Active Staff MIP Option C Summary

Effective January 1, 2019	U.S. Network Aetna Managed Choice POS	Out-of-Network or Out of USA
General		
A plan year is a calendar year, January 1 through December 31		
Medical Deductible (per person)	$350 per plan year	
Medical Deductible (per family)	$700 per plan year	
Medical Out-of-pocket limits (Office visit co-payments and dental services do not accrue toward the out of pocket limits)		
Medical out-of-pocket limits per person	$3,000 per plan year	
Medical out-of-pocket limits per family	$6,000 per plan year	
Office visits		
Office visits for Illness or Specialist	100% after $15 co-pay	80% after deductible
Option C: Registration of a Primary Care Physician (PCP) with Aetna is required for each covered family member and referrals from the PCP are required for network care. *Self referral only for annual routine eye, mental health services, and routine Ob/GYN.*		
Routine annual physicals and defined preventive services* provided by your PCP or referred Specialist	100%	
Ob/GYN (well woman) exam – one per plan year* *No PCP referral required*	100%	
Laboratory and X-rays		
All services; (unless covered under defined preventive services above)	100% when referred by PCP	80% after deductible
Emergency room related		
Emergency Room	100% after $50 co-pay 80% after deductible if non-emergency use	
Ambulance Services	100%	
Inpatient		
Hospital costs including anesthesia	100% when referred by PCP	80% after deductible
Surgery (physician)		
Hospice		
Outpatient		
Hospital/facility costs including anesthesia	100% when referred by PCP	80% after deductible
Surgery (physician)		
Hospice		
Chemotherapy and Radiation Therapy		
Chemotherapy and Radiation Therapy: Does not include oral or injectable medications purchased through pharmacy benefit	100%, no deductible In-office/facility administration only	
Maternity		
Obstetrics: Single fee/delivery charge incl. Office visits	100%	80% after deductible
Obstetrics: Routine prenatal office visits billed separately from single fee	100%	
Infertility	100% when referred by PCP	
Infertility Lifetime Limits: Contact Insurance Administrator for details		
Mental Health and Substance Abuse		
Inpatient hospitalization for mental health or substance abuse	100% when referred by PCP	80% after deductible
Outpatient facility, including day treatment programs		
Office visits – *No PCP referral required*	100% after $15 co-pay	

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Nursing and Home Health Care		
Skilled Nursing Facility – (e.g., Rehabilitation Center) *Maximum 60 days per condition per plan year*	100% when referred by PCP	80% after deductible
Convalescent Care *Maximum 60 days per condition per plan year*		
Visiting Nurse – *Maximum 120 days per condition per plan*		
Private Duty Nursing – *Contact Insurance Administrator for authorization*		
Short Term Rehabilitation		
Physical, occupational or speech therapy. Restorative after illness or accident. 75 visits of PT, OT or ST per condition per plan year. Visits over 75 are reviewed for medical necessity	100% after $15 office co-pay when referred by PCP	80% after deductible
Physical, occupational or speech therapy For diagnosis of Developmental Delay, a maximum of 75 visits PT, OT, or ST, per year, per child.		
Chiropractor (30 visit limit per year)		
Acupuncture (30 visit limit per year)	Currently no providers	
Durable Medical Equipment		
Durable Medical Equipment: Rentals *Purchases only if approved by Insurance Administrator*	100% when referred by PCP	80% after deductible
Vision Care		
Routine eye exams, one per plan year, including refraction. *No PCP referral required*	$20 co-pay	$20 reimbursement
Frames, lenses, contacts (Allowance is available for multiple time use until the dollar amount is exhausted.)	$350 Allowance for frame, lens, lens options and contact lenses. - 20% off balance over $350 for frame, lens and lens options - 15% off balance over $350 for conventional contact lenses, plus, balance over $350 for disposable contact lenses, - 5% off balance over $350 for medically necessary contact lenses Members also receive a 40% discount off additional complete pair eyeglass purchases	Up to $250 reimbursement per person, every year
Hearing Aids		
Hearing Aids	Maximum reimbursement $4,000 per person, every five plan years	

*Defined preventive care services will be provided at 100% when an In Network physician or facility is used (and a referral is received for those in Option C). Defined preventive services are determined by gender and age and recommendations may change from time to time. Always check the most recent recommendations with your Insurance Administrator and discuss them with your doctor.

For 2020 Prescription Drug benefits, please refer to the separate pharmacy benefit grid.

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Dental Benefit Summary – Active staff

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

	Cigna Dental PPO			
Network	Total Cigna DPPO		Out-of-Network	
Calendar Year Maximum (Class I, II & III expenses)	$3,200		$3,200	
Annual Deductible Individual Family	$250 $500		$250 $500	
Reimbursement Levels	Based on Reduced Contracted Fees		80th percentile of Reasonable & Customary Allowances	
Benefits	Plan Pays	You Pay	Plan Pays	You Pay
Class I: Preventive & Diagnostic Oral Exams Routine - 2 per calendar year Routine Cleanings - 2 per calendar year Routine X-rays - Bitewings Non-Routine X-Rays - Full mouth: 1 every 36 consecutive months; Panorex: 1 every 36 consecutive months Fluoride Application - 1 per calendar year Sealants - Limited to posterior tooth. 1 treatment per tooth every three years Space Maintainers - Limited to non-orthodontic treatment	100% No Deductible	No Charge No Deductible	80% No Deductible	20% No Deductible
Class II: Basic Restorative Fillings Root Canal Therapy / Endodontics Emergency Care to Relieve Pain Root Planing and Scaling - Various limitations depending on the service Splinting Oral Surgery – Simple Extractions Anesthesia	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Crowns – Replacement every 5 years Dentures – Replacement every 5 years Bridges – Replacement every 5 years Inlays / Onlays – Replacement every 5 years Prosthesis Over Implant - 1 per every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non- precious metals. Repairs to Dentures, Bridges, Crowns and Inlays - Reviewed if more than once Stainless Steel/Resin Crowns Transepithelial Cytologic / Brush Biopsies Relines, Rebases and Adjustments – Covered if more than 6 months after installation	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class IV: Orthodontia Lifetime Maximum Study Models or Diagnostic Casts - Payable only when in conjunction with orthodontic workup	80% After Deductible $2,400	20% After Deductible	80% After Deductible $2,400	20% After Deductible

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Class VI: Periodontal Gingivectomy Gingivioplasty Alveoplasty Vestibuloplasty Osseous Surgery Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class VII: Oral Surgery Surgical Extractions of Impacted Teeth Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class IX: Surgical Implants Separate $250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX No Annual or Lifetime Maximums apply	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible