



# Enroll Prime

**BMI**

**CIGNA Network**



Administered by:



# DVP Options

Plan	ESSENTIALS 7500	ESSENTIALS 5000	ESSENTIALS 2500
NETWORK	<a href="#">Cigna</a>	<a href="#">Cigna</a>	<a href="#">Cigna</a>
Deductible (Indv/Fam)	\$7,500 / \$15,000	\$5,000 / \$10,000	\$2,500 / \$5,000
Maximum Out of Pocket (Indv/Fam)	\$9,200 / \$18,400	\$9,200 / \$18,400	\$9,200 / \$18,400
Preventive, Physician & Diagnostic Services			
Preventive & Wellness (Non- Hospital Based)	Included	Included	Included
Primary Care Office Visit (Non- Hospital Based)	\$50 Copay (2 visits per plan year*)	\$25 Copay (2 visits per plan year*)	\$25 Copay (4 visits per plan year*)
Specialist Office Visit (Non-Hospital Based) (Includes Mental and Behavioral Health)	\$75 Copay (2 visits per plan year*)	\$50 Copay (2 visits per plan year*)	\$50 Copay (4 visits per plan year*)
Urgent Care	\$75 Copay (1 visit per plan year)	\$75 Copay (1 visit per plan year)	\$75 Copay (1 visit per plan year)
Telemedicine	\$0 Copay (Unlimited)	\$0 Copay (Unlimited)	\$0 Copay (Unlimited)
Laboratory Services & Radiology (Non-Hospital Based)	Deductible + 50% (3 visits per plan year)	Deductible + 50% (3 visits per plan year)	Deductible + 50% (3 visits per plan year)
CT / MRI / MRA / PET Scan (Non-Hospital Based) (Prior Authorization Required)	Deductible + 50% (1 visit per plan year)	Deductible + 50% (1 visit per plan year)	Deductible + 50% (1 visit per plan year)
Allergy Services (Applied to PCP or Specialist Office visit limits)	\$50 Copay	\$25 Copay	\$25 Copay

These plans are not traditional major medical insurance. These are limited day benefit plans. These plans have exclusions and limitations not associated with major medical plans. Please review the Summary of Benefits for each plan for a description of coverage and a list of exclusions.

\*Primary Care & Specialist Visits are combined limits.

**Plans utilize the CIGNA PPO Network. Plans are not insured by CIGNA.**

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## Hospital & Facility Services

<b>Inpatient Hospitalization (per admission) (Prior Authorization Required)</b>	<b>Deductible + 50% (5 days per plan year)</b>	<b>Deductible + 50% (5 days per plan year)</b>	<b>Deductible + 50% (5 days per plan year)</b>
<b>Inpatient Visits - Physician</b>	<b>Included in IP Hospitalization Copay</b>	<b>Included in IP Hospitalization Copay</b>	<b>Included in IP Hospitalization Copay</b>
<b>Inpatient Surgery (Prior Authorization Required)</b>	<b>Included in IP Hospitalization Copay (1 surgery per plan year**)</b>	<b>Included in IP Hospitalization Copay (1 surgery per plan year**)</b>	<b>Included in IP Hospitalization Copay (1 surgery per plan year**)</b>
<b>Outpatient Hospital or Free- Standing Facility Services and Surgery (Prior Authorization Required)</b>	<b>Deductible + 50% (1 visit per plan year**)</b>	<b>Deductible + 50% (1 visit per plan year**)</b>	<b>Deductible + 50% (1 visit per plan year**)</b>
<b>Anesthesia</b>	<b>Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay</b>	<b>Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay</b>	<b>Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay</b>
<b>Emergency Room</b>	<b>Deductible + 50% (1 visit per plan year)</b>	<b>Deductible + 50% (1 visit per plan year)</b>	<b>Deductible + 50% (1 visit per plan year)</b>
<b>Ambulance Service (Ground Services Only)</b>	<b>Deductible + 50% (1 per plan year)</b>	<b>Deductible + 50% (1 per plan year)</b>	<b>Deductible + 50% (1 per plan year)</b>
<b>Second Surgical Opinion</b>	<b>Deductible + 50%</b>	<b>Deductible + 50%</b>	<b>Deductible + 50%</b>

## Pregnancy Benefits

<b>Professional Services</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
<b>Maternity / Childbirth / Delivery (per admission) (Considered Inpatient Hospital Stay) (Prior Authorization Required)</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>

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\*\*Inpatient & Outpatient Surgery limits are combined for 1 per year.

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## Other Services

Home Health Care (Prior Authorization Required)	Deductible + 50% (10 visits per plan year)	Deductible + 50% (10 visits per plan year)	Deductible + 50% (10 visits per plan year)
Treatment for Chemical Abuse & Dependency – Inpatient (per Day) (Prior Authorization Required)	Deductible + 50% (5 days per plan year)	Deductible + 50% (5 days per plan year)	Deductible + 50% (5 days per plan year)
Treatment for Chemical Abuse & Dependency – Outpatient (per day) (Prior Authorization Required)	Deductible + 50% (5 days per plan year)	Deductible + 50% (5 days per plan year)	Deductible + 50% (5 days per plan year)
Rehabilitation / Habilitation Services (Physical, Speech, and Occupational) (Prior Authorization Required)	Not Covered	Not Covered	Not Covered

## Pharmacy Benefits (Subject to Formulary)

Mail Order copay is 3x's the retail copay for a 3-month supply where applicable.

Preventive (Generic Only)	\$0 Copay	\$0 Copay	\$0 Copay
Generic Non-Preventive (Retail)	Discount Plan	Discount Plan	Discount Plan
Preferred Brand Non-Preventive (Retail)	Not Covered	Not Covered	Not Covered
Non-Preferred Brand-Preventive (Retail)	Not Covered	Not Covered	Not Covered

Plan	ESSENTIALS 7500	ESSENTIALS 5000	ESSENTIALS 2500
Employee	\$433.48	\$501.48	\$582.08
Employee & Spouse	\$677.28	\$745.28	\$786.08
Employee & Child(ren)	\$626.28	\$694.28	\$735.08
Family	\$891.48	\$959.48	\$1,041.08

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# MVP Options

Plan	BASIC	VALUE	ADVANTAGE
NETWORK	<a href="#">Cigna</a>	<a href="#">Cigna</a>	<a href="#">Cigna</a>
Deductible (Indv/Fam)	\$0 / \$0	\$0 / \$0	\$0 / \$0
Maximum Out of Pocket (Indv/Fam)	\$8,700 / \$17,400	\$5,000 / \$10,000	\$5,000 / \$10,000

## Preventive, Physician & Diagnostic Services

Preventive & Wellness (Non- Hospital Based)	Included	Included	Included
Primary Care Office Visit (Non- Hospital Based)	\$25 Copay (8 visits per plan year)	\$15 Copay (10 visits per plan year)	\$15 Copay (12 visits per plan year)
Specialist Office Visit (Non-Hospital Based) (Includes Mental and Behavioral Health)	\$50 Copay (8 visits per plan year)	\$25 Copay (10 visits per plan year)	\$25 Copay (12 visits per plan year)
Urgent Care	\$50 Copay (2 visits per plan year)	\$35 Copay (3 visits per plan year)	\$35 Copay (3 visits per plan year)
Telemedicine	\$0 Copay (Unlimited)	\$0 Copay (Unlimited)	\$0 Copay (Unlimited)
Laboratory Services & Radiology (Non-Hospital Based)	\$50 Copay (3 visits per plan year)	\$50 Copay (3 visits per plan year)	\$50 Copay (4 visits per plan year)
CT / MRI / MRA / PET Scan (Non-Hospital Based) (Prior Authorization Required)	\$350 Copay (1 per plan year)	\$350 Copay (2 per plan year)	\$350 Copay (3 per plan year)
Allergy Services (Applied to PCP or Specialist Office visit limits)	\$25 Copay	\$25 Copay	\$25 Copay

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## Hospital & Facility Services

<b>Inpatient Hospitalization (per admission) (Prior Authorization Required)</b>	<b>\$350 Copay</b> (5 days per plan year)	<b>\$350 Copay</b> (7 days per plan year)	<b>\$350 Copay</b> (10 days per plan year)
<b>Inpatient Visits - Physician</b>	<b>Included in IP Hospitalization Copay</b>	<b>Included in IP Hospitalization Copay</b>	<b>Included in IP Hospitalization Copay</b>
<b>Inpatient Surgery (Prior Authorization Required)</b>	<b>Included in IP Hospitalization Copay</b> (2 surgeries per plan year)	<b>Included in IP Hospitalization Copay</b> (3 surgeries per plan year)	<b>Included in IP Hospitalization Copay</b> (4 surgeries per plan year)
<b>Outpatient Hospital or Free- Standing Facility Services and Surgery (Prior Authorization Required)</b>	<b>\$350 Copay</b> (1 visit per plan year)	<b>\$350 Copay</b> (2 visits per plan year)	<b>\$350 Copay</b> (2 visits per plan year)
<b>Anesthesia</b>	<b>Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay</b> (2 IP and 1 OP per plan year)	<b>Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay</b> (3 IP and 2 OP per plan year)	<b>Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay</b> (4 IP and 2 OP per plan year)
<b>Emergency Room</b>	<b>\$350 Copay</b> (1 visit per plan year)	<b>\$350 Copay</b> (1 visit per plan year)	<b>\$350 Copay</b> (2 visits per plan year)
<b>Ambulance Service (Ground Services Only)</b>	<b>\$250 Copay</b> (1 per plan year)	<b>\$250 Copay</b> (1 per plan year)	<b>\$250 Copay</b> (2 per plan year)
<b>Second Surgical Opinion</b>	<b>\$0 Copay</b>	<b>\$0 Copay</b>	<b>\$0 Copay</b>

## Pregnancy Benefits

\*12 - Month Waiting Period\*

<b>Professional Services</b>	<b>Not Covered</b>	<b>\$350 Copay</b>	<b>\$350 Copay</b>
<b>Maternity / Childbirth / Delivery (per admission) (Considered Inpatient Hospital Stay) (Prior Authorization Required)</b>	<b>Not Covered</b>	<b>\$350 Copay</b>	<b>\$350 Copay</b>

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## Other Services

Home Health Care (Prior Authorization Required)	\$25 Copay (10 visits per plan year)	\$25 Copay (15 visits per plan year)	\$25 Copay (20 visits per plan year)
Treatment for Chemical Abuse & Dependency – Inpatient (per Day) (Prior Authorization Required)	\$250 Copay (5 days per plan year)	\$250 Copay (7 days per plan year)	\$250 Copay (10 days per plan year)
Treatment for Chemical Abuse & Dependency – Outpatient (per day) (Prior Authorization Required)	\$25 Copay (5 days per plan year)	\$25 Copay (7 days per plan year)	\$25 Copay (10 days per plan year)
Rehabilitation / Habilitation Services (Physical, Speech, and Occupational) (Prior Authorization Required)	Not Covered	Not Covered	\$50 Copay per Day (12 visits per plan year)

## Pharmacy Benefits (Subject to Formulary)

Mail Order copay is 3x's the retail copay for a 3-month supply where applicable.

Preventive (Generic Only)	\$0 Copay	\$0 Copay	\$0 Copay
Generic Non-Preventive (Retail)	\$5 Copay	\$5 Copay	\$5 Copay
Preferred Brand Non-Preventive (Retail)	Not Covered	Not Covered	Not Covered
Non-Preferred Brand-Preventive (Retail)	Not Covered	Not Covered	Not Covered

Plan	BASIC	VALUE	ADVANTAGE
Employee	\$651.51	\$712.12	\$759.45
Employee & Spouse	\$993.24	\$1,126.60	\$1,206.10
Employee & Child(ren)	\$886.80	\$995.93	\$1,057.21
Family	\$1,228.54	\$1,410.39	\$1,503.86

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# FAQ: Frequently Asked Questions

## 1. What Providers are In-Network?

Providers that participate with the national CIGNA PPO network!

## 2. Where can I use my plan?

In all 50 states!

## 3. Do I need a referral to see a specialist?

No, go to any in-network specialist to access an affordable co-pay.

## 4. What Pharmacies are in network?

All national recognized pharmacies (Walmart, CVS, Walgreens, and many local pharmacies as well)!

## 5. When should I use an Emergency Room vs Urgent Care?



Most medical conditions can be treated at an Urgent Care facility. By choosing Urgent Care, your cost may be greatly reduced compared to an ER visit. However, if you are experiencing an extreme medical condition such as stroke, heart attack, uncontrolled bleeding, severe burns, or electrical shock, please go directly to the nearest Emergency Room. The average cost for an Urgent Care visit is \$90 to \$100, while the average cost for an Emergency Room visit is \$1,300 to \$3,000.

## 6. Do I Need prior authorization for services?


Yes, most services outside of Primary Care or Specialist will require prior authorization.

## 6. What will my ID card look like?

Front of Card

	For immediate \$0 Copay Call Telehealth 956-MYMDNOW
<b>John Doe</b> Member ID #: 123456789 Employer Group ID: Medical Plan: Major Medical 4500 PPO	<b>Collect at time of service:</b> Telehealth: \$0      Urgent Care: \$90 PCP: \$40      ER: Deductible Specialist: \$75
<b>Prescription Drug Plan</b> Rx BIN: 012345 Rx PCN: SXXL01 Rx GROUP: BENEFIT	<b>Participating Pharmacies Only:</b> Preventative Prescriptions: \$0 Copay Non-Preventative Generic: \$20 Copay Preferred Brand: \$65 Copay Non-Preferred Brand: \$95 Copay Specialty: \$200 Copay
Call MBATPA at 844-462-6334 to check on benefits, claims, or to confirm eligibility	

Back of Card

<b>This card is not a statement of benefits or guarantee of coverage</b>	
Members and Providers may visit <a href="http://www.benefitlogistics.com">www.benefitlogistics.com</a> for online access to eligibility and benefits as not all members have lines of coverage.  Medical plan questions? Call MBATPA Help desk: 844-462-6334	 Prescription questions? Call ScriptClaim Help Desk: 800-970-5281
<b>This Plan Requires Pre-Treatment Authorization / Precertification</b>  Before hospital admission or any surgery or other services performed by your plan, your physician must call for pre-treatment authorization (precertification). Failure may result in reduction of benefits. Emergency hospital admissions must be reported within 48 hours or by the next regular working day following admission (72 hours in some states).	<b>PLEASE SUBMIT ALL CLAIMS TO:</b> CIGNA PO BOX 188061 Chattanooga, TN 37422-8051  <b>PAYOR ID: 62308</b>  