Active Staff MIP Option B Summary

Effective Date January 1, 2024	Services rendered in the U.S. (In-Network)	Services rendered in the U.S. (Out-of-Network)	Services rendered out of US (Out-of-Network)
General			
A plan year is a calendar year, January 1 through December 31			
Medical Deductible (per person)	$650 per plan year		No deductible
Medical Deductible (per family)	$1300 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	$2,500 per plan year		
Medical out-of-pocket limits per family	$5,000 per plan year		
Office visits			
Minute Clinic (Located in CVS Pharmacies)	100% after $10 copay	N/A	N/A
Office visits for Illness or Specialist	100% after $20 co-pay	80% after deductible	80% unless the visit is for Preventive Care services outlined in the Preventive Care Guide, then 100%
Routine annual physicals and defined preventive services*	100%		
Ob/GYN (well woman) exam – one per plan year *	100%		
All services; (unless covered under defined preventive services above)	90% after deductible	80% after deductible	80%
Emergency room related			
Emergency Room	90% after deductible 80% after deductible if non-emergency use		90% 80% if non-emergency use
Ambulance Services	90% after deductible		
Inpatient			
Hospital costs including anesthesia	90% after deductible	80% after deductible	80%
Surgery (physician)			
Hospice			
Outpatient			
Hospital costs including anesthesia	90% after deductible	80% after deductible	80%
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		100%, no deductible In-office/facility administration only
Maternity			
Obstetrics: Single fee/delivery charge incl. Office visits	90% after deductible Routine prenatal office visits covered at 100%, no deductible	80% after deductible	80%
Infertility	90% after deductible		
Infertility Lifetime Maximum - $75,000			
Mental Health and Substance Abuse			
Inpatient facility hospitalization for mental health or substance abuse	90% after deductible	80% after deductible	80%
Outpatient facility, including day treatment programs			
Office visits and Therapy	100% after $20 co-pay	90% after deductible	90%

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Effective Date January 1, 2023	Services rendered in the U.S. (In-Network)	Services rendered in the U.S. (Out-of-Network)	Services rendered out of US (Out-of-Network)
Nursing and Home Health Care			
Skilled Nursing Facility – (e.g., Rehabilitation Center) *Maximum 60 days per condition per plan year*	90% after deductible	80% after deductible	80%
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 $20 copay	80% after deductible	80%
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)			
Durable Medical Equipment			
Durable Medical Equipment: Rentals *Purchases only if approved by Insurance Administrator*	90% after deductible	80% after deductible	80%
Vision Care			
Routine eye exams, one per plan year, including refraction. *No PCP referral required*	$20 co-pay	$20 reimbursement	$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	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 (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 2023 Prescription Drug benefits, please refer to the separate pharmacy benefit reference guide available on the MIP web page

Active Staff MIP Option B Summary

Dental Benefit Summary

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 -4 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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	Cigna Dental PPO			
Network	**Total Cigna DPPO**		**Out-of-Network**	
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