



# Cigna International Option RMIP Plan 1

| Effective January 1, 2019  | Services rendered in the U.S. (In-Network)  | Services rendered in the U.S. (Out-of-Network)<br>Services rendered outside the U.S.                                   |
|--|---|--|
| <b>General</b>   |   |  |
| A plan year is a calendar year, January 1 through December 31  |   |  |
| Medical deductible (per person)  | \$400 per plan year   |  |
| Medical deductible (per family)  | \$800 per plan year   |  |
| <b>Medical out-of-pocket limits (Office visit co-payments and dental services do not accrue toward the out-of-pocket limits)</b> |   |  |
| Medical out-of-pocket limits per person  | \$4,500 per plan year   |  |
| Medical out-of-pocket limits per family  | \$9,000 per plan year   |  |
| <b>Office Visits</b>   |   |  |
| Office visits for illness or specialist  | 100% after \$15 co-pay  | 80% after deductible unless the visit is for Preventive Care services outlined in the Preventive Care Guide, then 100% |
| Routine annual physical and defined preventive services*   | 100%  |  |
| <b>Laboratory and X-rays</b>   |   |  |
| All services (unless covered under defined preventive services above)  | 90% after deductible  | 80% after deductible   |
| <b>Emergency Room Related</b>  |   |  |
| Emergency room   | 90% after deductible<br>80% after deductible if non-emergency use                     |  |
| Ambulance services   | 90% after deductible  |  |
| <b>Inpatient</b>   |   |  |
| Hospital costs including anesthesia  | 90% after deductible  | 90% after deductible   |
| Surgery (physician)  |   |  |
| Hospice  |   |  |
| <b>Outpatient</b>  |   |  |
| Hospital costs including anesthesia  | 90% after deductible  | 90% after deductible   |
| Surgery (physician)  |   |  |
| Hospice  |   |  |
| <b>Chemotherapy and Radiation Therapy</b>  |   |  |
| Chemotherapy and radiation therapy: does not include oral or injectable medications purchased through pharmacy benefit           | 100% no deductible<br>In-office/facility administration only                          |  |
| <b>Maternity</b>   |   |  |
| Obstetrics:<br>Single fee/delivery charge including office visits  | 90% after deductible<br>Routine prenatal office visits covered at 100%, no deductible | 80% after deductible   |
| Obstetrics:<br>Routine prenatal office visits billed separately from single fee  | 100% after \$15 co-pay  |  |
| Infertility  | 90% after deductible  |  |
| Infertility lifetime limits: contact Insurance Administrator for details   |   |  |
| <b>Mental Health and Substance Abuse</b>   |   |  |
| Inpatient hospitalization for mental health or substance abuse   | 90% after deductible  | 90% after deductible   |
| Outpatient facility, including day treatment programs  |   |  |
| Office visits  | 100% after \$15 co-pay  |  |
| <b>Nursing and Home Health Care</b>  |   |  |
| Skilled nursing facility (e.g., rehabilitation center) <i>maximum 60 days per condition per plan year</i>                        | 90% after deductible  | 80% after deductible   |



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|   |   |                      |
|---|---|----------------------|
| Convalescent Care <i>Maximum 60 days per condition per plan year</i>  |   |                      |
| Visiting nurse: <i>maximum 120 days per condition per plan year</i>   |   |                      |
| Private duty nursing: <i>contact Insurance Administrator for authorization</i>  |   |                      |
| <b>Short-Term Rehabilitation</b>  |   |                      |
| 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                                   | 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 plan year)   |   |                      |
| Acupuncture (30 visit limit per plan year)  |   |                      |
| <b>Durable Medical Equipment</b>  |   |                      |
| Durable medical equipment: Rental<br><i>Purchases only if approved by Insurance Administrator</i>   | 90% after deductible  | 80% after deductible |
| <b>Vision Care</b>  |   |                      |
| Routine eye exams, one per plan year, including refraction. <i>No PCP referral required</i>   | \$20 co-pay   | 80% after deductible |
| Frames, lenses, contacts  | Up to \$200 reimbursement per person, every two plan years      |                      |
| <b>Hearing Aids</b>   |   |                      |
| 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. Defined preventive services are determined by gender and age and recommendations may change from time-to-time. Always check with the Insurance Administrator for the most recent recommendations provided separately from this general overview and discuss them with your doctor.

**For U.S. Prescription drug coverage, please refer to the separate Pharmacy Benefit grid.**

Note: For International Option participants, the U.S. pharmacy benefit manager will send a record of U.S. network pharmacy purchases to Cigna after the end of the plan year for reconciliation. International Option participants who met their medical out of pocket maximum and who also had U.S. pharmacy out of pocket expenses during the same plan year will receive reimbursement for the out of pocket U.S. pharmacy costs from Cigna after reconciliation.



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## Dental Benefit Summary –Retiree - Plan 1

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

| Network  | Cigna Dental PPO                 |                            |  |                         |
|--|----------------------------------|----------------------------|--|-------------------------|
|  | Total Cigna DPPO                 |                            | Out-of-Network                                       |                         |
| Calendar Year Maximum<br>(Class I, II & III expenses)  | \$3,200                          |                            | \$3,200  |                         |
| Annual Deductible<br>Individual<br>Family  | \$250<br>\$500                   |                            | \$250<br>\$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<br>Oral Exams Routine - 2 per calendar year<br>Routine Cleanings - 2 per calendar year<br>Routine X-rays - Bitewings: 2 per calendar year<br>Non-Routine X-Rays - Full mouth: 1 every 36 consecutive months; Panorex: 1 every 36 consecutive months<br>Fluoride Application - 1 per calendar year under age 19<br>Sealants - Limited to posterior tooth. 1 treatment per tooth every three years up to age 14<br>Space Maintainers - Limited to non-orthodontic treatment   | 100%<br>No Deductible            | No Charge<br>No Deductible | 80%<br>No Deductible                                 | 20%<br>No Deductible    |
| Class II: Basic Restorative<br>Fillings<br>Root Canal Therapy / Endodontics<br>Emergency Care to Relieve Pain<br>Root Planing and Scaling - Various limitations depending on the service<br>Splinting<br>Oral Surgery - Simple Extractions<br>Anesthesia   | 80%<br>After Deductible          | 20%<br>After Deductible    | 80%<br>After Deductible                              | 20%<br>After Deductible |
| Class III: Major Restorative<br>Crowns - Replacement every 5 years<br>Dentures - Replacement every 5 years<br>Bridges - Replacement every 5 years<br>Inlays / Onlays - Replacement every 5 years<br>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.<br>Repairs to Dentures, Bridges, Crowns and Inlays - Reviewed if more than once<br>Stainless Steel/Resin Crowns<br>Transepithelial Cytologic / Brush Biopsies<br>Relines, Rebases and Adjustments - Covered if more than 6 months after installation | 80%<br>After Deductible          | 20%<br>After Deductible    | 80%<br>After Deductible                              | 20%<br>After Deductible |



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|   |  |   |  |   |
|---|--|---|--|---|
| <p>Class IV: Orthodontia</p> <p>Lifetime Maximum</p> <p>Study Models or Diagnostic Casts - Payable only when in conjunction with orthodontic workup</p>   | <p style="text-align: center;">80%<br/>After Deductible</p> <p style="text-align: center;">\$2,400</p> | <p style="text-align: center;">20%<br/>After Deductible</p> | <p style="text-align: center;">80%<br/>After<br/>Deductible</p> <p style="text-align: center;">\$2,400</p> | <p style="text-align: center;">20%<br/>After Deductible</p> |
| <p>Class VI: Periodontal</p> <p>Gingivectomy<br/>Gingivoplasty<br/>Alveoplasty<br/>Vestibuloplasty<br/>Osseous Surgery</p> <p>Separate \$250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX</p> <p>No Annual or Lifetime Maximums apply</p> | <p style="text-align: center;">90%<br/>After Deductible</p>  | <p style="text-align: center;">10%<br/>After Deductible</p> | <p style="text-align: center;">80%<br/>After<br/>Deductible</p>  | <p style="text-align: center;">20%<br/>After Deductible</p> |
| <p>Class VII: Oral Surgery</p> <p>Surgical Extractions of Impacted Teeth</p> <p>Separate \$250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX</p> <p>No Annual or Lifetime Maximums apply</p>   | <p style="text-align: center;">90%<br/>After Deductible</p>  | <p style="text-align: center;">10%<br/>After Deductible</p> | <p style="text-align: center;">80%<br/>After<br/>Deductible</p>  | <p style="text-align: center;">20%<br/>After Deductible</p> |
| <p>Class IX: Surgical Implants</p> <p>Separate \$250 Calendar Year Deductible to cross accumulate between classes VI, VII, IX</p> <p>No Annual or Lifetime Maximums apply</p>   | <p style="text-align: center;">90%<br/>After Deductible</p>  | <p style="text-align: center;">10%<br/>After Deductible</p> | <p style="text-align: center;">80%<br/>After<br/>Deductible</p>  | <p style="text-align: center;">20%<br/>After Deductible</p> |