**

## SUPPLEMENTAL IN-HOSPITAL EXPENSE POLICY

The purpose of the Policy is to provide reimbursement for specified hospital expenses. The benefits of this Policy will be in addition to those you may receive from your group health plan or any individual health plan that you may have.

Since this is a supplemental policy, no other insurance carrier may coordinate with the benefits that are payable under this policy. You are eligible for benefits for specified hospital charges due to sickness, injury, or pregnancy (including complications of pregnancy), if charges were incurred on the recommendation or approval of an attending physician, and you or your dependents have not exhausted the benefits of the policy.

**This Policy does not meet the minimum standards for Basic Hospital Expense Insurance. It is intended to be a supplement to any Basic Hospital Insurance or group coverage.**

## BENEFIT AMOUNTS

| BENEFIT | AMOUNT WE PAY |
|---|---|
| **INPATIENT HOSPITAL EXPENSE BENEFIT** | |
| First $250 of eligible expense per admission | 100% |
| Next $25,000 of eligible expense | 10% |
| **AMBULATORY SURGICAL CENTER BENEFIT** | |
| First $25,000 of eligible expenses | 10% |
| **ALCOHOL/DRUG TREATMENT CENTER INPATIENT BENEFIT** | |
| First $25,000 of eligible expense | 10% |
| ***Benefits paid at 10% will be subject to a maximum payment of $2,500 during one continuous period of inpatient confinement.**** | |
| **AMBULANCE BENEFIT** | |
| Maximum amount per continuous period of inpatient confinement | $100 |
| **OUT-OF-STATE EMERGENCY HOSPITAL BENEFIT** | |
| First $250 per individual per confinement | 100% |
| Next $12,500 of miscellaneous hospital charges | 20% |
| Daily room and board benefit | $30 |
| Additional daily ICU benefit | $30 |
| ***Benefits paid at 20% will be subject to a maximum payment of $2,500 during one continuous period of inpatient confinement.**** | |

*** "One continuous period of inpatient confinement" means all periods of confinement of an insured person as an inpatient or for outpatient surgery which arise out of sickness or injury due to the same or related causes and are not separated by at least three consecutive months.***

*If you are hospitalized for an emergency while traveling out-of-state, and are confined to a hospital, this plan will upgrade to the 30/20 Plus.*

## EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for any hospital confinement when confinement is on account of or in connection with:

- Injury due to participation in a riot or insurrection;
- War or any act of war, if declared or not;
- The Normal Pregnancy of a dependent daughter;
- Routine care or treatment of an infant not due to the child's Sickness or Injury.

Benefits will not be paid for confinement in a Hospital owned or operated by the United States Government or any of its agencies, subject to the right, if any, of the United States Government to recover reasonable and customary charges for inpatient care provided through a military or veteran's hospital.

## PREMIUM CHANGES

Cigna can make premium and benefit changes as claims experience dictates, but only if: (a) these changes are made to all policies issued to employees within your Agency or Department; and (b) 45 days advance notice is given to the sponsoring employer.

## TERMINATION

You may cancel your Policy during any open enrollment. Your Policy will terminate on the earliest of: (a) the date you stop active work with the sponsoring employer; or (b) the effective date of your Medicare coverage; or (c) the date You reach age 70. If your spouse is insured under the policy, his or her coverage will terminate on the earliest of: (a) the effective date of his or her Medicare coverage; (b) the date he or she reaches age 70; or (c) the date he or she becomes legally separated or divorced from you. If your children are insured under the policy, each child's coverage will terminate on the date he or she is no longer an eligible dependent. Coverage for all of your dependents will automatically terminate on the date your coverage terminates.

If coverage for any person terminates for any reason other than non-payment of premium, and termination occurs prior to attainment of age 65 or eligibility for Medicare, the conversion privilege in your policy would give that person the right to obtain an individual policy similar to the terminated policy.

***The Outline of Coverage is only a brief summary of the Policy and is not the Contract of Insurance. The Policy itself sets forth the rights and obligations of the Insured and Cigna.***

## Preferred Provider Plus/PPP • Monthly Rate

*To calculate BI-WEEKLY PAYROLL DEDUCTION, divide by 2*

| AGE | SINGLE | FAMILY | AGE | SINGLE | FAMILY | AGE | SINGLE | FAMILY |
|---|---|---|---|---|---|---|---|---|
| 18 | $19.10 | $44.78 | 39 | $30.56 | $76.08 | 60 | $66.90 | $138.84 |
| 19 | $19.12 | $45.02 | 40 | $31.78 | $78.24 | 61 | $69.26 | $142.82 |
| 20 | $19.16 | $45.06 | 41 | $32.84 | $80.08 | 62 | $71.38 | $146.14 |
| 21 | $19.38 | $46.56 | 42 | $33.90 | $81.80 | 63 | $72.52 | $147.52 |
| 22 | $19.46 | $46.92 | 43 | $35.12 | $83.84 | 64 | $73.78 | $149.08 |
| 23 | $19.60 | $47.56 | 44 | $36.46 | $86.22 | 65 | $75.66 | $151.90 |
| 24 | $19.72 | $48.24 | 45 | $38.28 | $89.70 | 66 | $77.56 | $155.14 |
| 25 | $20.08 | $49.50 | 46 | $40.18 | $93.28 | 67 | $79.48 | $158.96 |
| 26 | $20.64 | $51.26 | 47 | $41.60 | $95.66 | 68 | $81.52 | $163.02 |
| 27 | $21.20 | $53.02 | 48 | $42.94 | $97.88 | 69 | $83.48 | $167.00 |
| 28 | $21.76 | $54.82 | 49 | $44.42 | $100.42 | | | |
| 29 | $22.58 | $57.20 | 50 | $46.58 | $104.42 | | | |
| 30 | $23.32 | $59.56 | 51 | $48.74 | $108.48 | | | |
| 31 | $24.16 | $62.10 | 52 | $50.54 | $111.44 | | | |
| 32 | $24.98 | $64.64 | 53 | $52.16 | $114.10 | | | |
| 33 | $25.68 | $66.92 | 54 | $53.98 | $117.16 | | | |
| 34 | $26.42 | $69.24 | 55 | $56.38 | $121.42 | | | |
| 35 | $27.24 | $70.98 | 56 | $58.76 | $125.60 | | | |
| 36 | $28.18 | $72.48 | 57 | $60.72 | $128.76 | | | |
| 37 | $28.88 | $73.44 | 58 | $62.66 | $131.98 | | | |
| 38 | $29.64 | $74.52 | 59 | $64.52 | $134.88 | | | |

**Any eligible employee may purchase a policy during the allowable enrollment periods without restriction due to their age on the 365+ and SIS plans. PPP and 30/20 plans have an age restriction at 70.*

# State Insurance Supplement/SIS

**PEOPLE FIRST BENEFIT PLAN CODES 8120 | FRANCHISE SUPPLEMENTAL HOSPITAL INSURANCE POLICY**

You may want to consider enrolling in this plan if you and your dependents are based outside of the State of Florida as a condition of employment, or live in a county where network providers are not available.

## OUTLINE OF COVERAGE

**For Policy Form Number 60064**

## HOSPITAL CONFINEMENT INDEMNITY POLICY

The purpose of the Policy is to provide reimbursement for specified hospital expenses. The benefits of this policy will be in addition to those you may receive from your group health plan or any individual health plan that you may have.

Since this is a supplemental policy, no other insurance carrier may coordinate with the benefits that are payable under this policy. You are eligible for benefits with each hospital confinement due to sickness, injury, or complications of pregnancy, but only if confinement has been recommended or approved by an attending physician and you or your dependents have not exhausted the benefits of the policy.

**This Policy does not meet the minimum standards for Basic Hospital Expense Insurance. It is intended to be a supplement to any Basic Hospital Insurance or group coverage.**

*The SIS helps to offset your hospital admission deductible each time you are admitted to the Hospital. All other hospital benefits have a limit up to $2,500 per person per calendar year.*

## BENEFIT AMOUNTS

| BENEFIT | AMOUNT WE PAY |
|---|---|
| **NETWORK HOSPITAL EXPENSE BENEFIT** | |
| First $100 of eligible expenses per admission | 100% |
| Next $25,000 of eligible expenses | 10%* |
| **AMBULATORY SURGICAL CENTER BENEFIT** | |
| First $25,000 of eligible expenses per calendar year | 10%* |
| **ALCOHOL/DRUG TREATMENT CENTER INPATIENT BENEFIT** | |
| First $25,000 of eligible expenses | 10%* |
| ***All benefits paid at 10% will be subject to a maximum payment of $2,500 per person per calendar year.*** | |
| **NON-NETWORK HOSPITAL EXPENSE BENEFIT** | |
| First $250 per individual per admission | 100% |
| Next $12,500 of miscellaneous hospital charges<br>***All benefits paid at 20% will be subject to a maximum payment of $2,500 per person per calendar year.*** | 20% |
| Daily room and board benefit | $100 |
| Daily ICU benefit | $200 |
| **OCCUPATIONAL AND SPEECH THERAPY** | |
| Benefit insured percentage | 80% |
| Maximum per person per calendar year | $1,000 |
| **AMBULANCE BENEFIT** | |
| Insured percentage | 80% |
| Maximum per occurrence | $400 |

## EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for any hospital confinement when confinement is on account of or in connection with:

- Injury due to participation in a riot or insurrection;
- War or any act of war, if declared or not;
- The Normal Pregnancy of a dependent daughter;
- Routine care or treatment of an infant not due to the child's Sickness or Injury;
- A sickness or injury for which benefits are paid or payable under Workers' Compensation of any occupational disease or similar law whether such benefits are insured or self-insured; or
- Intentionally self-inflicted injury or attempted suicide, whether sane or insane.

Benefits will not be paid for confinement in a Hospital owned or operated by the United States Government or any of its agencies, subject to the right, if any, of the United States Government to recover reasonable and customary charges for inpatient care provided through a military or veteran's hospital.

Maximum benefits will not exceed $2,500 per person per calendar year except for benefits provided in connection with:

- Non-network room and board and intensive care services;
- Occupational and speech therapy services; and
- Ambulance services.

Room and board and intensive care services will not be paid for more than 60 days per calendar year in either a network or non-network hospital.

## PREMIUM CHANGES

Cigna can make premium and benefit changes as claims experience dictates, but only if: (a) these changes are made to all policies issued to employees within your Agency or Department; and (b) 45 days advance notice is given to the sponsoring employer.

## TERMINATION

You may cancel your Policy during an open enrollment period or within 31 days of a qualifying event. Your Policy will terminate on the date you stop active work with the sponsoring employer. If your spouse is insured under the policy, his or her coverage will terminate on the date he or she becomes legally separated or divorced from you. If your children are insured under the policy, each child's coverage will terminate on the date he or she is no longer an eligible dependent. Coverage for all of your dependents will automatically terminate on the date your coverage terminates.

**This Outline of Coverage is only a brief summary of the policy and is not the contract of insurance. The policy itself sets forth the rights and obligations of the insured and Cigna.**

## State Insurance Supplement/SIS • Monthly Rate *To calculate BI-WEEKLY PAYROLL DEDUCTION, divide by 2*

| AGE | SINGLE | FAMILY | AGE | SINGLE | FAMILY | AGE | SINGLE | FAMILY |
|---|---|---|---|---|---|---|---|---|
| 18 | $18.04 | $42.60 | 39 | $29.92 | $73.66 | 60 | $65.20 | $134.44 |
| 19 | $18.06 | $42.96 | 40 | $30.92 | $75.40 | 61 | $67.18 | $137.60 |
| 20 | $18.18 | $43.56 | 41 | $31.92 | $77.02 | 62 | $68.30 | $138.88 |
| 21 | $18.32 | $44.18 | 42 | $33.06 | $78.96 | 63 | $69.48 | $140.34 |
| 22 | $18.44 | $44.82 | 43 | $34.30 | $81.16 | 64 | $71.24 | $143.00 |
| 23 | $18.58 | $45.44 | 44 | $36.04 | $84.44 | 65 | $73.02 | $146.06 |
| 24 | $18.90 | $46.62 | 45 | $37.82 | $87.82 | 66 | $74.82 | $149.66 |
| 25 | $19.40 | $48.26 | 46 | $39.14 | $90.06 | 67 | $76.74 | $153.48 |
| 26 | $19.96 | $49.92 | 47 | $40.42 | $92.16 | 68 | $78.62 | $157.24 |
| 27 | $20.50 | $51.62 | 48 | $41.78 | $94.54 | 69 | $80.56 | $161.14 |
| 28 | $21.26 | $53.86 | 49 | $43.86 | $98.32 | 70 | $82.48 | $165.00 |
| 29 | $21.96 | $56.08 | 50 | $45.94 | $102.12 | 71 | $84.54 | $169.06 |
| 30 | $22.74 | $58.46 | 51 | $47.58 | $104.92 | 72 | $86.60 | $173.22 |
| 31 | $23.50 | $60.84 | 52 | $49.12 | $107.42 | 73 | $88.70 | $177.42 |
| 32 | $24.20 | $63.02 | 53 | $50.82 | $110.32 | 74 | $90.86 | $181.74 |
| 33 | $24.84 | $65.22 | 54 | $53.10 | $114.34 | 75 | $93.10 | $186.22 |
| 34 | $25.66 | $66.86 | 55 | $55.30 | $118.24 | 76 | $95.36 | $190.78 |
| 35 | $26.52 | $68.24 | 56 | $57.14 | $121.24 | 77 | $97.74 | $195.52 |
| 36 | $27.18 | $69.18 | 57 | $58.98 | $124.24 | 78 | $100.08 | $200.20 |
| 37 | $27.90 | $70.20 | 58 | $60.74 | $127.00 | 79 | $100.10 | $200.22 |
| 38 | $28.78 | $71.62 | 59 | $62.98 | $130.74 | | | |

**Any eligible employee may purchase a policy during the allowable enrollment periods without restriction due to their age on the 365+ and SIS plans. PPP and 30/20 plans have an age restriction at 70.*

# Questions & Answers

**Plans Underwritten by Cigna Health and Life Insurance Company (CHLIC)**

Below are general, commonly asked questions and answers which apply to all four of the hospital supplemental plans.

### May I enroll in more than one plan?

Yes. See *What Are My Options* on page 4.

### Who is eligible for the plans?

**30/20 Plus or PPP:** All active full-time and part-time employees under age 70 and their eligible dependents.
**S.I.S. or 365 Plus:** All active full-time and part-time employees and their eligible dependents.

### Who are eligible dependents?

Eligible dependents include the employee's spouse* and all dependent children. Includes dependent children through the calendar year in which they turn 26, (a) if they are legal dependents, (b) depend on you for support and maintenance, and (c) live in your household or are a full-time or part-time student. (Please refer to the policy for a full definition of eligible dependents and the age extension guidelines for an Insured child who has a physical handicap or mental retardation.)

***30/20 – PPP: Spouse to age 70***

***365+ - SIS: No age restriction for spouse***

### Will my coverage continue if I'm still working at age 70?

If you are an active Employee of the State and have the **30/20** or **PPP Plan**, coverage will terminate at the end of the year you turn age 70. If your spouse is also on your Plan his/her coverage will terminate the earlier of: a) the end of the year he/she turns age 70 or b) when your coverage terminates.

The **SIS** and **365+ Plans** do not have an age limit for active Employees.

### Are benefits provided for services performed in ambulatory or outpatient surgical centers?

Yes. The covered facility charges for outpatient surgery in a licensed ambulatory or outpatient surgical center will be covered up to the Plan limits as long as it is a procedure which would be covered if performed in a hospital.

### Can the benefit be paid directly to me or does it have to be paid to the hospital?

You can choose whether to have the benefits paid directly to you or to the hospital.

### Could you give me an example of how the 30/20 Plus Plan PAYS?

Yes. Assume an insured person is confined in a hospital for 5 nights. In addition to the daily room and board charges, assume the hospital makes a charge of $9,250 for specified "special charges."

| Amount Paid By 30/20 Plus Plan | |
|---|---|
| First $250 of specified "special charges" Paid at 100% | $250 |
| Balance of specified "special charges" Paid at 20% (20% X $9,000): | $1,800 |
| 5 nights of hospital confinement times $30 per night: | $150 |
| Total payment from 30/20 Plus Plan: | $2,200 |

**The $2,200 payment paid in this example is in addition to any other benefits you receive from any group or individual hospitalization plan.**

### Are pre-existing conditions covered?

Yes. Pre-existing conditions ARE COVERED on the effective date of the plan.

### Will my plans pay if I am confined in a hospital because of a worker's compensation injury?

The State Insurance Supplement Plan does not. The Preferred Provider Plus, 30/20 Plus Plan and the 365 Plus Plan will pay up to the limits of the plan selected.

### Will the plans pay if I am hospitalized in an observation room?

Only if billed in an observation room for longer than 24 hours.

### Will my physician's charges for inpatient professional services be covered?

No. Doctor charges and professional fees are NOT covered. Only allowable facility or supply charges for inpatient hospital stays and ambulatory surgical centers are covered up to the Plan limits.

### I have other group or individual hospitalization insurance. Will these plans pay in addition to any other benefits I may receive?

Yes. If you have a claim, inform your other health insurance companies that these are "Franchise Plans". Therefore, Coordination of Benefits is NOT ALLOWED and benefits from other policies should not be reduced.

# How To Enroll

## HOW TO ENROLL

- Enroll during the ANNUAL OPEN ENROLLMENT PERIOD or as a NEW EMPLOYEE (within the firsts 60 days of employment).
- **You must contact the People First Service Center, toll free 866-663-4735, or access their web site at https://peoplefirst.myflorida.com to make your election.**

**NOTE: Enrollment will not be complete unless People First is notified. PEOPLE FIRST IS THE SYSTEM OF RECORD.**

## HOW TO FILE A CLAIM

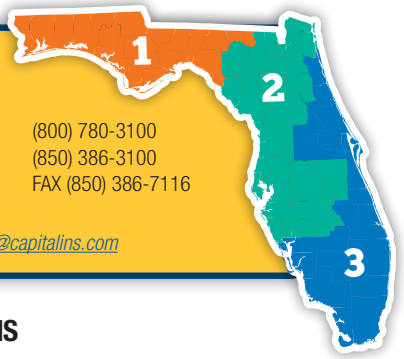
1. Obtain a copy of your itemized hospital facility bill with a diagnosis or UB04 hospital form.
2. Check the bill to make sure all charges are correct.
3. Use "Notice of Claim" Form included with your policy, or obtain a form from www.capitalins.com (Forms/claim forms/CHLIC Notice of Claim)
4. Complete all parts of the "Notice of Claim" Form. Claim(s) must be submitted no later than 15 months from the date of occurrence.
5. Mail the itemized hospital facility bill or UB04 hospital form and "Notice of Claim" Form to:
   **Cigna Health and Life Insurance Company (CHLIC)**
   P.O. Box 2568
   Jacksonville, Florida 32203-2568

**For verification of Cigna Coverage and claim information, call Cigna Customer Service in Jacksonville, Florida 1-800-888-5256.**

**CAPITAL INSURANCE AGENCY, INC.**

*"We're Here To Help You!"*

Contact Capital Insurance Agency

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**Regional Director**
5491 North University Dr.,
Suite 103
Coral Springs, FL 33067

**www.capitalins.com**

I understand that if accepted, my coverage will take effect on the day following the end of the month during which two biweekly or one monthly deduction was made. I understand that my elections are IRREVOCABLE unless I experience a QSC as defined by the Internal Revenue Code and Rule 60P 6.006 FAC Florida Administrative Code (F.A.C.). I hereby certify that I am an Employee of the Sponsoring Employer in an Eligible Class (as specified above), and authorize my Employer to reduce my salary by an amount sufficient to pay the premium for the insurance. I hereby acknowledge that I have received the Outline of Coverage which describes the insurance that I am applying for.

# We've Got You Covered

## No one can predict when

you or one of your family members may need to be hospitalized. When it happens, the financial effects of even a short hospital stay can be costly. Medical bills and other out-of-pocket expenses not covered by your primary health insurance can burden your family's budget for months or even years.

As an employee of the State of Florida, you can help protect you and your family against those extra hospital facility expenses with Supplemental Hospital Expense Insurance from Cigna.

Cigna Healthy Rewards®

# Looking for more healthy choices? *We'll help.*

*To take advantage of Healthy Rewards savings, go to Cigna.com/rewards (password: savings) or call us at 1.800.258.3312.*

**From acupuncture to natural supplements. Aerobic classes to therapeutic massage. You and your family have health choices like never before. And as part of our ongoing efforts to help people make healthy choices that lead to healthier lifestyles, the Cigna Healthy Rewards* program offers discounts on a wide variety of health programs and services – and it's available at no additional cost if you have a Cigna supplemental hospital plan.**

- No referrals. No claim forms.
- Weight management and nutrition
- Vision and hearing care
- Tobacco cessation
- Alternative medicine
- Mind/body
- Fitness
- Vitamins, health and wellness products

*Healthy Rewards is a discount program. A discount program is NOT insurance, and the member must pay the entire discounted charge. These discounts are separate from and in addition to any benefits under your plan. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time.

Cigna®

PLANS UNDERWRITTEN BY

*Cigna Health and Life Insurance Company (CHLIC)*
*Administrative Office: Jacksonville, Florida*

**Call Your Capital Representative today!**
**1.800.780.3100**

PLANS MARKETED AND SERVICED BY

**Capital Insurance Agency, Inc.**

*1425 East Piedmont Drive, Suite 301 • Tallahassee, FL 32308*
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**6/2020**

STATE OF FLORIDA & UNIVERSITY EMPLOYEES

# HOW TO APPLY

1. Enroll during Open Enrollment or as a New Employee (within the first 60 days of employment). Contact the People First Service Center, toll-free 866.663.4735, or access their web site at https://peoplefirst.myflorida.com to make your election.

   ***Your enrollment is not complete until you have notified People First.*

2. Contact your local Capital Representative with any questions and for enrollment assistance.

**Enroll Now**

For more information on how to enroll, please contact the Group Benefits Dept. by phone at 800.780.3100 or email at groupdepartment@capitalins.com.

# A Good Reason to Smile.

Department of MANAGEMENT SERVICES
Division of State Group Insurance

Cigna®

PEOPLE FIRST BENEFIT PLAN CODE 4034

# Healthy Gums May Lead to a Healthier You!

## DID YOU KNOW THAT YOUR ORAL HEALTH COULD BE AN INDICATOR OF YOUR OVERALL HEALTH?

Regular visits to the dentist may do more than brighten your smile. Research has linked periodontal (gum) disease to complications for heart disease, stroke, diabetes, preterm birth and other health issues. Healthy gums support healthy teeth. Follow the suggestions provided to help prevent gum disease. And if you are diagnosed with gum disease, it's important to complete the periodontal treatment plan recommended by your dentist.

**Gum disease may be painless, but symptoms can appear, such as:**

- Tender, swollen or bleeding gums when you brush your teeth
- Dark red or receding gums
- Bad breath or a bad taste in your mouth
- Loose teeth
- Gum disease is treatable. Be sure to visit your dentist on a regular basis.

### Healthy Gums May Mean a Healthier Heart

People with advanced gum disease may be more likely to have heart disease than those with healthy gums[1]. Bacteria and their byproducts from the gum tissues may enter the blood stream, causing small blood clots that may contribute to the clogging of arteries[2]. Clots in the coronary arteries can lead to heart attacks. A blood clot in the brain can cause a stroke. Bottom line: care for your gums, and they may help guard your heart!

### Healthy Gums May Help Control Blood Sugar

Those with diabetes may have more complications with gum disease. Why? As a general rule, diabetics have a tougher time healing. And research shows they suffer greater tooth loss than patients without diabetes. One study[3] found that when diabetic patients' gum infections were treated, they found it easier to manage their blood sugar. Good dental health may be linked to a reduced risk of diabetic complications!

### Healthy Gums May Help Reduce the Risk of Pre-term Birth

Mom's gum disease may increase the probability of a pre-term birth. Pregnant women with chronic periodontal (gum) disease during the second trimester are up to seven times more likely to give birth prematurely.[3,4] It's recommended that pregnant women should focus on brushing and flossing and getting regular dental check ups. This possible link between gum disease and preterm birth is another reason to protect your dental health!

**PREVENTION IS POWERFUL!**

The American Dental Association (ADA) suggests the following behaviors to help prevent gum disease[5].

- Brush your teeth twice a day with a soft-bristle toothbrush
- Floss daily
- Eat a healthy diet and limit snacks between meals
- See your dentist regularly


1 American Academy of Periodontology (www.perio.org), Feb. 2002.
2 U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes for Health, 2000.
3 Journal of the American Dental Association, Oct. 2003.
4 Journal of the American Dental Association, July 2001 "Oral Health During Pregnancy: An Analysis of Information."
5 American Dental Association Frequently Asked Questions.


**For more information, visit us on the web at www.cigna.com or call 1.800.CIGNA24 (1.800.244.6224)**

Cigna®

# Cigna Dental Care - We Plan to Make You Smile!

Cigna Dental is proud to offer State of Florida employees one of the most comprehensive dental coverage plans in the market today. Our Prepaid Patient Charge Schedule (PCS) reflects a fixed co-payment amount that allows you to plan and budget for you and your family's dental care needs with confidence. Your benefits include:

- If you require specialty care, your network general dentist will refer you to a network specialist. You do not require a specialty referral to visit a network orthodontist or network pediatric dentist. You are responsible for paying the network dentist the applicable co-payments listed on your Patient Charge Schedule (PCS).
- Choose from 1,076 dental offices with 3,577 general dentists throughout Florida.
- Orthodontic coverage for children and adults.
- Coverage on procedure(s) to detect oral cancer in its early stages.
- No age limit on sealants.
- Coverage for most preventive services (exams, x-rays and routine cleanings) is provided at no charge.*
- No waiting period, coverage begins immediately.
- No deductibles to meet.
- No claim forms to file.
- No annual or lifetime dollar maximums to exceed.
- No restrictions on pre-existing conditions, except for work in progress.
- Knowledgeable, caring customer service.
- Participating dentists to complete a credentialing process and participate in a Quality Management Program.
- Access to myCigna.com, a secure on-line tool that makes it easier and faster for you to access:
  1) your personalized dental benefits information;
  2) dental health articles via WebMD; and
  3) the Dental Treatment Cost Estimator, which allows you to estimate and plan dental care costs before receiving services.

* Frequency Limitations apply; see your Patient Charge Schedule, starting on page 4, for further information.

## What should I budget for my family's dental health care?

| PLAN | BI-WEEKLY | MONTHLY |
|---|---|---|
| Employee Only | $12.01 | $24.01 |
| Employee + Spouse | $23.66 | $47.31 |
| Employee + Child(ren) | $28.21 | $56.41 |
| Employee + Family | $36.03 | $72.06 |

People First Benefit Plan Code 4034

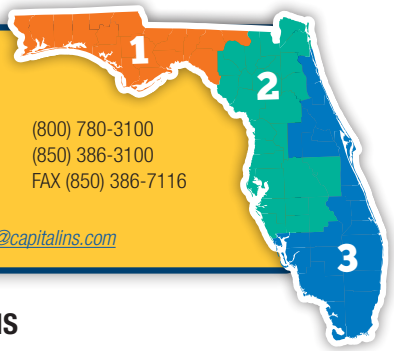
## How To Enroll

Enrolling in the Cigna Dental Care plan is easy. Just call People First, toll free 866.663.4735 or enroll online at https://peoplefirst.myflorida.com. For further information, contact the Capital Insurance representative nearest you. Telephone numbers and e-mail addresses are listed for your convenience.

## CAPITAL INSURANCE AGENCY, INC.

*"We're Here To Help You!"*

Contact Capital Insurance Agency

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# Your Patient Charge Schedule

| CODE | PROCEDURE DESCRIPTION | PATIENT CHARGE |
|---|---|---|
| Office visit fee (Per patient, per office visit in addition to any other applicable patient charges) | | |
| | Office visit fee | $5.00 |
| Diagnostic/preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145). | | |
| D9310 | Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician) | $0.00 |
| D9430 | Office visit for observation – No other services performed | $0.00 |
| D9450 | Case presentation – Detailed and extensive treatment planning | $0.00 |
| D0120 | Periodic oral evaluation – Established patient | $0.00 |
| D0140 | Limited oral evaluation – Problem focused | $0.00 |
| D0145 | Oral evaluation for a patient under 3 years of age and counseling with primary caregiver | $0.00 |
| D0150 | Comprehensive oral evaluation – New or established patient | $0.00 |
| D0160 | Detailed and extensive oral evaluation - Problem focused, by report (limit 2 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation) | $0.00 |
| D0170 | Re-evaluation – Limited, problem focused (established patient; not post-operative visit) | $0.00 |
| D0171 | Re-evaluation – Post-operative office visit | $0.00 |
| D0180 | Comprehensive periodontal evaluation – New or established patient | $33.00 |
| D0210 | X-rays intraoral – Complete series of radiographic images (limit 1 every 3 years) | $0.00 |
| D0220 | X-rays intraoral – Periapical – First radiographic image | $0.00 |
| D0230 | X-rays intraoral – Periapical – Each additional radiographic image | $0.00 |
| D0240 | X-rays intraoral – Occlusal radiographic image | $0.00 |
| D0251 | Extra-oral posterior dental radiographic image (limit 1 per calendar year) | $0.00 |
| D0270 | X-rays (bitewing) – Single radiographic image | $0.00 |
| D0272 | X-rays (bitewings) – 2 radiographic images | $0.00 |
| D0273 | X-rays (bitewings) – 3 radiographic images | $0.00 |
| D0274 | X-rays (bitewings) – 4 radiographic images | $0.00 |
| D0277 | X-rays (bitewings, vertical) – 7 to 8 radiographic images | $0.00 |
| D0330 | X-rays (panoramic radiographic image) – (limit 1 every 3 years) | $0.00 |

| CODE | PROCEDURE DESCRIPTION | PATIENT CHARGE |
|---|---|---|
| D0368 | Cone beam CT capture and interpretation for TMJ series including two or more exposures *(limit 1 per calendar year; only covered in conjunction with Temporomandibular Joint (TMJ) evaluation)* | $240.00 |
| D0431 | Oral cancer screening using a special light source | $50.00 |
| D0460 | Pulp vitality tests | $14.00 |
| D0470 | Diagnostic casts | $0.00 |
| D0472 | Pathology report – Gross examination of lesion (only when tooth related) | $0.00 |
| D0473 | Pathology report – Microscopic examination of lesion (only when tooth related) | |
| D0474 | Pathology report – Microscopic examination of lesion and area (only when tooth related) | $0.00 |
| D1110 | Prophylaxis (cleaning) – Adult (limit 2 per calendar year)<br>Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year | $0.00<br>$45.00 |
| D1120 | Prophylaxis (cleaning) – Child (limit 2 per calendar year)<br>Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year | $0.00<br>$30.00 |
| D1206 | Topical application of fluoride varnish (limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.<br>Additional topical application of fluoride varnish in addition to any combination of two (2) D1206s (topical application of fluoride varnish) and/or D1208s (topical application of fluoride - excluding varnish) per calendar year | $0.00<br>$15.00 |
| D1208 | Topical application of fluoride - Excluding varnish (limit 2 per calendar year) There is a combined limit of a total of 2 D1208s and/or D1206s per calendar year.<br>Additional topical application of fluoride - Excluding varnish - In addition to any combination of two (2) D1206s (topical applications of fluoride varnish) and/or D1208s (topical application of fluoride - excluding varnish) per calendar year | $0.00<br>$15.00 |
| D1330 | Oral hygiene instructions | $0.00 |
| D1351 | Sealant – Per tooth | $12.00 |
| D1352 | Preventive resin restoration in a moderate to high caries risk patient – Permanent tooth | $12.00 |
| D1353 | Sealant repair – Per tooth | $8.00 |
| D1354 | Interim caries arresting medicament application | $0.00 |
| D1510 | Space maintainer – Fixed – Unilateral | $110.00 |
| D1515 | Space maintainer – Fixed – Bilateral | $170.00 |
| D1550 | Re-cement or re-bond space maintainer | $0.00 |
| D1555 | Removal of fixed space maintainer | $0.00 |

| CODE | PROCEDURE DESCRIPTION | PATIENT CHARGE |
|---|---|---|
| D1575 | Distal shoe space maintainer – Fixed – Unilateral | $121.00 |
| Restorative (fillings, including polishing) | | |
| D2140 | Amalgam – 1 surface, primary or permanent | $0.00 |
| D2150 | Amalgam – 2 surfaces, primary or permanent | $0.00 |
| D2160 | Amalgam – 3 surfaces, primary or permanent | $0.00 |
| D2161 | Amalgam – 4 or more surfaces, primary or permanent | $0.00 |
| D2330 | Resin-based composite – 1 surface, anterior | $0.00 |
| D2331 | Resin-based composite – 2 surfaces, anterior | $0.00 |
| D2332 | Resin-based composite – 3 surfaces, anterior | $0.00 |
| D2335 | Resin-based composite – 4 or more surfaces or involving incisal angle, anterior | $88.00 |
| D2390 | Resin-based composite crown, anterior | $88.00 |
| D2391 | Resin-based composite – 1 surface, posterior | $47.00 |
| D2392 | Resin-based composite – 2 surfaces, posterior | $59.00 |
| D2393 | Resin-based composite – 3 surfaces, posterior | $82.00 |
| D2394 | Resin-based composite – 4 or more surfaces, posterior | $115.00 |
| Crown and bridge – All charges for crown and bridge (fixed partial denture) are per unit (each replacement or supporting tooth equals 1 unit). Coverage for replacement of crowns and bridges is limited to 1 every 5 years. | | |
| | Additional charge per tooth/unit for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) services. Same day in-office CAD/CAM (ceramic) services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine. | $150.00 |
| D2510 | Inlay – Metallic – 1 surface | $410.00 |
| D2520 | Inlay – Metallic – 2 surfaces | $410.00 |
| D2530 | Inlay – Metallic – 3 or more surfaces | $410.00 |
| D2542 | Onlay – Metallic – 2 surfaces | $470.00 |
| D2543 | Onlay – Metallic – 3 surfaces | $470.00 |
| D2544 | Onlay – Metallic – 4 or more surfaces | $470.00 |
| D2740 | Crown – Porcelain/ceramic substrate | $490.00 |
| D2750 | Crown – Porcelain fused to high noble metal | $450.00 |
| D2751 | Crown – Porcelain fused to predominantly base metal | $400.00 |
| D2752 | Crown – Porcelain fused to noble metal | $425.00 |
| D2780 | Crown – 3/4 cast high noble metal | $460.00 |
| D2781 | Crown – 3/4 cast predominantly base metal | $410.00 |
| D2782 | Crown – 3/4 cast noble metal | $435.00 |

| CODE | PROCEDURE DESCRIPTION | PATIENT CHARGE |
|---|---|---|
| D2790 | Crown – Full cast high noble metal | $460.00 |
| D2791 | Crown – Full cast predominantly base metal | $410.00 |
| D2792 | Crown – Full cast noble metal | $435.00 |
| D2794 | Crown – Titanium | $460.00 |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | $43.00 |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | $43.00 |
| D2920 | Re-cement or re-bond crown | $43.00 |
| D2929 | Prefabricated porcelain/ceramic crown - Primary tooth | $165.00 |
| D2930 | Prefabricated stainless steel crown – Primary tooth | $105.00 |
| D2931 | Prefabricated stainless steel crown – Permanent tooth | $105.00 |
| D2932 | Prefabricated resin crown | $135.00 |
| D2933 | Prefabricated stainless steel crown with resin window | $165.00 |
| D2934 | Prefabricated esthetic coated stainless steel crown – Primary tooth | $165.00 |
| D2940 | Protective restoration | $13.00 |
| D2941 | Interim therapeutic restoration - Primary dentition | $13.00 |
| D2950 | Core buildup – Including any pins | $135.00 |
| D2951 | Pin retention – Per tooth – In addition to restoration | $13.00 |
| D2952 | Post and core – In addition to crown, indirectly fabricated | $165.00 |
| D2954 | Prefabricated post and core – In addition to crown | $135.00 |
| D2960 | Labial veneer (resin laminate) – Chairside | $94.00 |
| D6210 | Pontic – Cast high noble metal | $450.00 |
| D6211 | Pontic – Cast predominantly base metal | $410.00 |
| D6212 | Pontic – Cast noble metal | $435.00 |
| D6214 | Pontic – Titanium | $460.00 |
| D6240 | Pontic – Porcelain fused to high noble metal | $450.00 |
| D6241 | Pontic – Porcelain fused to predominantly base metal | $410.00 |
| D6242 | Pontic – Porcelain fused to noble metal | $435.00 |
| D6245 | Pontic – Porcelain/ceramic | $455.00 |
| D6602 | Retainer inlay – Cast high noble metal, 2 surfaces | $450.00 |
| D6603 | Retainer inlay – Cast high noble metal, 3 or more surfaces | $460.00 |
| D6604 | Retainer inlay – Cast predominantly base metal, 2 surfaces | $390.00 |
| D6605 | Retainer inlay – Cast predominantly base metal, 3 or more surfaces | $400.00 |

| CODE | PROCEDURE DESCRIPTION | PATIENT CHARGE |
|---|---|---|
| D6606 | Retainer inlay – Cast noble metal, 2 surfaces | $415.00 |
| D6607 | Retainer inlay – Cast noble metal, 3 or more surfaces | $425.00 |
| D6610 | Retainer onlay – Cast high noble metal, 2 surfaces | $440.00 |
| D6611 | Retainer onlay – Cast high noble metal, 3 or more surfaces | $460.00 |
| D6612 | Retainer onlay – Cast predominantly base metal, 2 surfaces | $390.00 |
| D6613 | Retainer onlay – Cast predominantly base metal, 3 or more surfaces | $400.00 |
| D6614 | Retainer onlay – Cast noble metal, 2 surfaces | $415.00 |
| D6615 | Retainer onlay – Cast noble metal, 3 or more surfaces | $435.00 |
| D6624 | Retainer inlay – Titanium | $450.00 |
| D6634 | Retainer onlay – Titanium | $450.00 |
| D6740 | Retainer crown – Porcelain/ceramic | $500.00 |
| D6750 | Retainer crown – Porcelain fused to high noble metal | $460.00 |
| D6751 | Retainer crown – Porcelain fused to predominantly base metal | $410.00 |
| D6752 | Retainer crown – Porcelain fused to noble metal | $435.00 |
| D6780 | Retainer crown – 3/4 cast high noble metal | $460.00 |
| D6781 | Retainer crown – 3/4 cast predominantly base metal | $410.00 |
| D6782 | Retainer crown – 3/4 cast noble metal | $435.00 |
| D6790 | Retainer crown – Full cast high noble metal | $460.00 |
| D6791 | Retainer crown – Full cast predominantly base metal | $410.00 |
| D6792 | Retainer crown – Full cast noble metal | $435.00 |
| D6794 | Retainer crown – Titanium | $460.00 |
| D6930 | Re-cement or re-bond fixed partial denture<br><br>Complex rehabilitation – Additional charge per unit for multiple crown units/complex rehabilitation (6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines) | $61.00<br><br>$135.00 |
| Endodontics (root canal treatment, excluding final restorations) | | |
| D3110 | Pulp cap – Direct (excluding final restoration) | $14.00 |
| D3120 | Pulp cap – Indirect (excluding final restoration) | $14.00 |
| D3220 | Pulpotomy – Removal of pulp, not part of a root canal | $72.00 |
| D3221 | Pulpal debridement (not to be used when root canal is done on the same day) | $72.00 |
| D3222 | Partial pulpotomy for apexogenesis – Permanent tooth with incomplete root development | $72.00 |
| D3310 | Anterior root canal – Permanent tooth (excluding final restoration) | $210.00 |
| D3320 | Bicuspid root canal – Permanent tooth (excluding final restoration) | $245.00 |
| D3330 | Molar root canal – Permanent tooth (excluding final restoration) | $335.00 |
| D3331 | Treatment of root canal obstruction – Nonsurgical access | $97.00 |
| D3332 | Incomplete endodontic therapy – Inoperable, unrestorable or fractured tooth | $97.00 |
| D3333 | Internal root repair of perforation defects | $97.00 |
| D3346 | Retreatment of previous root canal therapy – Anterior | $300.00 |
| D3347 | Retreatment of previous root canal therapy – Bicuspid | $345.00 |
| D3348 | Retreatment of previous root canal therapy – Molar | $430.00 |
| D3410 | Apicoectomy/periradicular surgery – Anterior | $275.00 |
| D3421 | Apicoectomy/periradicular surgery – Bicuspid (first root) | $305.00 |
| D3425 | Apicoectomy/periradicular surgery – Molar (first root) | $340.00 |
| D3426 | Apicoectomy/periradicular surgery (each additional root) | $110.00 |
| D3427 | Periradicular surgery without apicoectomy | $275.00 |
| D3430 | Retrograde filling per root | $72.00 |
| Periodontics (treatment of supporting tissues (gum and bone) of the teeth) - Periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. The relevant procedure codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 teeth (or 8 sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule. | | |
| D4210 | Gingivectomy or gingivoplasty – 4 or more teeth per quadrant | $180.00 |
| D4211 | Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant | $91.00 |
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | $91.00 |
| D4240 | Gingival flap (including root planing) – 4 or more teeth per quadrant | $235.00 |
| D4241 | Gingival flap (including root planing) – 1 to 3 teeth per quadrant | $125.00 |
| D4245 | Apically positioned flap | $235.00 |
| D4249 | Clinical crown lengthening – Hard tissue | $255.00 |
| D4260 | Osseous surgery – 4 or more teeth per quadrant | $400.00 |
| D4261 | Osseous surgery – 1 to 3 teeth per quadrant | $240.00 |
| D4263 | Bone replacement graft – Retained natural tooth - First site in quadrant | $290.00 |
| D4264 | Bone replacement graft – Retained natural tooth - Each additional site in quadrant | $225.00 |
| D4266 | Guided tissue regeneration – Resorbable barrier per site | $380.00 |

| CODE | PROCEDURE DESCRIPTION | PATIENT CHARGE |
|---|---|---|
| D4267 | Guided tissue regeneration – Nonresorbable barrier per site (includes membrane removal) | $430.00 |
| D4270 | Pedicle soft tissue graft procedure | $300.00 |
| D4275 | Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft | $310.00 |
| D4277 | Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant or edentulous (missing) tooth position in graft | $310.00 |
| D4278 | Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous (missing) tooth position in same graft site | $155.00 |
| D4285 | Non-autogenous connective tissue graft procedure (including recipient surgical site and donor materials) – Each additional contiguous tooth, implant or edentulous tooth position in same graft site | $155.00 |
| D4341 | Periodontal scaling and root planing – 4 or more teeth per quadrant (limit 4 quadrants per consecutive 12 months) | $83.00 |
| D4342 | Periodontal scaling and root planing – 1 to 3 teeth per quadrant (limit 4 quadrants per consecutive 12 months) | $42.00 |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation – Full mouth, after oral evaluation (limit 1 per calendar year)<br>Additional scaling in presence of generalized moderate or severe gingival inflammation – Full mouth, after oral evaluation (limit 2 per calendar year) | $0.00<br>$45.00 |
| D4355 | Full mouth debridement to allow evaluation and diagnosis (1 per lifetime) | $65.00 |
| D4381 | Localized delivery of antimicrobial agents per tooth | $45.00 |
| D4910 | Periodontal maintenance (limit 4 per calendar year) (only covered after active periodontal therapy) | $53.00 |
| Prosthetics (removable tooth replacement – dentures) - Includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years. | | |
| D5110 | Full upper denture | $625.00 |
| D5120 | Full lower denture | $625.00 |
| D5130 | Immediate full upper denture | $680.00 |
| D5140 | Immediate full lower denture | $680.00 |
| D5211 | Upper partial denture – Resin base (including clasps, rests and teeth) | $525.00 |
| D5212 | Lower partial denture – Resin base (including clasps, rests and teeth) | $525.00 |
| D5213 | Upper partial denture – Cast metal framework (including clasps, rests and teeth) | $715.00 |
| D5214 | Lower partial denture – Cast metal framework (including clasps, rests and teeth) | $715.00 |
| D5221 | Immediate maxillary partial denture – Resin base (including any conventional clasps, rests and teeth) | $525.00 |
| D5222 | Immediate mandibular partial denture – Resin base (including conventional clasps, rests and teeth) | $525.00 |

| CODE | PROCEDURE DESCRIPTION | PATIENT CHARGE |
|---|---|---|
| D5223 | Immediate maxillary partial denture – Cast metal framework with resin denture base (including any conventional clasps, rests and teeth) | $715.00 |
| D5224 | Immediate mandibular partial denture – Cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $715.00 |
| D5225 | Upper partial denture – Flexible base (including clasps, rests and teeth) | $605.00 |
| D5226 | Lower partial denture – Flexible base (including clasps, rests and teeth) | $605.00 |
| D5410 | Adjust complete denture – Upper | $43.00 |
| D5411 | Adjust complete denture – Lower | $43.00 |
| D5421 | Adjust partial denture – Upper | $46.00 |
| D5422 | Adjust partial denture – Lower | $46.00 |
| Repairs to prosthetics | | |
| D5510 | Repair broken complete denture base | $88.00 |
| D5520 | Replace missing or broken teeth – Complete denture (each tooth) | $76.00 |
| D5610 | Repair resin denture base | $88.00 |
| D5630 | Repair or replace broken clasp - Per tooth | $110.00 |
| D5640 | Replace broken teeth – Per tooth | $81.00 |
| D5650 | Add tooth to existing partial denture | $88.00 |
| D5660 | Add clasp to existing partial denture - Per tooth | $110.00 |
| Denture relining (limit 1 every 36 months) | | |
| D5710 | Rebase complete upper denture | $250.00 |
| D5711 | Rebase complete lower denture | $250.00 |
| D5720 | Rebase upper partial denture | $250.00 |
| D5721 | Rebase lower partial denture | $250.00 |
| D5730 | Reline complete upper denture – Chairside | $145.00 |
| D5731 | Reline complete lower denture – Chairside | $145.00 |
| D5740 | Reline upper partial denture – Chairside | $145.00 |
| D5741 | Reline lower partial denture – Chairside | $145.00 |
| D5750 | Reline complete upper denture – Laboratory | $210.00 |
| D5751 | Reline complete lower denture – Laboratory | $210.00 |
| D5760 | Reline upper partial denture – Laboratory | $210.00 |
| D5761 | Reline lower partial denture – Laboratory | $210.00 |
| Interim dentures (limit 1 every 5 years) | | |
| D5810 | Interim complete denture – Upper | $315.00 |

| CODE | PROCEDURE DESCRIPTION | PATIENT CHARGE |
|---|---|---|
| D5811 | Interim complete denture – Lower | $315.00 |
| D5820 | Interim partial denture – Upper | $280.00 |
| D5821 | Interim partial denture – Lower | $280.00 |
| Implant/abutment supported prosthetics – All charges for crown and bridge (fixed partial denture) are per unit (each replacement on a supporting implant(s) equals 1 unit). Coverage for replacement of crowns and bridges and implant supported dentures is limited to 1 every 5 years. | | |
| | Additional charge per tooth/unit for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) services. Same day in-office CAD/CAM (ceramic) services refer to dental restorations that are created in the dental office by the use of a digital impression and an in-office CAD/CAM milling machine. | $150.00 |
| D6058 | Abutment supported porcelain/ceramic crown | $790.00 |
| D6059 | Abutment supported porcelain fused to metal crown (high noble metal) | $750.00 |
| D6060 | Abutment supported porcelain fused to metal crown (predominantly base metal) | $700.00 |
| D6061 | Abutment supported porcelain fused to metal crown (noble metal) | $725.00 |
| D6062 | Abutment supported cast metal crown (high noble metal) | $750.00 |
| D6063 | Abutment supported cast metal crown (predominantly base metal) | $700.00 |
| D6064 | Abutment supported cast metal crown (noble metal) | $725.00 |
| D6065 | Implant supported porcelain/ceramic crown | $790.00 |
| D6066 | Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) | $750.00 |
| D6067 | Implant supported metal crown (titanium, titanium alloy, high noble metal) | $750.00 |
| D6068 | Abutment supported retainer for porcelain/ceramic fixed partial denture | $790.00 |
| D6069 | Abutment supported retainer for porcelain fused to metal fixed partial denture (high noble metal) | $750.00 |
| D6070 | Abutment supported retainer for porcelain fused to metal fixed partial denture (predominantly base metal) | $700.00 |
| D6071 | Abutment supported retainer for porcelain fused to metal fixed partial denture (noble metal) | $725.00 |
| D6072 | Abutment supported retainer for cast metal fixed partial denture (high noble metal) | $750.00 |
| D6073 | Abutment supported retainer for cast metal fixed partial denture (predominantly base metal) | $700.00 |
| D6074 | Abutment supported retainer for cast metal fixed partial denture (noble metal) | $725.00 |
| D6075 | Implant supported retainer for ceramic fixed partial denture | $790.00 |
| D6076 | Implant supported retainer for porcelain fused to metal fixed partial denture (titanium, titanium alloy, high noble metal) | $750.00 |
| D6077 | Implant supported retainer for cast metal fixed partial denture (titanium, titanium alloy, high noble metal) | $750.00 |
| D6092 | Re-cement implant/abutment supported crown | $82.00 |

| CODE | PROCEDURE DESCRIPTION | PATIENT CHARGE |
|---|---|---|
| D6093 | Re-cement implant/abutment supported fixed partial denture | $99.00 |
| D6094 | Abutment supported crown (titanium) | $750.00 |
| D6110 | Implant /abutment supported removable denture for edentulous arch – Maxillary | $925.00 |
| D6111 | Implant /abutment supported removable denture for edentulous arch – Mandibular | $925.00 |
| D6112 | Implant /abutment supported removable denture for partially edentulous arch – Maxillary | $1,015.00 |
| D6113 | Implant /abutment supported removable denture for partially edentulous arch – Mandibular | $1,015.00 |
| D6114 | Implant /abutment supported fixed denture for edentulous arch – Maxillary | $925.00 |
| D6115 | Implant /abutment supported fixed denture for edentulous arch – Mandibular | $925.00 |
| D6116 | Implant /abutment supported fixed denture for partially edentulous arch – Maxillary | $1,015.00 |
| D6117 | Implant /abutment supported fixed denture for partially edentulous arch – Mandibular | $1,015.00 |
| D6194 | Abutment supported retainer crown for fixed partial denture (titanium) | $750.00 |
| | Complex rehabilitation on implant/abutment supported prosthetic procedures – Additional charge per unit for multiple crown units/complex rehabilitation (6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines) | $135.00 |
| Oral surgery (includes routine postoperative treatment) - Surgical removal of impacted tooth – Not covered for ages below 15 unless pathology (disease) exists. | | |
| D7111 | Extraction of coronal remnants – Deciduous tooth | $12.00 |
| D7140 | Extraction, erupted tooth or exposed root – Elevation and/or forceps removal | $12.00 |
| D7210 | Extraction, erupted tooth – Removal of bone and/or section of tooth | $53.00 |
| D7220 | Removal of impacted tooth – Soft tissue | $46.00 |
| D7230 | Removal of impacted tooth – Partially bony | $91.00 |
| D7240 | Removal of impacted tooth – Completely bony | $115.00 |
| D7241 | Removal of impacted tooth – Completely bony, unusual complications (narrative required) | $125.00 |
| D7250 | Removal of residual tooth roots – Cutting procedure | $53.00 |
| D7251 | Coronectomy – Intentional partial tooth removal | $91.00 |
| D7260 | Oroantral fistula closure | $125.00 |
| D7261 | Primary closure of a sinus perforation | $125.00 |
| D7270 | Tooth stabilization of accidentally evulsed or displaced tooth | $14.00 |
| D7280 | Exposure of an unerupted tooth (excluding wisdom teeth) | $14.00 |
| D7283 | Placement of device to facilitate eruption of impacted tooth | $8.00 |

| CODE | PROCEDURE DESCRIPTION | PATIENT CHARGE |
|---|---|---|
| D7285 | Incisional biopsy of oral tissue – Hard (bone, tooth) (tooth related – not allowed when in conjunction with another surgical procedure) | $78.00 |
| D7286 | Incisional biopsy of oral tissue – Soft (all others) (tooth related – not allowed when in conjunction with another surgical procedure) | $65.00 |
| D7287 | Exfoliative cytological sample collection | $78.00 |
| D7288 | Brush biopsy – Transepithelial sample collection | $78.00 |
| D7310 | Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant | $58.00 |
| D7311 | Alveoloplasty in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant | $33.00 |
| D7320 | Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces per quadrant | $78.00 |
| D7321 | Alveoloplasty not in conjunction with extractions – 1 to 3 teeth or tooth spaces per quadrant | $40.00 |
| D7450 | Removal of benign odontogenic cyst or tumor – Up to 1.25 cm | $14.00 |
| D7451 | Removal of benign odontogenic cyst or tumor – Greater than 1.25 cm | $14.00 |
| D7471 | Removal of lateral exostosis – Maxilla or mandible | $14.00 |
| D7472 | Removal of torus palatinus | $14.00 |
| D7473 | Removal of torus mandibularis | $14.00 |
| D7485 | Reduction of osseous tuberosity | $78.00 |
| D7510 | Incision and drainage of abscess – Intraoral soft tissue | $14.00 |
| D7511 | Incision and drainage of abscess – Intraoral soft tissue – Complicated | $20.00 |
| D7880 | Occlusal orthotic device, by report - (limit 1 per 24 months; only covered in conjunction with Temporomandibular Joint (TMJ) treatment) | $330.00 |
| D7881 | Occlusal orthotic device adjustment | $43.00 |
| D7960 | Frenulectomy – Also known as frenectomy or frenotomy – Separate procedure not incidental to another procedure | $14.00 |
| D7963 | Frenuloplasty | $20.00 |
| Orthodontics (tooth movement) - Orthodontic treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.) | | |
| D8050 | Interceptive orthodontic treatment of the primary dentition – Banding | $480.00 |
| D8060 | Interceptive orthodontic treatment of the transitional dentition – Banding | $480.00 |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition – Banding | $500.00 |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition – Banding | $515.00 |
| D8090 | Comprehensive orthodontic treatment of the adult dentition – Banding | $515.00 |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development | $67.00 |
| D8670 | Periodic orthodontic treatment visit Children – Up to 19th birthday:<br>24-month treatment fee<br>Charge per month for 24 months<br>Adults:<br>24-month treatment fee<br>Charge per month for 24 months | <br>$2,040.00<br>$85.00<br><br>$2,376.00<br>$99.00 |
| D8680 | Orthodontic retention – Removal of appliances, constructionand placement of retainer(s) | $345.00 |
| D8681 | Removable orthodontic retainer adjustment | $0.00 |
| D8999 | Unspecified orthodontic procedure – By report (orthodontic treatment plan and records) | $195.00 |
| General anesthesia/IV sedation – General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or IV sedation when used for the purpose of anxiety control or patient management. | | |
| D9223 | Deep sedation/general anesthesia – Each 15 minute increment | $95.00 |
| D9243 | Intravenous moderate (conscious) sedation/analgesia – Each 15 minute increment | $95.00 |
| Emergency services | | |
| D9110 | Palliative (emergency) treatment of dental pain – Minor procedure | $0.00 |
| D9440 | Office visit – After regularly scheduled hours | $55.00 |
| Miscellaneous services | | |
| D9940 | Occlusal guard – By report (limit 1 per 24 months) | $205.00 |
| D9941 | Fabrication of athletic mouthguard (limit 1 per 12 months) | $110.00 |
| D9943 | Occlusal guard adjustment | $0.00 |
| D9951 | Occlusal adjustment – Limited | $40.00 |
| D9952 | Occlusal adjustment – Complete | $210.00 |
| D9975 | External bleaching for home application, per arch; includes materials and fabrication of custom trays (all other methods of bleaching are not covered) | $165.00 |

This may contain CDT Dental Procedure Codes and/or portions of, or excerpts from the Code on Dental Procedures and Nomenclature (CDT Code) contained within the current version of the "Dental Procedure Codes", a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.

# We Give You More Reasons to Smile!

## Cigna Dental makes it easier for children under seven to seek dental care.

Another benefit enhancement to the ***Prepaid Plan - Pediatric Dentist Simplification Plan**

- You can now select a participating pediatric dentist as a primary care dentist for your dependent child(ren) under age seven. You can locate a participating pediatric dentist by visiting www.cigna.com, www.mycigna.com or by calling the number on your ID card and speaking with a representative.
- Because of this benefit enhancement, you no longer need a referral for your dependent child(ren) to receive dental care from a network pediatric dentist. In addition, preauthorization is not required.
- If your network general dentist refers your dependent child(ren) under age seven to a network pediatric dentist, your child(ren) will be automatically transferred to the pediatric dentist as his/her primary care dentist.
- If a network pediatric dentist is not available in your area, you must contact Cigna Dental prior to starting a new treatment plan. We will advise you if a network pediatric dentist has been added to your area because coverage will then be available from the network pediatric dentist.
- You have the option to transfer back to any network general dentist or you may select another network pediatric dentist.
- The pediatric dentist can provide dental examination and treatment without sending the treatment plan to Cigna Dental for prior payment authorization.
- As always, your standard co-payment will apply for each visit your dependent child(ren) will make to a pediatric dentist.
- Review your Patient Charge Schedule carefully so you will know what procedures are covered and what your financial responsibilities are.
- Once your dependent child(ren) reaches their seventh birthday, they will be transferred to your participating network general dentist.

*Prepaid is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

Cigna Dental refers to the following operating subsidiaries of Cigna Corporation: Connecticut General Life Insurance Company, and Cigna Dental Health, Inc., and its operating subsidiaries and affiliates. The Cigna Dental Care plan is provided by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska), Cigna Dental Health of Kentucky, Inc., Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, the Cigna Dental Care plan is underwritten by Connecticut General Life Insurance Company or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc.

Cigna®

# CALL OR CLICK TO FIND A NETWORK DENTIST

## It's easy with Cigna Dental Care (DHMO)*

Finding a Cigna Dental Care® network dentist or specialist is quick and easy. And how you do it is up to you. You can search online or call to speak with a customer service representative. **Remember to always pick a network general dentist who's within 25 miles of your location to ensure adequate access.**

**Here's how**

### From myCigna.com – the easiest way

Once you enroll in a Cigna Dental Care plan, register at **myCigna.com**. Then the site will give you information for your specific dental plan. You can search for a dentist using your location, dentist name or procedure. Results can be further narrowed down using the prompts on the results page.

On the go? Not a problem. This information is also on the **myCigna® App**.**

**We're with you every step of the way. To help you find better savings, better health and a better experience. From full-service to self-service, Cigna has your dentist search covered.**

* The term DHMO ("Dental HMO") is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features. The Cigna Dental Care (DHMO) product availability varies by state and is subject to change.

** The downloading and use of the myCigna Mobile App is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

### From Cigna.com

- To search for a dentist on **Cigna.com**, visit the site and click **"Find a Doctor, Dentist or Facility."**
- Follow the prompts on screen and when asked to choose your plan, select "CIGNA DENTAL CARE DHMO > Cigna Dental Care Access Plus.
- Review the lists given by specialty. Or narrow your search by typing in provider name, specialty or office name.
- Once you get your search results, you can further refine your search by:
  - Distance
  - Specialty
  - Years in practice
  - Additional languages
- Click on a dentist's name for more details. Such as office hours and location listings with map view.

### Call us at 800.Cigna24 (800.244.6224)

Need help finding a Cigna Dental Care network dentist or specialist? Just give us a call. You can use the automated Dental Office Locator. Or, you can speak directly with a customer service representative. You can also ask for a directory customized by dentist type and location.

### Call your current dentist

Your current dentist could be in-network. Call the office and ask if they participate in the Cigna Dental Care Access Plus network.

**Together, all the way.®**

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**Offered by Cigna Health and Life Insurance Company or its affiliates.**

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# Cigna Dental Oral Health Integration Program®

A Cigna Dental Health Connect™ solution

# NEED MORE? GET MORE.

## Cigna Dental Oral Health Integration Program®

**Get the dental services you need for your medical condition. Enroll in the Cigna Dental Oral Health Integration Program today.**

## What is the Cigna Dental Oral Health Integration Program?

It's a program that reimburses out-of-pocket costs for specific dental services used to treat gum disease and tooth decay. The program is for people with certain medical conditions that have been found to be associated with gum disease. There's no additional cost for the program – if you qualify, you get reimbursed!*

## Do I qualify?

If you have a Cigna dental plan, you're eligible for the program. You do NOT have to be enrolled in a Cigna medical plan to be eligible for this program. You must currently be under treatment by a doctor for any of the following conditions:

- Heart disease
- Stroke
- Diabetes
- Maternity
- Chronic kidney disease
- Organ transplants
- Head and neck cancer radiation

## How does it work?

**In order to receive benefits through this program, you must first enroll to participate. Once you've registered, you visit your dentist and pay your usual copay or coinsurance amount.** If you visit a Cigna network dentist, they will send us a claim. If you choose to see a dentist not in the Cigna network, you may need to submit the claim yourself. We review the claim and will refund your copay or coinsurance for eligible dental services. Once we receive your claim, you can expect to be reimbursed in about 30 days.

## What else does the Oral Health Integration Program include?

You can ask us for information on issues that aff ect your oral health and your overall wellness – such as fear of going to the dentist. Or the impact of stress or tobacco products. We'll also give you guidance on how to overcome these behaviors.

**Together, all the way.®**

Cigna®

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**Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, or their affiliates.**

## How do I enroll and use the program?

1. Fill out the online registration form found on **myCigna.com**. You can also download a fillable form from Cigna.com or call the number on the back of your ID card to have an enrollment form sent to you. You only need to complete the form one time per qualifying condition.
2. Visit your dentist and pay your usual out-of-pocket cost for the covered service. Once we have received your claim, we will send your reimbursement.

## What dental services are covered under the Cigna Dental Oral Health Integration Program?

Check the chart below to see which dental services are covered for each qualifying medical condition.

| | Medical Conditions (check mark indicates covered dental service[1]) | | | | | | |
|---|---|---|---|---|---|---|---|
| **Dental Services** | **Heart Disease** | **Stroke** | **Diabetes** | **Maternity** | **Chronic Kidney Disease** | **Organ Transplants** | **Head and neck cancer radiation** |
| Periodontal Treatment & Maintenance (D4341, D4342, D4910[2]) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Periodontal Evaluation (D0180) | | | | ✓ | | | |
| Oral Evaluation (D0120[3], D0140[3], D0150[3]) | | | | ✓ | | | |
| Cleaning (D1110[4]) | | | | ✓ | | | |
| Scaling in the presence of inflammation – Full Mouth (D4346[4]) | | | | ✓ | | | |
| Emergency Palliative Treatment (D9110[5]) | | | | ✓ | | | |
| Topical application of fluoride & Topical application of fluoride varnish (D1206[6]) | | | | | ✓ | ✓ | ✓ |
| Topical application of fluoride – excluding varnish (D1208[6]) | | | | | ✓ | ✓ | ✓ |
| Sealants (D1351[6]) | | | | | ✓ | ✓ | ✓ |
| Sealant Repair – per tooth (D1353[6]) | | | | | ✓ | ✓ | ✓ |

1. Eligibility, reimbursement and coverage for eligible services are subject to plan year maximums. 2. Four times per year subject to plan guidelines. 3. One additional evaluation. 4. One additional cleaning. 5. No limitations. 6. Age limits removed, all other limitations (including frequency limitations) apply.

## Questions?

If you have questions about the Cigna Dental Oral Health Integration Program, or the impact that oral health can have on some medical conditions, please call us 24/7 at **800.Cigna24**.

* You do not have to meet your DPPO or indemnity deductible to receive reimbursement for these services. However, reimbursement will apply to and is subject to your annual benefits maximum for traditional indemnity and DPPO plans as well as plan rules for visits to network dentists and out-of-network dentists.


The Cigna Dental Oral Health Integration Program may not be available under your specific plan. Reimbursement under OHIP is subject to plan terms and conditions, including applicable annual benefit maximums and other exclusions and limitations. For costs and details of coverage, contact your Cigna representative or see your plan documents.

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# HEALTHY CHOICES DESERVE HEALTHY DISCOUNTS

**Start saving today with Cigna Healthy Rewards®.***

Get discounts on the health products and programs you use every day. Just use your ID card when you pay and let the savings begin.

Real brands. Real discounts. Real awesomeness.

**To start saving today, visit myCigna.com or call 800.244.6224.**

*Healthy Rewards is a discount program. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge. All goods, services and discounts offered through Healthy Rewards are provided by third-party providers and not by Cigna. Cigna assumes no responsibility for any circumstances arising out of the use, misuse, or application of any of the goods, services, discounts or information made available through such third-party providers.

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# Cigna Dental Care - Limitations on covered services

Listed below are limitations on services covered by the Dental Plan:

**Frequency** — The frequency of certain covered services, such as cleanings, is limited. The Patient Charge Schedule lists any limitations on frequency.

**Specialty Care** — Payment authorization is required for coverage of services by a Network Specialist.

**Pediatric Dentistry** — Coverage to a Pediatric Dentist ends on an enrolled child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. The Network General Dentist shall provide care after the child's 7th birthday.

**Oral Surgery** — The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

## Exclusions - Cigna Dental Care

Listed below are the services or expenses which are NOT covered under the Dental Plan and which are the Covered Person's responsibility at the dentist's Usual Fees. There is no coverage for:

- Services not listed on the Patient Charge Schedule.
- Services provided by a non-Network Dentist without Cigna Dental Health's prior approval (except emergencies as described in Plan Documents).
- Services related to an injury or illness covered under workers' compensation, occupational disease or similar laws. (FL — This exclusion relates to such services paid under Workers' Compensation, occupational disease or similar laws.)
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program other than Medicaid.
- Services relating to injuries which are intentionally self-inflicted.
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your dental fee overview.
- Prescription drugs.
- Procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact) or (2) diagnose or treat abnormal conditions of the temporomandibular joint, except as specifically listed on the Patient Charge Schedule.
- The completion of crown and bridge, dentures or root canal treatment already in progress on the date Covered Person becomes covered by the Dental Plan.
- Replacement of fixed and/or removable prosthodontic appliances that have been lost; stolen; or damaged due to patient abuse, misuse or neglect.
- Services associated with the placement or prosthodontic restoration of a dental implant.
- Services considered to be unnecessary or experimental in nature.
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Hospitalization, including any associated incremental charges for dental services performed in a hospital.
- Services to the extent the Covered Person is compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy.
- Crowns and bridges used solely for splinting.
- Resin bonded retainers and associated pontics.

Additional clinical guidelines maybe specified in your plan documents.
Except as set forth above, pre-existing conditions are not excluded.

# Frequently Asked Questions

### What if I need to see a specialist?
If you require specialty care, your network general dentist will refer you to a network specialist. You do not require a specialty referral to visit a network orthodontist or network pediatric dentist. You are responsible for paying the network dentist/specialist the applicable co-payments listed on your Patient Charge Schedule (PCS).

### Are braces covered?
Yes, both for children and adults. For orthodontic treatment started before you joined the Cigna Dental Care plan, call Customer Service to determine if any benefit is available.

### How do I choose a dentist?
There are over 3,577 general dentists in Florida who serve State employees. More than 73% of you will have access to two or more dental offices within ten miles of your home. Select your dentist by visiting www.cigna.com. For your convenience, we encourage members to register at www.mycigna.com. The automated Dental Office Locator always gives you the most up-to-date network information, available 24 hours a day. Customer Service and the Dental Office Locator are available at 1.800.CIGNA24.

### Can I change dentists?
Yes! Just call 1.800.CIGNA24 and use the Quick Transfer automated service available 24 hours a day or speak with a representative during business hours. The change will take effect on the first day of the following month. Transfers take approximately five days to process.

### Can family members use different dentists?
Yes! Covered family members can select their own network dentists.

### How much will I pay for covered services?
When there is a charge, your Patient Charge Schedule in your post-enrollment kit will tell you what the charge will be for covered procedures. Cigna Dental Care members know exact amounts, not just a percentage of what the dentist would usually charge, so they are able to budget accordingly.

### What about pre-existing conditions?
Treatment in progress prior to the effective date of coverage is not covered.

### Do I have to select a Network General Dentist?
As a Prepaid member, you are required to select and visit a network general dentist (provider) for all your dental care needs.

### What happens if I do not select a dentist from the Cigna Prepaid Network?
If you receive covered service from a dentist who does not participate in the Prepaid network, your benefits may be significantly reduced or the services received may not be covered at all. At the time of enrollment in the Prepaid plan, you are required to select a network general dentist. If the dentist you choose is not available, then Cigna Dental will select one for you.

### Did you know that you can access information about your dental benefits information online by visiting myCigna.com?
Register at myCIGNA.com to:

- View your personalized dental benefits information
- Download a Patient Charge Schedule
- Request an I.D. card
- Print a temporary I.D. card
- Change your network general dentist
- Learn more about dental health topics

**Want to learn more?**
**Simply visit www.myCigna.com**
**http://www.myCigna.com and register.**

**Capital Insurance Agency, Inc.**

P.O. Box 15949
Tallahassee, FL 32317-5949
1.800.780.3100
www.capitalins.com

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STATE OF FLORIDA & UNIVERSITY EMPLOYEES

# HOW TO APPLY

1. Enroll during Open Enrollment or as a New Employee (within the first 60 days of employment). Contact the People First Service Center, toll-free 866.663.4735, or access their web site at https://peoplefirst.myflorida.com to make your election.

   ***Your enrollment is not complete until you have notified People First.*

2. Contact your local Capital Representative with any questions and for enrollment assistance.

**Enroll Now**

For more information on how to enroll, please contact the Group Benefits Dept. by phone at 800.780.3100 or email at groupdepartment@capitalins.com.

MetLife | Dental Insurance

Department of MANAGEMENT SERVICES
Division of State Group Insurance

# State of Florida Dental Benefit for the State Group Insurance Program

Navigating life together

# Welcome!

## Why is having a good Dental plan so important?

A healthier smile can be important to maintaining overall health.

Maintaining good oral health matters. Keeping up with your dental cleanings and other preventive care now can help you avoid costly dental problems and treatments in the future. Plus, going to the dentist regularly can help prevent problems that have been linked to diabetes or heart disease.[1] That's where a good dental plan comes in. The right coverage makes it easier to visit the dentist and helps lower your costs.[2] You get support to keep up with dental cleanings and other preventive care that helps you live healthier. Now that's something to smile about!

### MetLife Mobile App[4]

It's easy. Search "MetLife" in the Apple App Store or Google Play to download the app. Then use your MetLife MyBenefits log in information to access these features.

### How can having MetLife Dental insurance benefit you?

By lowering your out-of-pocket costs, MetLife Dental makes it easier to get the care you need.

### Freedom to go to any dentist.

MetLife's dental benefits plan featuring the Preferred Dentist Program is a Dental PPO plan. So you can visit any licensed dentist, in or out of the network, and receive benefits.

- If you prefer to go to a participating dentist, you can count on our large and constantly growing network.[5]
- All participating dentists must meet rigorous selection standards.[3] Find a participating dentist today at **metlife.com/stateoffl.**

For more savings,[2] visit a participating general dentist or specialist. You can visit any licensed dentist, even if he or she is out of network, but your out-of-pocket costs will usually be less when you visit a participating provider. With MetLife Dental, you have a large network of providers in the state of Florida.

### Managing your dental benefits is easy!

- Once enrolled, MetLife's MyBenefits tool, **mybenefits.metlife.com**, is your secure self-service website available 24/7. You can use the site to get estimates on costs or check coverage and claim status.
- Call 1-844-222-9104 - representatives are available 8:00am until 11:00pm ET, Monday through Friday.

1. American Dental Association; Dentists: Doctors of Oral Health ada.org/en/about-the-ada/dentists-doctors-of-oralhealth; Accessed March 2018.
2. Savings from enrolling in a dental benefits plan featuring the MetLife Preferred Dentist Program will depend on various factors, including how the cost of the plan, often participants visit the dentist and the cost of services rendered
3. Certain providers may participate with MetLife through an agreement that MetLife has with a vendor. Providers available through a vendor are subject to the vendor's credentialing process and requirements, not MetLife's.
4. Certain features of the MetLife Mobile App are not available for all MetLife Dental Plans.
5. Based on MetLife internal analysis.

# State of Florida Dental

Network: PDP Plus

| | Indemnity with PPO<br>People First Plan Code 4031 | | Standard PPO<br>People First Plan Code 4032 | | Preventive PPO<br>People First Plan Code 4033 | |
|---|---|---|---|---|---|---|
| **Coverage Type** | **In-Network**<br>% of Negotiated Fee* | **Out-of-Network**<br>% of R&C Fee** | **In-Network**<br>% of Negotiated Fee* | **Out-of-Network**<br>% of R&C Fee** | **In-Network**<br>% of Negotiated Fee* | **Out-of-Network**<br>% of R&C Fee** |
| **Type A: Preventive** (cleanings, exams, X-rays) | 100% | 100% | 100% | 80% | 100% | 80% |
| **Type B: Basic Restorative** (fillings, extractions) | 80% | 80% | 80% | 50% | 80% | 50% |
| **Type C: Major Restorative** (bridges, dentures) | 50% | 50% | 50% | 30% | No Benefit | No Benefit |
| **Type D: Orthodontia** | 50% | 50% | 50% | 30% | No Benefit | No Benefit |
| **Deductible†** | | | | | | |
| Employee Only | $50 | $50 | $50 | $50 | $50 | $50 |
| Employee + Spouse or Employee + Child(ren) | $100 | $100 | $100 | $100 | $100 | $100 |
| Employee + Child(ren) + Spouse | $150 | $150 | $150 | $150 | $150 | $150 |
| **Annual Maximum Benefit** | | | | | | |
| Per Person | $2,000 | $2,000 | $1,500 | $1,500 | $1,000 | $1,000 |
| **Orthodontia Lifetime Maximum** | | | | | | |
| Per Person | $2,500 | $2,500 | $2,000 | $1,500 | No Benefit | No Benefit |

**Late enrollment waiting period:** None.
Employees can enroll upon date of hire or during each Open Enrollment. There's no late enrollment permitted.

* Negotiated fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

** R&C fee refers to the Reasonable and Customary charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

† Applies only to Type B & C Services. Once the Annual Employee + Child(ren) + Spouse Deductible is satisfied, no further Annual Individual Deductibles are required to be met.

# Monthly costs

The following monthly costs are effective through 12/31/2021. Your premium will be paid through convenient payroll deduction. Monthly cost covers all eligible children for Employee + Child(ren) and Employee + Child(ren) + Spouse plans.

| | **Indemnity with PPO**<br>People First Plan Code 4031 | **Standard PPO**<br>People First Plan Code 4032 | **Preventative PPO**<br>People First Plan Code 4033 |
|---|---|---|---|
| **Employee Only** | $49.44 | $34.86 | $23.88 |
| **Employee + Spouse** | $91.48 | $64.50 | $44.18 |
| **Employee + Child(ren)** | $102.20 | $72.06 | $49.36 |
| **Employee + Child(ren) + Spouse** | $148.38 | $104.64 | $71.66 |

## A hypothetical example[1]

Visiting an in-network dentist can help you significantly lower your costs while getting the care you need.

| Service | Dentist's Usual Fee | Negotiated Fee | Percent Covered | MetLife Pays | Out-of-Pocket Cost | Savings |
|---|---|---|---|---|---|---|
| **Exams & Cleanings** | $122 | $82 | 100% | $82 | $0 | $122 |
| **X-rays** | $130 | $74 | 100% | $74 | $0 | $130 |
| **Fillings** | $163 | $93 | 80% | $74.40 | $18.60 | $144.40 |
| **Root Canals** | $705 | $437 | 80% | $349.60 | $87.40 | $617.60 |
| **Crowns** | $1,117 | $699 | 50% | $349.50 | $349.50 | $767.50 |

1. These hypothetical in-network savings examples are based on average charges within the Tallahassee ZIP code, for procedure codes D0120, D1110, D0210, D2391, D3310 and D2740. They assume that the annual deductible has been met and the annual maximum benefit has not been reached. Actual benefit payments, out-of-pocket costs and savings may vary.

# List of Primary Covered Services & Limitations

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

| | Indemnity with PPO | Standard PPO | Preventative PPO |
|---|---|---|---|
| **Type A – Preventative** | **How Many/How Often** | | |
| **Prophylaxis (cleanings)** | • One cleaning in 6 consecutive months | | |
| **Oral Examinations** | • One exam in 6 consecutive months | | |
| **Topical Fluoride Applications** | • One fluoride treatment in 12 consecutive months for dependent children up to his/her 14th birthday | | |
| **X-rays** | • Full mouth X-rays; one per 60 months<br>• Bitewings X-rays; two times per 12 consecutive months | | |
| **Space Maintainers** | • 1 per lifetime, per area of the mouth | | |
| **Sealants** | • One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 16th birthday | | |
| **Type B – Basic Restorative** | **How Many/How Often** | | |
| **Fillings** | • One per tooth surface, per 24 consecutive months | | |
| **Simple Extractions** | | | |
| **Oral Surgery** | | | |
| **Endodontics** | • Root canal treatment limited to once per tooth per lifetime | | |
| **General Anesthesia** | • When dentally necessary in connection with oral surgery, extractions or other covered dental services | | |
| **Periodontics** | • Periodontal scaling and root planing once per quadrant, every 24 months<br>• Periodontal surgery once per quadrant, every 36 months | | |

# List of Primary Covered Services & Limitations

(continued)

| | Indemnity with PPO | Standard PPO | Preventative PPO |
|---|---|---|---|
| **Type C – Major Restorative** | **How Many/How Often** | | |
| **Implants** | • One per tooth position in 60 consecutive months. | | Not Covered |
| **Bridges and Dentures** | • Initial placement to replace one or more natural teeth, which are lost while covered by the plan.<br>• Dentures and bridgework replacement; one per 84 consecutive months.<br>• Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed. | | Not Covered |
| **Crowns, Inlays and Onlays** | • Replacement once every 84 months | | Not Covered |
| **Type D – Orthodontia** | **How Many/How Often** | | |
| | • You, Your Spouse, and Your Children, up to the last day of the calendar year in which Your Child reaches age 26, are covered while Dental Insurance is in effect.<br>• All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.<br>• Payments are on a repetitive basis.<br>• 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary.<br>• Orthodontic benefits end at cancellation of coverage. | | Not Covered |

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

# Frequently Asked Questions

### Who is a participating dentist?

A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees are typically 30%-45% below the average fees charged in a dentist's community for the same or substantially similar services.†

### How do I find a participating dentist?

You can receive a list of participating dentists online at metlife.com/stateoffl or call 1-844-222-9104. There are thousands of general dentists and specialists to choose from nationwide - so you are sure to find one that meets your needs.

### What services are covered under this plan?

The services covered under the plan are set forth in the certificate of insurance.

### May I choose a non-participating dentist?

Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher.

### Can my dentist apply for participation in the network?

Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit **metdental.com**, or call **1-866-PDP-NTWK** for an application.†† The website and phone number are for use by dental professionals only.

### How are claims processed?

Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit **metlife.com/mybenefits** or request one by calling **1-844-222-9104.**

### Can I get an estimte of what my out-of-pocket expenses will be before receiving a service?

Yes. You can ask for a pretreatment estimate. Your general dentist or specialist can send MetLife a plan for your care and request an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pretreatment estimate for services in excess of $300. Simply have your dentist submit a request online at **metdental.com** or call **1-877-MET-DDS9.** You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums from the pretreatment estimate, deductibles, frequency limits, and other conditions at time of payment.

### Can MetLife help me find a dentist outside of the U.S. if I am traveling?

Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling **1-312-356-5970** (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

### How does MetLife coordinate benefits with other insurance plans?

Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

### Do I need an ID card?

No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in a MetLife dental benefits plan. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

† Based on internal analysis by MetLife. Negotiated Fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

†† Due to contractual requirements, MetLife is prevented from soliciting certain providers.

* AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife.

** Refer to your dental benefits plan summary for your out-of-network dental coverage.

# Exclusions

**This plan does not cover the following services, treatments or supplies:**

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images.

## Exclusions (continued)

**Alternate Benefits:** Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's payment for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-844-222-9104 and using the MetLife Dental Automated Information Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other conditions at time of payment.

**Cancellation/Termination of Benefits:** Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. For complete details of coverage and availability, please refer to the certificate of insurance or contact MetLife.



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STATE OF FLORIDA & UNIVERSITY EMPLOYEES

# HOW TO APPLY

1. Enroll during Open Enrollment or as a New Employee (within the first 60 days of employment). Contact the People First Service Center, toll-free 866.663.4735, or access their web site at https://peoplefirst.myflorida.com to make your election.

   ***Your enrollment is not complete until you have notified People First.*

2. Contact your local Capital Representative with any questions and for enrollment assistance.

**Enroll Now**

For more information on how to enroll, please contact the Group Benefits Dept. by phone at 800.780.3100 or email at groupdepartment@capitalins.com.

# Humana Dental

## State of Florida Employees

**Dental plans to choose from:**

- Prepaid Plan
- Indemnity Plan

Humana®

Department of MANAGEMENT SERVICES
Division of State Group Insurance

FLHHB32HH 0820

# Two plans to choose from

Humana is pleased to offer you two dental plans to choose from this year. While some of the benefits are similar, others are distinct to each plan. Be sure to review the features in this book to make the right choice for your dental health and budget.

### Choice of plans

- Prepaid Plan – a managed care plan
- Indemnity Plan – a reimbursement plan

**Dental care is an important part of keeping your good overall health.**

### Your cost in monthly premium

| People First Benefit plan code | 4044 | 4084 |
|---|---|---|
| Dental plan name | Prepaid | Indemnity |
| Employee only | $12.64 | $14.74 |
| Employee + spouse | $21.20 | $21.96 |
| Employee + child(ren) | $23.00 | $23.30 |
| Employee + family | $32.98 | $37.10 |

If you have questions, visit our website at **HumanaDental.com/custom/fl/** or call **1-866-879-3630 (TTY: 711)**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

# A dental plan that will make you smile

### How do the plans work?

**Prepaid** covers preventive care and other dental procedures as listed when you're treated by your selected primary care dentist. If your dentist decides you need more specialized treatment, you'll be referred to a participating specialist. With the Prepaid plan, the participating specialist's fees may be discounted at 25%. General dentistry and specialty services are available only in areas where Humana has a participating general dentist and/or specialist.

**Indemnity** covers preventive care and other dental procedures as listed when you're treated by any dentist you choose. You'll be responsible for expenses not reimbursed by the plan and there are benefit maximums.

### Do I have to file a claim form?

**Prepaid:** No, all treatment will be coordinated by your primary care dentist. You're only responsible for the copayment listed on the benefits schedule.

**Indemnity:** Yes, you must submit a claim form to be reimbursed for your dental expenses.

**Submit claim forms to:** Humana P.O. Box 14284, Lexington, KY 40512-4284

**Predetermination:** If covered dental expenses for a procedure are expected to be more than $200, it's recommended that you send a dental treatment plan before beginning treatment. You and/or your dentist will be notified of the benefits payable based on the dental treatment plan.

### How do I know which dentist to see?

**Prepaid:** For participating dentist information, visit **HumanaDental.com/custom/fl/**. Once you enroll in your plan, you'll need to select a primary care general dentist by registering at **www.mycompbenefits.com**.

**Indemnity:** You can see any dentist.

### Does everyone in my family need to use the same dentist?

No, each family member can have a different dentist. For instance, a spouse might choose to visit a dentist close to a workplace, a dependent college student living away from home might pick a dentist near school, and parents might choose to send their children to pediatric dentists (specialist) who are more comfortable treating young children.

### What should I do if I have a question or concern?

Visit our website at **HumanaDental.com/custom/fl/** or contact Humana by calling **1-866-879-3630 (TTY: 711)**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

# HD205 Prepaid Plan
# People First Plan Code #4044

The **HD205 Prepaid Plan** focuses on maintaining oral health, prevention and cost containment. Members may see a participating primary care dentist as often as necessary. There are no yearly maximums, no deductibles to meet and no waiting periods. The HD plan copayments for listed procedures are applicable only at a participating general dentist. For procedures not listed on the summary of services, members may be eligible to receive up to a 25% discount.

Member costs listed here are for services provided by a selected participating primary care general dentist (PCD) only. A PCD may decide that a member needs to see a participating specialist. No referral is necessary to see a participating specialist.

### Selecting a participating primary care general dentist

For participating dentist information, you may visit our website **HumanaDental.com/custom/fl/** or call our dedicated Customer Care number at **1-866-879-3630 (TTY: 711)**. Once you become enrolled in the HD205 Prepaid plan, you will need to select a participating primary care general dentist by registering at **www.mycompbenefits.com** or by calling our dedicated Customer Care number at **1-866-879-3630 (TTY: 711)**.

Specialists: Should members need a specialist (i.e., endodontist, orthodontist, oral surgeon, periodontist, prosthodontist, pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. Members may be eligible to receive up to a 25% discount by visiting a participating specialist. Specialist services are available only in areas where the dental plan has a participating specialist.

### Summary of services

Services marked with a single asterisk (*) below also require separate payment of laboratory charges, not to exceed $200. The laboratory charges must be paid to the plan dentist in addition to any applicable copayment for the service.

| ADA Code | Procedure | |
|---|---|---|
| **Appointments** | | **Member cost** |
| D9310 | Consultation (diagnostic service provided by dentist other than practitioner providing treatment) | $5 |
| D9430 | Office visit (normal hours) | no charge |
| D9440 | Office visit (after regularly scheduled hours) | $35 |
| D9986 | Missed appointment | $10 |
| D9987 | Cancelled appointment | $10 |
| D9999 | Emergency visit during regularly scheduled hours, by report | $20 |
| **Diagnostic** | | **Member cost** |
| D0120 | Periodic oral examination (limited to twice in any 12 calendar months) | no charge |
| D0140 | Limited oral evaluation – problem focused | no charge |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | no charge |
| D0150 | Comprehensive oral evaluation – new or established patient (limited to twice in any 12 calendar months) | no charge |
| D0160 | Detailed and extensive oral evaluation – problem focused, by report | no charge |
| D0170 | Re-evaluation – problem focused (not post-operative visit) | no charge |
| D0180 | Comprehensive periodontal evaluation (limited to twice in any 12 calendar months) | $15 |
| D0210 | X-ray intraoral – complete series including bitewings (once per three calendar years) | no charge |
| D0220 | X-ray intraoral – periapical, first radiographic image | no charge |
| D0230 | X-ray intraoral – periapical, each additional radiographic image | no charge |
| D0240 | X-rays intraoral – occlusal radiographic image(s) | no charge |
| D0250 | Extra-oral – 2D projection radiographic image created using a stationary radiation source and detector | no charge |
| D0270 | X-ray bitewing – single radiographic image (limited to twice in any 12 calendar months) | no charge |
| D0272 | X-ray bitewings – two radiographic images (limited to twice in any 12 calendar months) | no charge |

| **Diagnostic** (cont.) | | **Member cost** |
|---|---|---|
| D0273 | X-ray bitewings – three radiographic images (limited to twice in any 12 calendar months) | no charge |
| D0274 | Bitewings – four radiographic images (limited to twice in any 12 calendar months) | no charge |
| D0277 | X-ray bitewings, vertical – seven to eight radiographic images (limited to twice in any 12 calendar months) | no charge |
| D0330 | Panoramic radiographic image (once per three calendar years) | no charge |
| D0350 | Oral/facial photography images | no charge |
| D0415 | Collect microorganisms culture & sensitivity | no charge |
| D0425 | Caries susceptibility tests | no charge |
| D0431 | Oral cancer screening using a special light source | $50 |
| D0460 | Pulp vitality tests (not covered if a root canal is performed) | no charge |
| D0470 | Diagnostic casts | no charge |
| D0472 | Pathology report – gross examination of lesion | no charge |
| D0473 | Pathology report – microscopic examination of lesion | no charge |
| D0474 | Pathology report – microscopic examination of lesion and area | no charge |
| **Preventive** | | **Member cost** |
| D1110 | Prophylaxis – adult, routine (limited to twice in any 12 calendar months, by primary care dentist) | no charge |
| D1120 | Prophylaxis – child (limited to twice in any 12 calendar months) | no charge |
| D1206 | Topical application of fluoride varnish (for child <16) (limited to twice in any 12 calendar months) | no charge |
| D1208 | Topical application of fluoride - excluding varnish (limited to twice in any 12 calendar months) | no charge |
| D1310 | Nutrition counseling for the control of dental disease | no charge |
| D1320 | Tobacco counseling services for the control or prevention of oral disease | no charge |
| D1330 | Oral hygiene instruction | no charge |
| D1351 | Sealant – per tooth (permanent teeth only to age 16) | $10 |
| D1510* | Space maintainer – fixed, unilateral (through age 14) | $50 |
| D1516* | Space maintainer – fixed – bilateral, maxillary (through age 14) | $70 |
| D1517* | Space maintainer – fixed – bilateral, mandibular (through age 14) | $70 |
| D1520* | Space maintainer – removable, unilateral (through age 14) | $85 |
| D1526* | Space maintainer – removable – bilateral, maxillary (through age 14) | $90 |
| D1527* | Space maintainer – removable – bilateral, mandibular (through age 14) | $90 |
| D1550 | Re-cement or re-bond space maintainer | $10 |
| D1575 | Distal shoe space maintainer – fixed unilateral (through age 14; primary teeth only) | $130 |
| **Restorative** | | **Member cost** |
| D2140 | Amalgam – one surface, primary or permanent | $5 |
| D2150 | Amalgam – two surfaces, primary or permanent | $5 |
| D2160 | Amalgam – three surfaces, primary or permanent | $5 |
| D2161 | Amalgam – four or more surfaces, primary or permanent | $5 |
| D2940 | Protective restoration | $10 |
| **Resin restorative** (inlays and onlays limited to one per tooth every five years) | | **Member cost** |
| D2330 | Resin based composite – one surface, anterior | $30 |
| D2331 | Resin based composite – two surfaces, anterior | $40 |
| D2332 | Resin based composite – three surfaces, anterior | $45 |
| D2335 | Resin based composite – four or more surfaces or involving incisal angle (anterior) | $65 |
| D2390 | Resin based composite crown, anterior | $70 |
| D2391 | Resin based composite – one surface, posterior | $45 |
| D2392 | Resin based composite – two surfaces, posterior | $55 |
| D2393 | Resin based composite – three surfaces, posterior | $80 |

| **Resin restorative** (cont.) | | **Member cost** |
|---|---|---|
| D2394 | Resin based composite – four or more surfaces, posterior | $90 |
| D2510* | Inlay – metallic, one surface | $225 |
| D2520* | Inlay – metallic, two surfaces | $235 |
| D2530* | Inlay – metallic, three or more surfaces | $245 |
| D2542* | Onlay – metallic, two surfaces | $250 |
| D2543* | Onlay – metallic, three surfaces | $260 |
| D2544* | Onlay – metallic, four or more surfaces | $270 |
| D2610* | Inlay – porcelain/ceramic, one surface | $250 |
| D2620* | Inlay – porcelain/ceramic, two surfaces | $260 |
| D2630* | Inlay – porcelain/ceramic, three or more surfaces | $270 |
| D2642* | Onlay – porcelain/ceramic, two surfaces | $275 |
| D2643* | Onlay – porcelain/ceramic, three surfaces | $285 |
| D2644* | Onlay – porcelain/ceramic, four or more surfaces | $295 |
| D2650* | Inlay – resin based composite, one surface | $225 |
| D2651* | Inlay – resin based composite, two surfaces | $235 |
| D2652* | Inlay – resin based composite, three or more surfaces | $245 |
| D2662* | Onlay – resin based composite, two surfaces | $250 |
| D2663* | Onlay – resin based composite, three surfaces | $260 |
| D2664* | Onlay – resin based composite, four or more surfaces | $270 |
| **Crown and bridge** (limited to one per tooth every five years) | | **Member cost** |
| D2710* | Crown – resin based composite, indirect | $270 |
| D2712* | Crown – 3/4 resin based composite, indirect | $270 |
| D2720* | Crown – resin with high noble metal | $270 |
| D2721 | Crown – resin with predominantly base metal | $270 |
| D2722* | Crown – resin with noble metal | $270 |
| D2740* | Crown – porcelain/ceramic | $270 |
| D2750* | Crown – porcelain fused to high noble metal | $270 |
| D2751 | Crown – porcelain fused to predominantly base metal | $270 |
| D2752* | Crown – porcelain fused to noble metal | $270 |
| D2780* | Crown – 3/4 cast high noble metal | $270 |
| D2781 | Crown – 3/4 cast predominantly base metal | $270 |
| D2782* | Crown – 3/4 cast noble metal | $270 |
| D2783* | Crown – 3/4 porcelain/ceramic | $270 |
| D2790* | Crown – full cast high noble metal | $270 |
| D2791 | Crown – full cast predominantly base metal | $270 |
| D2792* | Crown – full cast noble metal | $270 |
| D2794* | Crown – titanium | $270 |
| D2799 | Provisional crown | no charge |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | $15 |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | no charge |
| D2920 | Re-cement or re-bond crown | $15 |
| D2929 | Crown-Prefabricated porcelain/ceramic crown – primary tooth | $75 |
| D2930 | Prefabricated stainless steel crown – primary tooth | $75 |
| D2931 | Prefabricated stainless steel crown – permanent tooth | $25 |
| D2932 | Prefabricated resin crown | $50 |

| **Crown and bridge** (Cont.) | | **Member cost** |
|---|---|---|
| D2933 | Prefabricated stainless steel crown with resin window | $50 |
| D2934 | Prefabricated esthetic coated stainless steel crown – primary tooth | $50 |
| D2950 | Core buildup, including any pins | $50 |
| D2951 | Pin retention – per tooth, in addition to restoration | $15 |
| D2952* | Cast post and core in addition to crown | $95 |
| D2953* | Each additional cast post – same tooth | $100 |
| D2954 | Prefabricated post and core in addition to crown | $85 |
| D2955 | Post removal (not in conjunction with endodontic therapy) | $10 |
| D2957 | Each additional prefabricated post – same tooth, base metal post | $35 |
| D2960 | Labial veneer (resin laminate) – chairside | $250 |
| D2961* | Labial veneer (resin laminate) – laboratory | $300 |
| D2962* | Labial veneer (porcelain laminate) – laboratory | $350 |
| D2971 | Additional procedure – new crown existing partial denture | $50 |
| D2980 | Crown repair, necessitated by restorative material failure | no charge |
| D2981 | Inlay repair, necessitated by restorative material failure | no charge |
| D2982 | Onlay repair, necessitated by restorative material failure | no charge |
| D2983 | Veneer repair, necessitated by restorative material failure | no charge |
| D6940 | Stress breaker | $150 |
| D6950 | Precision attachment, separate from prosthesis | $195 |
| **Prosthodontics – fixed** (replacement limited to every five years, adjustments once per year) | | **Member cost** |
| D6210* | Pontic – cast high noble metal | $270 |
| D6211 | Pontic – cast predominantly base metal | $270 |
| D6212* | Pontic – cast noble metal | $270 |
| D6240* | Pontic – porcelain fused to high noble metal | $270 |
| D6241 | Pontic – porcelain fused to predominantly base metal | $270 |
| D6242* | Pontic – porcelain fused to noble metal | $270 |
| D6750* | Crown – porcelain fused to high noble metal | $270 |
| D6751 | Crown – porcelain fused to predominantly base metal | $270 |
| D6752* | Crown – porcelain fused to noble metal | $270 |
| D6790* | Retainer crown – full cast high noble metal | $270 |
| D6791 | Retainer crown – full cast predominantly base metal | $270 |
| D6792* | Retainer crown – full cast noble metal | $270 |
| D6794* | Retainer crown – titanium | $270 |
| D6930 | Re-cement or re-bond fixed partial denture (per unit) | $15 |
| **Prosthodontics** (replacement limited to every five years) | | **Member cost** |
| D5110* | Complete denture – maxillary | $375 |
| D5120* | Complete denture – mandibular | $375 |
| D5130* | Immediate denture – maxillary | $375 |
| D5140* | Immediate denture – mandibular | $375 |
| D5211* | Maxillary partial denture-resin base (including retentive/clasping materials, rests and teeth) | $400 |
| D5212* | Mandibular partial denture-resin base (including retentive/clasping materials, rests and teeth) | $400 |
| D5213* | Maxillary partial denture – cast metal framework, resin denture bases (including any conventional clasps, rests and teeth) | $425 |
| D5214* | Mandibular partial denture – cast metal framework, resin denture bases (including any conventional clasps, rests and teeth) | $425 |

| **Prosthodontics** (cont.) | | **Member cost** |
|---|---|---|
| D5221 | Immediate maxillary partial denture-resin base (including any conventional clasps, rests and teeth) | $263 |
| D5222 | Immediate mandibular partial denture-resin base (including any conventional clasps, rests and teeth) | $263 |
| D5223 | Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $413 |
| D5224 | Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $413 |
| D5225* | Maxillary partial denture – flexible (including clasps, rests and teeth | $425 |
| D5226* | Mandibular partial denture – flexible (including clasps, rests and teeth) | $425 |
| D5282* | Removable unilateral partial denture – one piece metal (including clasps and teeth), maxillary | $350 |
| D5283* | Removable unilateral partial denture – one piece metal (including clasps and teeth), mandibular | $350 |
| D5410 | Adjust complete denture – maxillary | $15 |
| D5411 | Adjust complete denture – mandibular | $15 |
| D5421 | Adjust partial denture – maxillary | $15 |
| D5422 | Adjust partial denture – mandibular | $15 |
| D5660* | Add clasp to existing partial denture – per tooth | $90 |
| **Endodontics** (each procedure limited to once per tooth per life) | | **Member cost** |
| D3110 | Pulp cap – direct (excluding final restoration) | $15 |
| D3120 | Pulp cap – indirect (excluding final restoration) | $10 |
| D3220 | Therapeutic pulpotomy (excluding final restoration) | $40 |
| D3221 | Pulpal debridement, primary and permanent teeth (not to be used when root canal is done on the same day) | $85 |
| D3230 | Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) | $45 |
| D3240 | Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) | $50 |
| D3310 | Root canal therapy – anterior tooth (excluding final restoration) | $110 |
| D3320 | Endodontic therapy, premolar tooth (excluding final restorations) | $195 |
| D3330 | Endodontic therapy, molar tooth (excluding final restorations) | $250 |
| D3331 | Treatment of root canal obstruction – non-surgical access | $80 |
| D3332 | Incomplete endodontic therapy – inoperable or fractured tooth | $80 |
| D3333 | Internal root repair of perforation defects | $90 |
| D3351 | Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.) | $90 |
| D3352 | Apexification/recalcification – interim medication replacement (includes any necessary radiographs) | $80 |
| D3353 | Apexification/recalcification – final visit (includes any necessary radiographs) | $90 |
| D3410 | Apicoectomy – anterior | $135 |
| D3421 | Apicoectomy – premolar (first root) | $120 |
| D3425 | Apicoectomy – molar (first root) | $120 |
| D3426 | Apicoectomy – (each additional root) | $60 |
| D3430 | Retrograde filling – per root | $40 |
| D3450 | Root amputation – per root (not covered in conjunction with procedure D3920 | $95 |
| D3910 | Surgical procedure to isolate tooth with rubbed dam | $20 |
| D3920 | Hemisection not included in root canal therapy | $90 |
| D3950 | Canal preparation and fitting of preformed dowel or post | $15 |

| Periodontics – gum treatment | | Member cost |
|---|---|---|
| D4210 | Gingivectomy/gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant | $120 |
| D4211 | Gingivectomy/gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant | $55 |
| D4240 | Gingival flap, including root planing – four or more teeth, per quadrant | $150 |
| D4241 | Gingival flap, including root planing – one to three teeth, per quadrant | $120 |
| D4245 | Apically positioned flap | $175 |
| D4249 | Clinical crown lengthening – hard tissue | $150 |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant | $350 |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) one to three contiguous teeth or tooth bounded spaces per quadrant | $325 |
| D4263 | Bone replacement graft – retained natural tooth – first site in quadrant | $180 |
| D4264 | Bone replacement graft – retained natural tooth – each additional site in quadrant | $95 |
| D4265 | Biological materials which can aid soft and osseous tissue regeneration | $95 |
| D4266 | Guided tissue regeneration – resorbable barrier, per site | $230 |
| D4267 | Guided tissue regeneration – non resorbable barrier, per site (includes membrane removal) | $275 |
| D4270 | Pedicle soft tissue graft procedure | $260 |
| D4273 | Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft | $350 |
| D4274 | Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) | $90 |
| D4275 | Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft | $380 |
| D4277 | Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft | $265 |
| D4278 | Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site | $130 |
| D4283 | Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site | $210 |
| D4285 | Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site | $228 |
| D4320 | Provisional splinting – intracoronal | $95 |
| D4321 | Provisional splinting – extracoronal | $85 |
| D4341 | Periodontal scaling and root planing – four or more teeth per quadrant (limited to a maximum of four (4) quadrants will be paid in any combination per 24 calendar months) | $55 |
| D4342 | Periodontal scaling and root planing one to three teeth per quadrant (a maximum of four quadrants will be paid in any combinations, per 24 calendar months) | $50 |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (this service will reduce the number of cleanings available under D1110 and/or D1120) | $55 |
| D4355 | Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit (once per five years) | $50 |
| D4381 | Localized delivery of chemotherapeutic agents (per tooth) (limited to once per tooth per 12 months to a maximum of three tooth sites per quadrant, and performed no less than three months following active periodontal therapy) | $60 |
| D4910 | Periodontal maintenance (covered only after active periodontal therapy) | $45 |

| Repairs to prosthetics | | Member cost |
|---|---|---|
| D5511* | Repair broken complete denture base, mandibular | $35 |
| D5512* | Repair broken complete denture base, maxillary | $35 |
| D5520* | Replace missing or broken teeth – complete denture (each tooth) | $35 |
| D5611* | Repair resin partial denture base, mandibular | $35 |
| D5612* | Repair resin partial denture base, maxillary | $35 |
| D5621* | Repair cast partial framework, mandibular | $35 |
| D5622* | Repair cast partial framework, maxillary | $35 |
| D5630* | Repair or replace broken retentive clasping materials – per tooth | $35 |
| D5640* | Replace broken teeth – per tooth | $35 |
| D5650* | Add tooth to existing partial denture | $35 |
| D5670* | Replace all teeth and acrylic on cast metal framework – maxillary | $210 |
| D5671* | Replace all teeth and acrylic on cast metal framework – mandibular | $225 |
| D5710* | Rebase complete maxillary denture | $200 |
| D5711* | Rebase complete mandibular denture | $200 |
| D5720* | Rebase maxillary partial denture | $200 |
| D5721* | Rebase mandibular partial denture | $200 |
| D5730 | Reline complete maxillary denture (chairside) | $60 |
| D5731 | Reline complete mandibular denture (chairside) | $60 |
| D5740 | Reline maxillary partial denture (chairside) | $60 |
| D5741 | Reline mandibular partial denture (chairside) | $60 |
| D5750* | Reline complete maxillary denture (laboratory) | $95 |
| D5751* | Reline complete mandibular denture (laboratory) | $95 |
| D5760* | Reline maxillary partial denture (laboratory) | $95 |
| D5761* | Reline mandibular partial denture (laboratory) | $95 |
| D5810* | Interim complete denture (maxillary) | $250 |
| D5811* | Interim complete denture (mandibular) | $250 |
| D5820* | Interim partial denture (maxillary) | $80 |
| D5821* | Interim partial denture (mandibular) | $80 |
| D5850 | Tissue conditioning, maxillary | $30 |
| D5851 | Tissue conditioning, mandibular | $30 |
| D6214* | Pontic titanium | $270 |
| D6245* | Pontic – porcelain/ceramic | $270 |
| D6250* | Pontic – resin with high noble metal | $270 |
| D6251 | Pontic – resin with predominantly base metal | $270 |
| D6252* | Pontic – resin with noble metal | $270 |
| D6253* | Provisional pontic | no charge |
| D6545* | Retainer – cast metal, resin bonded fixed prosthesis | $250 |
| D6548* | Retainer – porcelain/ceramic, resin bonded fixed prosthesis | $250 |
| D6549* | Resin retainer – for resin bonded fixed prosthesis | $250 |
| D6600* | Retainer inlay – porcelain/ceramic, two surfaces | $270 |
| D6601* | Retainer inlay – porcelain/ceramic, three or more surfaces | $270 |
| D6602* | Retainer inlay – cast high noble metal, two surfaces | $270 |
| D6603* | Retainer inlay – cast high noble metal, three or more surfaces | $270 |
| D6604* | Retainer inlay – cast predominantly base metal, two surfaces | $270 |
| D6605* | Retainer inlay – cast predominantly base metal, three or more surfaces | $270 |

| Repairs to prosthetics (cont.) | | Member cost |
|---|---|---|
| D6606* | Retainer inlay – cast noble metal, two surfaces | $270 |
| D6607* | Retainer inlay – cast noble metal, three or more surfaces | $270 |
| D6608* | Retainer onlay – porcelain/ceramic, two surfaces | $270 |
| D6609* | Retainer onlay – porcelain/ceramic, three or more surfaces | $270 |
| D6610* | Retainer onlay – cast high noble metal, two surfaces | $270 |
| D6611* | Retainer onlay – cast high noble metal, three or more surfaces | $270 |
| D6612 | Retainer onlay – cast predominantly base metal, two surfaces | $270 |
| D6613 | Retainer onlay – cast predominantly base metal, three or more surfaces | $270 |
| D6614* | Retainer onlay – cast noble metal, two surfaces | $270 |
| D6615* | Retainer onlay – cast noble metal, three or more surfaces | $270 |
| D6624* | Retainer inlay titanium | $270 |
| D6634* | Retainer onlay titanium | $270 |
| D6710* | Retainer crown – indirect resin based composition | $270 |
| D6720* | Retainer crown – resin with high noble metal | $270 |
| D6721 | Retainer crown – resin with predominantly base metal | $270 |
| D6722* | Retainer crown – resin with noble metal | $270 |
| D6740* | Retainer crown – porcelain/ceramic | $280 |
| D6780* | Retainer crown – 3/4 cast high noble metal | $270 |
| D6781 | Retainer crown – 3/4 cast predominantly base metal | $270 |
| D6782* | Retainer crown – 3/4 cast noble metal | $270 |
| D6783* | Retainer crown – 3/4 porcelain ceramic, denture | $270 |
| **Extractions/oral and maxillofacial surgery** | | **Member cost** |
| D7111 | Extraction, coronal remnants – primary tooth | no charge |
| D7140 | Removal of impacted tooth – completely bony | no charge |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | $40 |
| D7220 | Removal of impacted tooth – soft tissue | $55 |
| D7230 | Removal of impacted tooth – partially bony | $70 |
| D7240 | Removal of impacted tooth – completely bony | $85 |
| D7241 | Removal of impacted tooth – completely bony, unusual complications by report | $110 |
| D7250 | Surgical removal of residual tooth roots | $40 |
| D7260 | Oroantral fistula closure | $350 |
| D7261 | Primary closure of a sinus perforation | $225 |
| D7270 | Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth | $55 |
| D7280 | Exposure of an unerupted tooth (excluding wisdom teeth) | $100 |
| D7282 | Mobilization of erupted or malposed tooth to aid eruption | $90 |
| D7285 | Incisional biopsy of oral tissue – hard bone, tooth) | $350 |
| D7286 | Incisional biopsy of oral tissue – soft (all others) | $120 |
| D7287 | Exfoliative cytological sample collection | $50 |
| D7288 | Brush biopsy – transepithelial sample collection | $55 |
| D7310 | Alveoloplasty in conjunction with extractions – per quadrant | $40 |
| D7311 | Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | $15 |
| D7320 | Alveoloplasty not in conjunction with extractions – per quadrant | $75 |
| D7321 | Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | $30 |
| D7450 | Removal of benign odontogenic cyst or tumor – up to 1.25 cm | $160 |

| Extractions/oral and maxillofacial surgery (cont.) | | Member cost |
|---|---|---|
| D7451 | Removal of benign odontogenic cyst or tumor – greater than 1.25 cm | $235 |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | $90 |
| D7472 | Removal of torus palatinus | $65 |
| D7473 | Removal of torus mandibularis | $65 |
| D7485 | Reduction of osseous tuberosity | $60 |
| D7510 | Incision and drainage of abscess – intraoral soft tissue | $35 |
| D7970 | Excision hyperplastic tissue – per arch | $85 |
| D7971 | Excision of pericoronal gingival | $55 |
| **Adjunctive general service** | | **Member cost** |
| D9110 | Palliative (emergency) treatment of dental pain – minor procedure | $20 |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | no charge |
| D9222 | Deep sedation/general anesthesia – first 15 minutes | $83 |
| D9223 | Deep sedation/general anesthesia – each subsequent 15 minute increment | $71 |
| D9230 | Inhalation of nitrous oxide analgesia, anxiolysis | $15 |
| D9239 | Intravenous moderate (conscious) sedation/analgesia – first 15 minutes | $83 |
| D9243 | Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment | $71 |
| D9450 | Case presentation, detailed and extensive treatment planning | no charge |
| D9951 | Occlusal adjustment – limited | $35 |
| D9952 | Occlusal adjustment – complete | $165 |
| **Bleaching** | | **Member cost** |
| D9972 | External bleaching in office – per arch | $175 |
| D9975 | External bleaching in home – per arch | $175 |
| **Orthodontics** | | **Member cost** |
| **NOTE:** Members may receive up to a 25% discount by visiting a participating orthodontist. | | |

**NOTE:**

- No service of any dentist other than a participating general dentist or participating specialist will be covered except out-of-area emergency care as provided in the certificate of benefits.
- No coverage for any dental treatment started prior to the member's effective date.
- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availability of services.
- Unlisted procedures may be eligible for up to a 25% discount. Members may contact their participating provider to determine if any discounts apply.
- When crown and/or bridgework exceeds six units in the same treatment plan, the patient may be charged an additional $75 per unit.
- Some covered services are typically only offered by a specialist (like many oral surgery procedures).
- Additional exclusions and limitations are listed along with full plan information in your certificate of benefits.

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# Schedule B Indemnity Plan
# People First Plan Code #4084

## Schedule of benefits

| Benefit | Calendar year deductible | Calendar year maximum | Waiting period |
|---|---|---|---|
| Type I, II, III | $0 individual<br>$0 family (3 per family) | $1,000 per covered person | None |

| ADA Code | Procedure | Maximum Reimbursement |
|---|---|---|
| **TYPE I – Preventive Dental Services** | | |
| D0120 | Periodic oral examination – established patient | $23 |
| D0140 | Limited oral evaluation – problem focused[1] | $31 |
| D0145 | Oral evaluation for a patient under 3 years of age and counseling with primary caregiver[1] | $31 |
| D0150 | Comprehensive oral evaluation – new or established patient[1] | $31 |
| D0180 | Comprehensive periodontal evaluation – new or established patient[1] | $31 |
| D0210 | X-ray intraoral – complete series of radiographic images (once per three year period) | $61 |
| D0220 | X-ray intraoral – periapical, first radiographic image | $13 |
| D0230 | Extra-oral – 2D projection radiographic image created using a stationary radiation source and detector | $13 |
| D0240 | X-rays intraoral – occlusal radiographic image | $16 |
| D0250 | Extra-oral – 2D projection radiographic image created using a stationary radiation source and detector | $22 |
| D0251 | Extra-oral posterior dental radiographic image[1] | $32 |
| D0270 | X-ray bitewing – single radiographic image[1] | $20 |
| D0272 | X-ray bitewings – two radiographic images[1] | $25 |
| D0273 | Bitewings – three radiographic images[1] | $32 |
| D0274 | Bitewings – four radiographic images[1] | $32 |
| D0330 | Panoramic radiographic image (covered once per three year period) | $47 |
| D0415 | Collection of microorganisms for culture & sensitivity | $36 |
| D1110 | Prophylaxis – adult[1] | $38 |
| D1120 | Prophylaxis – child[1] | $36 |
| D1206 | Topical application of fluoride varnis (covered twice per 12 consecutive months for a dependent child under 16) | $31 |
| D1208 | Topical application of fluoride – excluding varnish (covered twice per 12 consecutive months for a dependent child under 16) | $31 |
| D1351 | Sealant – per tooth (Covered once per 12 consecutive months for a dependent child under age 13) | $13 |
| D1510 | Space maintainer – fixed, unilateral | $160 |
| D1515 | Space maintainer – fixed, bilateral | $216 |
| D1520 | Space maintainer – removable, unilateral | $202 |
| D1525 | Space maintainer – removable, bilateral | $220 |
| D1550 | Re-cement or re-bond space maintainer | $27 |
| D7285 | Incisional biopsy of oral tissue – hard (bone, tooth) | $90 |
| D7286 | Incisional biopsy of oral tissue – soft | $61 |
| D9110 | Palliative (emergency) treatment of dental pain – minor procedure | $29 |

| ADA Code | Procedure | Maximum Reimbursement |
|---|---|---|
| **TYPE II – Basic Dental Services** | | |
| D2140 | Amalgam – one surface, primary or permanent[2] | $19 |
| D2150 | Amalgam – two surfaces, primary or permanent[2] | $29 |
| D2160 | Amalgam – three surfaces, primary or permanent[2] | $36 |
| D2161 | Amalgam – four or more surfaces, primary or permanent[2] | $46 |
| D2330 | Resin based composite – one surface, anterior[3] | $24 |
| D2331 | Resin based composite – two surfaces, anterior[3] | $36 |
| D2332 | Resin based composite – three surfaces, anterior[3] | $49 |
| D2335 | Resin based composite – four or more surfaces or involving incisal angle (anterior)[3] | $46 |
| D2391 | Resin based composite – one surface, posterior[3] | $19 |
| D2392 | Resin based composite – two surfaces, posterior[3] | $29 |
| D2393 | Resin based composite – three surfaces, posterior[3] | $36 |
| D2394 | Resin based composite – four or more surfaces, posterior[3] | $36 |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | $19 |
| D2920 | Re-cement or re-bond crown | $19 |
| D2940 | Protective restoration (Covered as separate procedure if no other service, except X-rays, rendered during the visit) | $20 |
| D2950 | Core buildup, including any pins when required | $58 |
| D2951 | Pin retention – per tooth, in addition to restoration | $27 |
| D3220 | Therapeutic pulpotomy (excluding final restoration) | $33 |
| D3222 | Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development | $33 |
| D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | $259 |
| D3320 | Endodontic therapy, premolar tooth (excluding final restorations) | $317 |
| D3330 | Endodontic therapy, molar tooth (excluding final restorations) | $389 |
| D3351 | Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) | $73 |
| D3352 | Apexification/recalcification – interim medication replacement (includes any necessary radiographs) | $73 |
| D3353 | Apexification/recalcification – final visit (includes any necessary radiographs) | $73 |
| D3410 | Apicoectomy – anterior | $114 |
| D3421 | Apicoectomy – premolar (first root) | $114 |
| D3425 | Apicoectomy – molar (first root) | $114 |
| D3426 | Apicoectomy (each additional root) | $114 |
| D3430 | Retrograde filling – per root | $42 |
| D3450 | Root amputation – per root (not covered in conjunction with procedure D3920) | $62 |
| D3920 | Hemisection (including any root removal), not including root canal therapy | $62 |
| D4210 | Gingivectomy/gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)[4] | $82 |
| D4211 | Gingivectomy/gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant (Covered once per 12 consecutive months)[4] | $22 |
| D4240 | Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces, per quadrant (Covered once per 12 consecutive months)[4] | $92 |
| D4241 | Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces, per quadrant (covered once per 12 consecutive months)[4] | $92 |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant (covered once per 12 consecutive months) | $153 |

| ADA Code | Procedure | Maximum Reimbursement |
|---|---|---|
| **TYPE II – Basic Dental Services** (cont.) | | |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant (covered once per 12 consecutive months) | $153 |
| D4270 | Pedicle soft tissue graft procedure (Covered once per 12 consecutive months) | $92 |
| D4277 | Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft (covered once per 12 consecutive months) | $102 |
| D4278 | Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site (covered once per 12 consecutive months) | $102 |
| D4320 | Provisional splinting – intracoronal | $29 |
| D4321 | Provisional splinting – extracoronal | $29 |
| D4341 | Periodontal scaling and root planing – four or more teeth per quadrant[5] | $23 |
| D4342 | Periodontal scaling and root planing – one to three teeth per quadrant[5] | $23 |
| D4355 | Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit[5] | $49 |
| D4910 | Periodontal maintenance (covered only after active periodontal therapy)[5] | $32 |
| D5511 | Repair broken complete denture base, mandibular[6] | $42 |
| D5512 | Repair broken complete denture base, maxillary[6] | $42 |
| D5520 | Replace missing or broken teeth – complete denture (each tooth)[6] | $42 |
| D5611 | Repair resin partial denture base, mandibular[6] | $42 |
| D5612 | Repair resin partial denture base, maxillary[6] | $42 |
| D5621 | Repair cast partial framework, mandibular[6] | $42 |
| D5622 | Repair cast partial framework, maxillary[6] | $42 |
| D5630 | Repair or replace broken clasp – per tooth[6] | $49 |
| D5640 | Replace broken teeth – per tooth[6] | $30 |
| D5650 | Add tooth to existing partial denture[6] | $58 |
| D5660 | Add clasp to existing partial denture – per tooth[6] | $62 |
| D5710 | Rebase complete maxillary denture[6] | $122 |
| D5711 | Rebase complete mandibular denture[6] | $122 |
| D5720 | Rebase maxillary partial denture[6] | $122 |
| D5721 | Rebase mandibular partial denture[6] | $122 |
| D6930 | Re-cement or re-bond fixed partial denture (per unit) | $26 |
| D7111 | Extraction, coronal remnants – primary tooth | $23 |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | $23 |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | $42 |
| D7220 | Removal of impacted tooth – soft tissue | $58 |
| D7230 | Removal of impacted tooth – partially bony | $73 |
| D7240 | Removal of impacted tooth – completely bony | $98 |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | $46 |
| D7270 | Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth | $76 |
| D7272 | Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization) | $82 |
| D7310 | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | $35 |

| ADA Code | Procedure | Maximum Reimbursement |
|---|---|---|
| **TYPE II – Basic Dental Services** (cont.) | | |
| D7311 | Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | $35 |
| D7320 | Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | $40 |
| D7321 | Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | $40 |
| D7340 | Vestibuloplasty – ridge extension (second epithelialization) | $62 |
| D7350 | Vestibuloplasty – ridge extension (second epithelialization) | $122 |
| D7510 | Incision and drainage of abscess – intraoral soft tissue | $36 |
| D7520 | Incision and drainage of abscess – extraoral soft tissue | $55 |
| D7960 | Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure | $53 |
| D7970 | Excision hyperplastic tissue – per arch | $62 |
| D9222 | Deep sedation/general anesthesia – first 15 minute[7] | $54 |
| D9223 | Deep sedation/general anesthesia – each subsequent 15 minute increment[7] | $49 |
| D9610 | Therapeutic parenteral drug, single administration | $19 |
| D9951 | Occlusal adjustment – limited[8] | $23 |
| D9952 | Occlusal adjustment – complete[8] | $59 |
| **TYPE III – Major Dental Services** | | |
| D0470 | Diagnostic casts | $24 |
| D2510 | Inlay – metallic, one surface | $92 |
| D2520 | Inlay – metallic, two surfaces | $127 |
| D2530 | Inlay – metallic, three or more surfaces | $137 |
| D2610 | Inlay – porcelain/ceramic, one surface | $42 |
| D2620 | Inlay – porcelain/ceramic, two surfaces | $84 |
| D2630 | Inlay – porcelain/ceramic, three or more surfaces | $125 |
| D2710 | Crown – resin based composite, indirect | $82 |
| D2720 | Crown – resin with high noble metal | $157 |
| D2721 | Crown – resin with predominantly base metal | $137 |
| D2722 | Crown – resin with noble metal | $143 |
| D2740 | Crown – porcelain/ceramic | $153 |
| D2750 | Crown – porcelain fused to high noble metal | $288 |
| D2751 | Crown – porcelain fused to predominantly base metal | $147 |
| D2752 | Crown – porcelain fused to noble metal | $153 |
| D2790 | Crown – full cast high noble metal | $281 |
| D2791 | Crown – full cast predominantly base metal | $132 |
| D2792 | Crown – full cast noble metal | $143 |
| D2930 | Prefabricated stainless steel crown – primary tooth | $35 |
| D2931 | Prefabricated stainless steel crown – permanent tooth | $35 |
| D2952 | Post and core in addition to crown, indirectly fabricated | $58 |
| D2954 | Prefabricated post and core in addition to crown | $42 |
| D5110 | Complete denture – maxillary | $207 |
| D5120 | Complete denture – mandibular | $207 |
| D5130 | Immediate denture – maxillary | $217 |
| D5140 | Immediate denture – mandibular | $217 |

| ADA Code | Procedure | Maximum Reimbursement |
|---|---|---|
| **TYPE III – Major Dental Services** (cont.) | | |
| D5211 | Maxillary partial denture – resin base (including any conventional clasps, rests and teeth) | $127 |
| D5212 | Mandibular partial denture – resin base (including any conventional clasps, rests and teeth) | $127 |
| D5213 | Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $233 |
| D5214 | Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $215 |
| D5221 | Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth) | $127 |
| D5222 | Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth) | $127 |
| D5223 | Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $233 |
| D5224 | Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | $215 |
| D5281 | Removable unilateral partial denture – one piece cast metal (including clasps and teeth) | $46 |
| D5410 | Adjust complete denture – maxillary[9] | $13 |
| D5411 | Adjust complete denture – mandibular[9] | $13 |
| D5421 | Adjust partial denture – maxillary[9] | $13 |
| D5422 | Adjust partial denture – mandibular[9] | $13 |
| D5730 | Reline complete maxillary denture (chairside)[10] | $52 |
| D5731 | Reline complete mandibular denture (chairside)[10] | $52 |
| D5740 | Reline maxillary partial denture (chairside)[10] | $42 |
| D5741 | Reline mandibular partial denture (chairside)[10] | $42 |
| D5750 | Reline complete maxillary denture (laboratory)[10] | $76 |
| D5751 | Reline complete mandibular denture (laboratory)[10] | $76 |
| D5760 | Reline maxillary partial denture (laboratory)[10] | $66 |
| D5761 | Reline mandibular partial denture (laboratory)[10] | $66 |
| D6210 | Pontic – cast high noble metal | $281 |
| D6211 | Pontic – cast predominantly base metal | $132 |
| D6212 | Pontic – cast noble metal | $143 |
| D6240 | Pontic – porcelain fused to high noble metal | $288 |
| D6241 | Pontic – porcelain fused to predominantly base metal | $147 |
| D6242 | Pontic – porcelain fused to noble metal | $153 |
| D6250 | Pontic – resin with high noble metal | $157 |
| D6251 | Pontic – resin with predominantly base metal | $137 |
| D6252 | Pontic – resin with noble metal | $143 |
| D6602 | Retainer inlay – cast high noble metal, two surfaces[11] | $127 |
| D6603 | Retainer inlay – cast high noble metal, three or more surfaces[11] | $137 |
| D6604 | Retainer inlay – cast predominantly base metal, two surfaces[11] | $127 |
| D6605 | Retainer inlay – cast predominantly base metal, three or more surfaces[11] | $137 |
| D6606 | Retainer inlay – cast noble metal, two surfaces[11] | $127 |
| D6607 | Retainer inlay – cast noble metal, three or more surfaces[11] | $137 |
| D6720 | Retainer crown – resin with high noble metal[11] | $157 |
| D6721 | Retainer crown – resin with predominantly base metal[11] | $137 |
| D6722 | Retainer crown – resin with noble metal[11] | $143 |
| D6750 | Retainer crown – porcelain fused to high noble metal[11] | $288 |

| ADA Code | Procedure | Maximum Reimbursement |
|---|---|---|
| **TYPE III – Major Dental Services** (cont.) | | |
| D6751 | Retainer crown – porcelain fused to predominantly base metal[11] | $147 |
| D6752 | Retainer crown – porcelain fused to noble metal[11] | $153 |
| D6780 | Retainer crown – 3/4 cast high noble metal[11] | $147 |
| D6790 | Retainer crown – full cast high noble metal[11] | $281 |
| D6791 | Retainer crown – full cast predominantly base metal[11] | $137 |
| D6792 | Retainer crown – full cast noble metal[11] | $143 |

[1]Covered twice per 12 consecutive months.

[2]Multiple restorations on one surface will be covered as a single filling.

[3]Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be deemed single surface restorations.

[4]Only one of these procedures is covered per area of the mouth.

[5]Covered twice per area of the mouth per 12 consecutive months.

[6]Covered only if repairs/adjustments more than 1 year after the initial insertion.

[7]Covered as a separate procedure only when required for covered complex oral surgical procedures as determined by the company.

[8]Covered only when performed with periodontal surgery or nonsurgical TMJ dysfunction treatment.

[9]Covered only once per 12 consecutive months and only if done more than one year after the initial insertion of the denture.

[10]Covered only if relining is done more than 1 year after the initial insertion and then not more than once per 2-year period.

[11]Bridge retainers – initial placement of replacement

**PROCEDURES NOT LISTED ON THE SCHEDULE MAY BE CHARGED AT THE DENTIST'S USUAL AND CUSTOMARY FEE.**

## Limitations and exclusions

### Major restorative limitations:

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

- A denture, partial denture or fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy. However, this provision will not apply if the Policy replaces a prior policy You had with another insurer and You are covered by this Policy on its Effective Date without a break in coverage provided: a) the prosthetic replaces teeth that were extracted while insured under the prior policy; and b) the prosthetic work is completed within 12 months of the extraction;
- The replacement of a partial denture, full denture, fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
- The replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
- The replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
- The replacement of teeth up to the normal complement of 32.

### Exclusions:

Benefits will not be paid for:

- Procedures that are not included in the Schedule of Benefits; that are not medically necessary; that do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
- Any procedure, service or supply that may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by Company;
- Crowns, inlays, cast restorations or other laboratory prepared restorations on teeth that may be restored with an amalgam or composite resin filling;
- Appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting
- Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration or bite analysis.
- Pulp caps, adult fluoride treatments, athletic mouthguards; myofunctional therapy; infection control; precision or semi precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by third party; personal supplies (e.g., water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- Procedures performed by a Dentist who is a member of Your immediate family;
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- Charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
- Any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
- Charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment that is performed outside of the United States are limited to a maximum of $100 (U.S. dollars) per year;
- The care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
- Treatment for cosmetic purposes–facings on crowns or bridge units on molar teeth will always be considered cosmetic;
- Any services or supplies that do not meet the standards set by the American Dental Association or that are not reasonably necessary, or customarily used, for dental care;
- Procedures that are a covered expense under any other medical plan (established by the employer) that provides group hospital, surgical or medical benefits whether or not on an insured basis;
- An injury that arises out of or in the course of a job or employment for pay or profit for which benefits are available under any workers' compensation act or similar law; or
- Charges to the extent that they are more than the Reimbursement Rate. If the amount of the Reimbursement Rate for a service cannot be determined due to the unusual nature of the service, Company will determine the amount. Company will take into account: (a) the complexity involved; the degree of professional skill required; and (c) other pertinent factors.

# Important!

## At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
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## Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。
**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.
**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
**فارسی (Farsi)**

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Humana®


Insured or administered by Humana Insurance Company, or offered by CompBenefits Company.
FLHHB32HH 0820

STATE OF FLORIDA & UNIVERSITY EMPLOYEES

# HOW TO APPLY

1. Enroll during Open Enrollment or as a New Employee (within the first 60 days of employment). Contact the People First Service Center, toll-free 866.663.4735, or access their web site at https://peoplefirst.myflorida.com to make your election.

   ***Your enrollment is not complete until you have notified People First.*

2. Contact your local Capital Representative with any questions and for enrollment assistance.

**Enroll Now**

For more information on how to enroll, please contact the Group Benefits Dept. by phone at 800.780.3100 or email at groupdepartment@capitalins.com.

# Humana Vision

## State of Florida Employees

### Vision Care Plan

Humana®

Department of MANAGEMENT SERVICES
Division of State Group Insurance

FLHHMLGEN 0720

# We make it easy for you

Humana Vision VCP options have you covered and can make eye care more affordable. Select a plan that covers an eye exam, eyeglasses or contact lenses.

**At home or on the road, you'll find a provider with convenient hours and locations. With Humana Vision, you can:**

- Call the Customer Care center seven days a week at **1-800-939-5369**, 7:30 a.m. – 11 p.m. Eastern time, Monday – Saturday, and 11 a.m. – 8 p.m. Sunday, Eastern time
- View benefits, check eligibility and use other automated services at **HumanaVisionCare.com/custom/fl**
- Locate providers through **HumanaVisionCare.com/custom/fl**, Customer Care or our automated information line

**National network provides real savings**

You have access to one of the largest vision networks in the United States, with more than 108,000 access points with independent optometrists and ophthalmologists and national retail locations—and every one accepts new patients. You will be able to use your benefits at some of the top names in eye care, including LensCrafters®, Pearle Vision® and Target Optical® in addition to the many independent optometrists and ophthalmologists. Plus, you save on frames. You pay the wholesale price, avoiding high retail markups. And the cost of frames is the same at any provider location.

**A vision plan is one of the top five most desired benefits, after medical insurance, by employees.[1]**

[1]LIMRA International

PRIVATE PRACTITIONERS | LENSCRAFTERS | PEARLE VISION | OPTICAL

# Vision health impacts overall health

Eye health exams are an important part of routine preventive healthcare. Because many eye and vision conditions have no obvious symptoms, you may be unaware of problems. Early diagnosis and treatment are important for maintaining good vision and preventing permanent vision loss.[1]

Vision care is essential to maintaining a healthy lifestyle. Eye exams can detect symptoms of diseases such as diabetes, hypertension, multiple sclerosis, brain tumors, osteoporosis and rheumatoid arthritis.[2]

### Exceptional service

You expect exceptional service, and we deliver. You can talk to a Customer Care specialist Monday – Saturday, 7:30 a.m. – 11 p.m., and Sunday, 11 a.m. – 8 p.m., Eastern time. Our specialists resolve more than 95% of member inquiries during the first call.

### How the Vision Care Plan works

1. After signing up for the Vision Care Plan, you'll receive an ID card in the mail.
2. Prior to scheduling your appointment, select a participating provider through the Customer Care center, automated information line or **HumanaVisionCare.com/custom/fl**.
3. Schedule an appointment, providing your name, patient's name and employer.
4. Sign your provider's Vision Care Plan form after your exam. You'll pay any copays and/or costs of any upgrades at that time.

### Affordable frames

Benefits include a wholesale frame allowance. If the wholesale cost exceeds the frame allowance, employees pay twice the wholesale difference. They never pay full retail.

| Retail price* | Wholesale price | Wholesale allowance | Member cost | Savings |
|---|---|---|---|---|
| $150–$225 | $75 | $75 | $0 | $150–$225 |
| $200–$300 | $100 | $75 | $50 ($100–$75=$25x2=$50) | $150–$250 |

*Retail costs may differ and are based on two to three times the wholesale cost. Actual savings may vary.

[1]American Optometric Association
[2]Thompson Media Inc.

| **Vision Care Plan** (including exam and materials) | | |
|---|---|---|
| | **See a participating provider** | **See a nonparticipating provider** |
| Exam with dilation as necessary[1] | 100% after $10 copay | $40 allowance |
| **Lenses** | | |
| Single | 100% after $10 copay | $40 allowance |
| Bifocal | 100% after $10 copay | $60 allowance |
| Trifocal | 100% after $10 copay | $80 allowance |
| **Frames** | $75 wholesale allowance | $60 retail allowance |
| **Contact lenses**[2] | | |
| Elective (conventional and disposable)[3] | $150 allowance | $75 allowance |
| Medically necessary (limit one pair)[4] | 100% | $100 allowance |
| **Frequency** (based on date of service) | | |
| Examination | Once every 12 months | |
| Lenses or contact lenses | Once every 12 months | |
| Frame | Once every 24 months | |

| **Monthly member rates** (People First Benefit Plan Code: 3004) | |
|---|---|
| Employee only | $6.96 |
| Employee and spouse | $13.74 |
| Employee and child(ren) | $13.60 |
| Employee and family | $21.36 |

### Additional plan discounts through participating providers

- Members receive additional fixed copayments on lens options including progressive lens and polarized styles.
- Members also receive a 20% retail discount on a second pair of eyeglasses. This discount is available for 12 months after the covered eye exam and available through the participating provider who sold the initial pair of eyeglasses.
- After copay, standard polycarbonate available at no charge for dependents younger than 19 years old.
- Members' $25 scratch-resistant lens allowance covers factory and premium scratch-resistant coatings at no additional payment.
- Members' $50 anti-reflective lens allowance covers standard and premium anti-reflective (AR) coating products at no additional payment.

### Humana Vision Lasik discount

We have contracted with many well-known facilities and eye doctors to offer Lasik procedures at substantially reduced fees. You can take advantage of these low fees when procedures are done by network providers. Participants receive a 25% discount off the usual and customary price or 5% off advertised promotions or specials for Lasik services provided by in-network providers, whichever discount is greater. The discount includes consultations, laser procedure, follow-up visits and any additional necessary corrective procedures.

[1]Material copay is required for a complete pair of eyeglasses, lenses or frames.

[2]If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).

[3]The contact lens allowance applies to professional services (evaluation and fitting fee) and materials. Members may be eligible to receive up to a 15% discount on participating provider professional services. The discount for professional services is available for 12 months after the covered eye exam.

[4]Benefit provides coverage for professional services and one pair of medically necessary contact lenses with prior plan authorization.

**Limitations and exclusions**
The Vision Care Plan provides a complete analysis of the eyes and related structures to determine vision problems or other abnormalities once every 12 months. The plan covers any lenses needed for the patient's visual welfare as determined by the network doctor. Certain lenses such as those described in the "Limitations" are cosmetic in nature and are not necessary for the visual welfare of the patient. The extra cost of these must be borne by the patient. The plan offers a wide selection of frames every 24 months. The plan covers contact lenses every 12 months. The contact lens allowance replaces the lens and frame benefits, and plan copayments do not apply for the contact lens allowance.

**Limitations**
In no event will coverage exceed the lesser of:

1. The actual cost of covered services or materials
2. The limits of the policy, shown in the Schedule of Benefits or
3. The allowance as shown in the Schedule of Benefits. Materials covered by the policy that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits.

We will pay only for the basic cost for lenses and frames covered by the policy. The insured is responsible for extras selected, including but not limited to:

1. Blended lenses
2. Progressive multifocal lenses
3. Photochromatic lenses; tinted lenses, sunglasses, prescription and plano
4. Coating of lens or lenses
5. Laminating of lens or lenses
6. Groove, drill or notch, and roll and polish; unless otherwise specifically listed as a covered benefit in the Schedule of Benefits

**Exclusions**
We will not cover:

1. Orthopic or vision training and any associated supplemental testing
2. Two pair of glasses, in lieu of bifocals, trifocals or progressives
3. Medical or surgical treatment of the eyes
4. Any services and/or materials required by an employer as a condition of employment
5. Any injury or illness covered under any workers' compensation or similar law
6. Sub-normal vision aids, aniseikonic lenses or nonprescription lenses
7. Charges incurred after: (a) the policy ends; or (b) the insured's coverage under the policy ends, except as stated in the policy
8. Experimental or nonconventional treatment or device
9. Contact lenses, except as specifically covered by the policy
10. Hi index, aspheric and nonaspheric styles
11. Oversized 61 and above lens or lenses
12. Cosmetic items, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits

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**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
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**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
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**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
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الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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FLHHMLGEN 0720

STATE OF FLORIDA & UNIVERSITY EMPLOYEES

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