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|  **Effective January 1, 2017** | **U.S. Network** **Aetna Open Choice PPO** | **Out-of-Network** |
| **General** |
| **A plan year is a calendar year, January 1 through December 31** |
| Medical deductible (per person) | $ 600 per plan year |
| Medical deductible (per family) | $1,200 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 |  $4,000 per plan year  |
| Medical out-of-pocket limits per family |  $8,000 per plan year |
| **Office Visits** |
| Office visits for illness or specialist | 100% after $20 co-pay | 80% after deductible |
| Routine annual physical and defined preventive services\* | 100%  |
| Ob/GYN (well woman) exam – one per plan year\*  | 100% |
| **Laboratory and X-rays** |
| All services (unless covered under defined preventive services above) | 80% after deductible |
| **Emergency Room Related** |
| [Emergency room](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0%2C%2CcontentMDK%3A20377365~currentSitePK%3A328635~pagePK%3A64207891~piPK%3A64207885~theSitePK%3A328635%2C00.html) | 80% after deductible  |
| [Ambulance services](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0%2C%2CcontentMDK%3A20386767~currentSitePK%3A328635~pagePK%3A64207891~piPK%3A64207885~theSitePK%3A328635%2C00.html) |
| **Inpatient** |
| Hospital costs including anesthesia | 80% after deductible |
| Surgery (physician) |
| Hospice |
| **Outpatient** |
| Hospital costs including anesthesia | 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% In-office/facility administration only |
| **Maternity** |
| Obstetrics:Single fee/delivery charge including office visits | 80% after deductibleRoutine prenatal office visits covered at 100%, no deductible  | 80% after deductible |
| Obstetrics: Routine prenatal office visits billed separately from single fee | 100%  |
| [Infertility](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0%2C%2CcontentMDK%3A20605646~currentSitePK%3A328635~pagePK%3A64207891~piPK%3A64207885~theSitePK%3A328635%2C00.html) | 80% after deductible  |
| Infertility lifetime limits: contact Insurance Administrator for details  |
| **Mental Health and Substance Abuse** |
| Inpatient hospitalization for mental health or substance abuse | 80% after deductible  | 80% after deductible |
| Outpatient facility, including day treatment programs |
| Office visits | 100% after $20 co-pay |
| **Nursing and Home Health Care**  |
| Skilled nursing facility (e.g., rehabilitation center) *maximum 60 days per condition per plan year* | 80% after deductible |
| Convalescent Care *Maximum 60 days per condition per plan year* |
| Visiting nurse: *maximum 120 days per condition per plan year* |
| Private duty nursing: *contact Insurance Administrator for authorization*  |
| **Short-Term Rehabilitation** |
| Physical, occupational or speech therapy: *restorative service after illness or accident. 60 visits PT, OT, ST combined per condition per plan year. Visits over 60 review for medical necessity.* | 100% after $20 office co-pay | 80% after deductible |
| Physical, occupational or speech therapy: *for diagnosis of development delay a maximum 60 visits PT, OT, ST combined, per plan year, per child* |
| Chiropractor (30 visit limit per plan year) |
| Acupuncture (30 visit limit per plan year)  |
| **Durable Medical Equipment** |
| [Durable medical equipment](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0%2C%2CcontentMDK%3A20342793~currentSitePK%3A328635~pagePK%3A64207891~piPK%3A64207885~theSitePK%3A328635%2C00.html): Rental*Purchases only if approved by Insurance Administrator* | 80% after deductible |
| **Vision Care** |
| Routine eye exams, one per plan year, including refraction. *No PCP referral required* | $20 co-pay | 80% after deductible |
| Frames, lenses, contacts | Up to $200 reimbursements per person, every two plan years |
| 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.**

# Cigna Dental Benefit Summary – Retiree - Plan 2

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

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| --- | --- |
|  | Cigna Dental PPO |
| Network | Total Cigna DPPO | Out-of-Network |
| Calendar Year Maximum(Class I, II & III expenses) | $2,000 | $2,000 |
| Annual DeductibleIndividualFamily | $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 & DiagnosticOral Exams Routine - 2 per calendar yearRoutine Cleanings - 2 per calendar yearRoutine X-rays - Bitewings: 2 per calendar yearNon-Routine X-Rays - Full mouth: 1 every 36 consecutive months; Panorex: 1 every 36 consecutive monthsFluoride Application - 1 per calendar year under age 19Sealants - Limited to posterior tooth. 1 treatment per tooth every three years up to age 14Space Maintainers - Limited to non-orthodontic treatment | 100%No Deductible | No ChargeNo Deductible | 80%No Deductible | 20%No Deductible |
| Class II: Basic Restorative FillingsRoot Canal Therapy / EndodonticsEmergency Care to Relieve PainRoot Planing and Scaling - Various limitations depending on the serviceSplintingOral Surgery – Simple ExtractionsAnesthesia | 80%After Deductible | 20%After Deductible | 80%After Deductible | 20%After Deductible |
| Class III: Major RestorativeCrowns – Replacement every 5 yearsDentures – Replacement every 5 yearsBridges – Replacement every 5 yearsInlays / Onlays – Replacement every 5 yearsProsthesis 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 onceStainless Steel/Resin CrownsTransepithelial Cytologic / Brush BiopsiesRelines, Rebases and Adjustments – Covered if more than 6 months after installation | 50%After Deductible | 50%After Deductible | 50%After Deductible | 50%After Deductible |
| Relines, Rebases, Denture Adjustments - Covered if more than 6 months after installation |  |  |  |  |
| Class IV: OrthodontiaLifetime MaximumStudy Models or Diagnostic Casts - Payable only when in conjunction with orthodontic workup | 50%After Deductible$1,000 | 50%After Deductible | 50%After Deductible$1,000 | 50%After Deductible |
|  |
| Class VI: Periodontal GingivectomyGingivioplastyAlveoplastyVestibuloplastyOsseous SurgeryNo Annual or Lifetime Maximums apply | 50%After Deductible | 50%After Deductible | 50%After Deductible | 50%After Deductible |
| Class VII: Oral SurgerySurgical Extractions of Impacted TeethNo Annual or Lifetime Maximums apply | 50%After Deductible | 50%After Deductible | 50%After Deductible | 50%After Deductible |
| Class IX: Surgical ImplantsNo Annual or Lifetime Maximums apply | 50%After Deductible | 50%After Deductible | 50%After Deductible | 50%After Deductible |