Active Staff MIP Option A 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)	$300 per plan year		No deductible
Medical Deductible (per family)	$600 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 $15 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%		
Laboratory and X-rays			
All services; (unless covered under defined preventive services above)	90%	80% after deductible	80%
Emergency room related			
Emergency Room	90% 80% after deductible if non-emergency use		90% 80% if non-emergency use
Ambulance Services	90%		
Inpatient			
Hospital costs including anesthesia	90%	80% after deductible	80%
Surgery (physician)			
Hospice			
Outpatient			
Hospital costs including anesthesia	90%	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% Routine prenatal office visits covered at 100%	80% after deductible	80%
Infertility	90%		
Infertility Lifetime Maximum - $75,000			
Mental Health and Substance Abuse			
Inpatient facility hospitalization for mental health or substance abuse	90%	80% after deductible	80%
Outpatient Facility, including day treatment programs			
Office visits and Therapy	100% after $15 co-pay	90% after deductible	90%

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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)
Nursing and Home Health Care			
Skilled Nursing Facility – (e.g., Rehabilitation Center) *Maximum 60 days per condition per plan year*	90%	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 $15 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%	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 2024 Prescription Drug benefits, please refer to the separate pharmacy benefit reference guide available on the MIP web page

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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 Options	**In-Network: Total Cigna DPPO Network**		**Non-Network: See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II, III, VIII expenses	$3,200		$3,200	
Calendar Year Deductible Individual Family	$250 $500		$250 $500	
Benefit Highlights	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Class I: Diagnostic & Preventive Oral Evaluations - 2 per calendar year Prophylaxis: routine cleanings – 4 per calendar year including Periodontal Maintenance Routine X-rays: Bitewings; No frequency limit Non-routine X-rays: Full mouth; No frequency limit; Panorex; No Frequency limit Fluoride Application – 2 per calendar year Sealants: per tooth – 2 per calendar year Space Maintainers: non-orthodontic – Limited to non-orthodontic treatment	100% No Deductible	No Charge No Deductible	80% No Deductible	20% No Deductible
Class II: Basic Restorative Restorative: fillings Root Canal Therapy/Endodontics: minor and major Emergency Care to Relieve Pain depending on the service. Oral Surgery; simple extractions Splinting	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III: Major Restorative Prosthesis Over Implant – 2 per 10 years/120 months if unserviceable and cannot be repaired Benefits are based on the amount payable for non-precious metals. Crowns: prefabricated stainless steel / resin – 2 per 10 years/120 months Crowns: permanent cast and porcelain – 2 per 10 years/120 months Bridges and Dentures – 2 per 10 years/120 months Transepithelial Cytologic/Brush Biopsies Relines, Rebases and Adjustments – Covered if more than 6 months after installation Cone Beam Scan/X-ray Repairs to Dentures, Bridges, Crowns and Inlays – Reviewed if more than once Onlay/Porcelain Ceramic – 2 every 10 years/120 months	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible

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Class IV: Orthodontia Coverage for Employee and All Dependents Lifetime Benefits Maximum: $2,400 Study Models or Diagnostic Casts – Payable only when in conjunction with orthodontic workup	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class VI: Periodontal Gingivectomy Gingivioplasty Osseous Surgery Guided Tissue Regeneration – no limits on number of teeth eligible Full Mouth Debridement Root planing and Scaling – Various limitations **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 Alveoplasty Vestibuloplasty **No Annual or Lifetime Maximums Apply**	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class VIII: Anesthesia Includes Nitrous Oxide	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible
Class IX: Implants No Annual or Lifetime Maximums Apply Coverage when 4 or more teeth are missing from the arch	90% After Deductible	10% After Deductible	80% After Deductible	20% After Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider amounts in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Late Entrant Limitation Provision	Does Not Apply
Pretreatment Review	Does Not Apply
Oral Health Integration Program®	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Claims must be filed by December 31st of the year following the date the service was incurred.

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Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses
- Diagnostic: Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations;
- Prosthodontic: initial placement of a complete or partial denture per plan guidelines;
- Procedures, appliances of restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replace of an appliance per benefit guidelines;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Allowable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.