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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) | $400 per plan year | | | |
| Medical Deductible (per family) | $800 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 | $3,250 per plan year | | | |
| Medical out-of-pocket limits per family | $6,500 per plan year | | | |
| **Office visits** | | | | |
| Office visits for Illness or Specialist | 100% after $15 co-pay | | 80% after deductible | |
| Routine annual physicals 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) | 90% after deductible | | 80% after deductible | |
| **Emergency room related** | | | | |
| [Emergency Room](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0,,contentMDK:20377365~currentSitePK:328635~pagePK:64207891~piPK:64207885~theSitePK:328635,00.html) | 90% after deductible  80% after deductible if non-emergency use | | | |
| [Ambulance Services](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0,,contentMDK:20386767~currentSitePK:328635~pagePK:64207891~piPK:64207885~theSitePK:328635,00.html) | 90% after deductible | | | |
| **Inpatient** | | | | |
| Hospital costs including anesthesia | 90% after deductible | | | 90% after deductible |
| Surgery (physician) |
| Hospice |
| **Outpatient** | | | | |
| Hospital costs including anesthesia | 90% after deductible | | | 90% 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 | 90% after deductible  Routine prenatal office visits covered at 100%, no deductible | | 80% after deductible | |
| Obstetrics:  Routine prenatal office visits billed separately from single fee | 100% after $15 co-pay | |
| [Infertility](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0,,contentMDK:20605646~currentSitePK:328635~pagePK:64207891~piPK:64207885~theSitePK:328635,00.html) | 90% after deductible | |
| Infertility Lifetime Limits: Contact Insurance Administrator for details | | | | |
| **Mental Health and Substance Abuse** | | | | |
| Inpatient hospitalization for mental health or substance abuse | 90% after deductible | | | 90% after deductible |
| Outpatient facility, including day treatment programs | 90% after deductible | | | 90% after deductible |
| Office visits | 100% after $15 co-pay | | | 80% after deductible |
| **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 |
| 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 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 $15 copay | | | 80% after deductible |
| Physical, occupational or speech therapy –  *For diagnosis of Development Delay a maximum 60 visits PT, OT, ST combined, 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](http://intranet.worldbank.org/WBSITE/INTRANET/UNITS/HR/0,,contentMDK:20342793~currentSitePK:328635~pagePK:64207891~piPK:64207885~theSitePK:328635,00.html): Rentals  *Purchases only if approved by Insurance Administrator* | 90% after deductible | | | 80% after deductible |
| **Vision Care** | | | | |
| Routine eye exams, one per plan year, including refraction. | 100% after $15 co-pay | | | 80% after deductible |
| Frames, lenses, contacts | Up to $200 reimbursements per person, every two plan years | | | |
| **Hearing Aids** | | | | |
| Hearing Aids | | Maximum reimbursement $4,000 per person, every five plan years | | |

\*Defined preventive care services are 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 the most recent recommendations with your Insurance Administrator and discuss them with

your doctor.

**Prescription Benefits: For U.S. Prescription drug coverage, please refer to the separate pharmacy benefit grid.**

**Dental Benefits**

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| --- | --- | --- | --- | --- |
|  | ***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: 2 per calendar year  Non-Routine X-Rays - Full mouth: 1 every 36 consecutive months; Panorex: 1 every 36 consecutive months  Fluoride Application - 1 per calendar year under age19  Sealants - Limited to posterior tooth. 1 treatment per tooth every three years up to age 14  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 |
| Relines, Rebases, Denture Adjustments - Covered if more than 6 months after installation |  |  |  |  |
| ***Class IV: Orthodontia***  Coverage for Dependent Children to age 19  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 |
| ***Class VI: Periodontal***  Gingivectomy  Gingivioplasty  Alveoplasty  Vestibuloplasty  Osseous Surgery  ***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  ***No Annual or Lifetime Maximums apply*** | 90%  After Deductible | 10%  After Deductible | 80%  After Deductible | 20%  After Deductible |
| ***Class IX: Surgical Implants***  ***No Annual or Lifetime Maximums apply*** | 90%  After Deductible | 10%  After Deductible | 80%  After Deductible | 20%  After Deductible |