Active Staff MIP Comparison Benefit Grid

Effective January 01, 2019	U.S. Network Benefits	Out-of-Network Benefits ALL OPTIONS
A plan year is a calendar year, January 1 through December 31		
Deductible (per person)	$300 per plan year (Option A) $650 per plan year (Option B) $350 per plan year (Option C)	
Deductible (per family)	$600 per plan year (Option A) $1,300 per plan year (Option B) $700 per plan year (Option C)	
US Medical Network - Options A and B	Aetna Open Choice PPO	
US Medical Network - Option C	Aetna Managed Choice POS	
Option C: Registration of a Primary Care Physician (PCP) with Aetna is required for each covered family member and referrals from the PCP are required for network care. Self referral only for annual routine eye, mental health services, and routine Ob/GYN.		
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 (Option A) $2,500 per plan year (Option B) $3,000 per plan year (Option C)	
Medical out-of-pocket limits per family	$5,000 per plan year (Option A) $5,000 per plan year (Option B) $6,000 per plan year (Option C)	
Office visits		
Office visits for Illness or Specialist	100% after $15 co-pay (Option A) 100% after $20 co-pay (Option B) 100% after $15 co-pay (Option C)	80% after deductible
Routine annual physicals and defined preventive services*, including one annual Ob/GYN (well woman) exam	100%	
Laboratory and X-rays		
All services; (unless covered under defined preventive services above)	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	80% after deductible
Emergency room related		
Emergency Room	90% no deductible (Option A) 90% after deductible (Option B) 100% after $50 co-pay (Option C) *80% after deductible if non-emergency use*	
Ambulance Services	90% no deductible (Option A) 90% after deductible (Option B) 100% (Option C)	
Inpatient		
Hospital costs including anesthesia	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	80% after deductible
Surgery (physician)		
Hospice		

Active Staff MIP Comparison Benefit Grid

Outpatient		
Hospice Surgery (physician) Facility charges, including anesthesia	See next page 90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	80% after deductible
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 including Office visits	90% no deductible (Option A) 90% after deductible (Option B) 100% (Option C) Routine prenatal office visits covered at 100%, no deductible (Options A, B and C)	80% after deductible
Obstetrics: Routine prenatal office visits billed separately from single fee	100% (Options A, B and C)	
Infertility	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	
Infertility Lifetime Limits – All Options	Contact Insurance Administrator for benefits	
Mental Health and Substance Abuse		
Inpatient hospitalization for mental health or substance abuse Outpatient facility, including day treatment programs	90% no deductible (Option A) 90% after deductible (Option B) 100% (Option C)	80% after deductible
Office visit *No PCP referral required under Option C*	100% after $15 co-pay (Option A) 100% after $20 co-pay (Option B) 100% after $15 co-pay (Option C)	
Nursing and Home Health Care		
Skilled Nursing Facility (e.g., Rehabilitation Center): *Limited to 60 days per plan year per condition* Convalescent Care *Maximum 60 days per condition per plan year* Visiting Nurse: *Limited to 120 visits per plan year per condition*	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	80% after deductible

Active Staff MIP Comparison Benefit Grid

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 co-pay (Option A) 100% after $20 co-pay (Option B) 100% after $15 co-pay (Option C) *Option C: PCP Referral required*	80% after deductible
Physical, occupational or speech therap *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 *Purchases only if approved by Insurance Administrator*	90% no deductible (Option A) 90% after deductible (Option B) 100% if referred by PCP (Option C)	80% after deductible
Vision Care		
Routine eye exams (one per plan year) including refraction *No PCP referral required for Option C*	$20 co-pay	$20 reimbursement
Frames, lenses, contacts	Glasses: Up to $350 allowance/discount per person annually, with an additional 20% discount on any balance over $350 Contacts: Up to $250 reimbursement per person annually, 15% off the remaining balance for conventional contacts, but not for disposable	Up to $250 reimbursement per person, every year
Hearing Aids		
Hearing Aids	Up to $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 and 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 provided separately from this general overview and discuss them with your doctor.

Prescription Benefits: All Options - please refer to separate Pharmacy Benefit grid

Active Staff MIP Comparison Benefit Grid

Dental Benefit Summary – Active staff

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 - 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	I.100% No Deductible	II.No Charge No Deductible	III.80% No Deductible	IV.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

Active Staff MIP Comparison Benefit Grid

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
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