



BMI
CIGNA Network



Administered by:



DVP Options

Plan	ESSENTIALS 7500	ESSENTIALS 5000	ESSENTIALS 2500
NETWORK	<u>Cigna</u>	<u>Cigna</u>	<u>Cigna</u>
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.

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Hospital & Facility Services

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

Pregnancy Benefits

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

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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	<u>Cigna</u>	<u>Cigna</u>	<u>Cigna</u>
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

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

Pregnancy Benefits

12 - Month Waiting Period

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

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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?

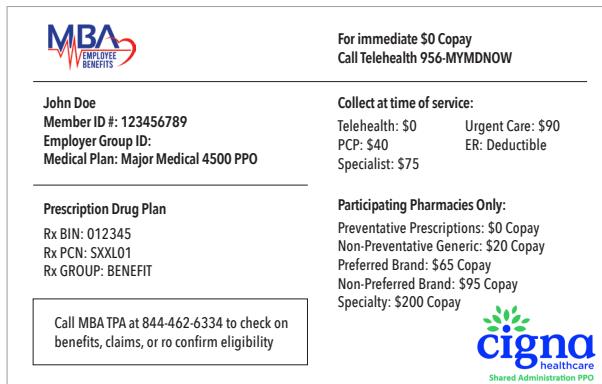
Most medical conditions can be treated at an Urgent Care facility. By choosing Urgent Care, your cost may be greatly reduced compared to an ER visit. However, if you are experiencing an extreme medical condition such as stroke, heart attack, uncontrolled bleeding, severe burns, or electrical shock, please 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



Back of Card

