



Retiree MIP Plan 1 Summary

Effective January 1, 2023	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	90% after deductible 80% after deductible if non-emergency use	
Ambulance Services	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
Infertility	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



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Nursing and Home Health Care		
Skilled Nursing Facility – (e.g., Rehabilitation Center) <i>Maximum 60 days per condition per plan year</i>	90% after deductible	80% after deductible
Convalescent Care <i>Maximum 60 days per condition per plan year</i>		
Visiting Nurse – <i>Maximum 120 days per condition per plan</i>		
Private Duty Nursing – <i>Contact Insurance Administrator for authorization</i>		
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 copay	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 <i>Purchases only if approved by Insurance Administrator</i>	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 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](#)



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Dental Benefits

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 (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: 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 age 19 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 Planning 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



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Network	Cigna Dental PPO			
	Total Cigna DPPO		Out-of-Network	
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 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 Gingivoplasty 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