Enroll Prime

BMI ASSOCIATION HEALTH PLAN

CIGNA PPO Network

Administered by:

MBA EMPLOYEE BENEFITS

DVP Options

Plan	ESSENTIALS 7500	ESSENTIALS 5000	ESSENTIALS 2500
Network	CIGNA PPO	CIGNA PPO	CIGNA PPO
Deductible (Ind/Fam)	$7,500 / $15,000	$5,000 / $10,000	$2,500 / $5,000
Maximum Out of Pocket (Ind/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 per plan year)	Deductible + 50% (1 per plan year)	Deductible + 50% (1 per plan year)
Allergy Services (Applied to PCP or Specialist Office visit limits)	$50 Copay	$25 Copay	$25 Copay
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 visits per plan year**)	Deductible + 50% (1 visits per plan year**)
Anesthesia	Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay 1 per plan year)	Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay 1 per plan year)	Included in IP Hospitalization or OP Hospital or FSF Services and Surgery Copay 1 per plan year)
Emergency Room	Deductible + 50% (1 visit per plan year)	Deductible + 50% (1 visit per plan year)	Deductible + 50% (1 visits per plan year)

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.

**Inpatient & Outpatient Surgery limits are combined for 1 per 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
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)	Discount Plan	Discount Plan	Discount Plan
Non-Preferred Brand-Preventive (Retail)	Discount Plan	Discount Plan	Discount Plan
Plan	**ESSENTIALS 7500**	**ESSENTIALS 5000**	**ESSENTIALS 2500**
Member	$424.98	$491.65	$570.67
Member & Spouse	$664.00	$730.67	$770.67
Mmebr & Child(ren)	$614.00	$680.67	$720.67
Family	$874.00	$940.67	$1,020.67

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MVP Options

Plan	BASIC	VALUE	ADVANTAGE
Network	CIGNA PPO	CIGNA PPO	CIGNA PPO
Deductible (Ind/Fam)	$0 / $0	$0 / $0	$0 / $0
Maximum Out of Pocket (Ind/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 Copay1 (1 per plan year)	$350 Copay1 (2 per plan year)	$350 Copay1 (3 per plan year)
Allergy Services (Applied to PCP or Specialist Office visit limits)	$25 Copay	$25 Copay	$25 Copay
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)

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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
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 (Generic)	$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**
Member	$638.73	$698.16	$744.56
Member & Spouse	$973.76	$1,104.51	$1,182.45
Mmebr & Child(ren)	$869.41	$976.40	$1,036.48
Family	$1,204.45	$1,382.73	$1,474.37

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Major Medical Options

Plan	HSA 8050	3500 HSA	COPAY 4500	COPAY 3500
NETWORK	**CIGNA PPO**	**CIGNA PPO**	**CIGNA PPO**	**CIGNA PPO**
Individual Deductible (In/Out)	**$8,050 / $18,900**	**$3,500 / $7,500**	**$4,500 / $8,500**	**$3,500 / $7,500**
Family Deductible (In/Out)	**$16,100 / Þотƹулл**	**$7,000 / $15,000**	**$9,000 / $17,000**	**$7,000 / $15,000**
Individual Out-of-Pocket Maximum (In/Out)	**$8,050 / $24,000**	**$7,000 / $17,500**	**$8,150 / $20,000**	**$7,350 / $17,500**
Family Out-of-Pocket Maximum (In/Out)	**$16,100 /$48,000**	**$14,000 / $35,000**	**$16,300 / $40,000**	**$14,700 / $35,000**
Co-Insurance: Member Pays (In/Out)	**0% / 100%**	**30% / 50%**	**30% / 50%**	**20% / 50%**
Direct Primary Care (Not Available in all Counties)				
Office Services-Value Choice DPC/PCP	**$0 Copay**	**$0 Copay**	**$0 Copay**	**$0 Copay**
Office Services-Value Choice DPC/Specialist	**$0 Copay**	**$20 Copay**	**$20 Copay**	**$20 Copay**
Preventive & Physician Services				
Preventative	**$0 Copay**	**$0 Copay**	**$0 Copay**	**$0 Copay**
Supplemental Benefit (Health Screen Benefit)	Pays $50 per year	Pays $50 per year	Pays $50 per year	Pays $50 per year
Telemedicine	**Unlimited $0 Copay**	**Unlimited $0 Copay**	**Unlimited $0 Copay**	**Unlimited $0 Copay**
Office Services-Family Physician	**Deductible + 0%**	**Deductible + 30%**	**$40 Copay**	**$40 Copay**
Office Services-Specialist	**Deductible + 0%**	**Deductible + 30%**	**$75 Copay**	**$75 Copay**
Supplemental Benefit (PCP/Spec. Visit Benefit)	Pays $25 per visit (3x per year)	Pays $25 per visit (3x per year)	Pays $25 per visit (3x per year)	Pays $25 per visit (3x per year)
Urgent Care	**Deductible + 0%**	**Deductible + 30%**	**$90 Copay**	**$90 Copay**
Laboratory & Imaging Services				
Labs & X-rays (Quest Diagnostics/Lab Corp)	**Deductible + 0%** *100% of covered charges up to $500 performed in **DPC Office***	**Deductible + 30%**	**100% of covered charges up to $500 then Deductible + 30%**	**100% of covered charges up to $500 then Deductible + 20%**
X-ray Benefit-Sickness (Payable 2x per year)	Pays $25	Pays $25	Pays $25	Pays $25
X-ray Benefit-Injury (Payable per separate incidents.)	Pays $85	Pays $85	Pays $85	Pays $85
Advanced Imaging	**Deductible + 0%** $200 Copay from **DPC Referral**	**Deductible + 30%**	**$300 Copay**	**$300 Copay**
Adv. Image. -Sickness (payable 1x per year)	Pays $500	Pays $500	Pays $500	Pays $500
Adv. Image. -for Injury (payable 1x per year)	Pays $700	Pays $700	Pays $700	Pays $700

Please review the Summary of Benefits for each plan for a description of coverage and a list of exclusions. These rates are good only if the employer offers the entire suite of products to their employees.

Hospital & Surgical Services				
Inpatient Hospital Services	**Deductible + 0%**	**Deductible + 30%**	**Deductible + 30%**	**Deductible + 20%**
Hospital Confinement: Sickness	Pays $2,500	Pays $2,500	Pays $2,500	Pays $2,500
Hospital Confinement: Injury	Pays $3,500	Pays $3,500	Pays $3,500	Pays $3,500
Outpatient Surgery	**Deductible + 0%**	**Deductible + 30%**	**Deductible + 30%**	**Deductible + 20%**
Outpatient Surgery Benefit (payable up to $1,500/year) Tier1 / Tier 2	Pays $500 / $1,000	Pays $500 / $1,000	Pays $500 / $1,000	Pays $500 / $1,000
Emergency Room	**Deductible + 0%**	**Deductible + 30%**	**Deductible + 30%**	**Deductible + 20%**
ER Benefit-Sickness (Payable 2x per year)	Pays $100	Pays $100	Pays $100	Pays $100
ER Benefit-Injury (Payable per separate incidents.)	Pays $250	Pays $250	Pays $250	Pays $250
Pharmacy Benefits (Subject to Formulary)				
Deductible	**In-Network Deductible**	**In-Network Deductible**	**$0**	**$0**
Preventive (Generic Only)	**$0 Copay**	**$0 Copay**	**$0 Copay**	**$0 Copay**
Generic Non-Preventive (Retail)	**Deductible + 0%**	**Deductible + 30%**	**$20 Copay**	**$20 Copay**
Preferred Brand Non-Preventive (Retail)	**Deductible + 0%**	**Deductible + 30%**	**$65 Copay**	**$65 Copay**
Non-Preferred Brand-Preventive (Retail)	**Deductible + 0%**	**Deductible + 30%**	**$95 Copay**	**$95 Copay**
Specialty Drugs (Retail)	**Deductible + 0%**	**Deductible + 30%**	**$200 Copay**	**$200 Copay**
Plan Specific Pharmacy Notes	**All prescriptions up to $200 covered, above $200 not covered.**	**N/A**	**N/A**	**N/A**
Plan	**HSA 8050**	**HSA 3500**	**COPAY 4500**	**COPAY 3500**
Premium Notes	**Incl. $25/month towards HSA Visa Card**	**N/A**	**N/A**	**N/A**
Member	***$624.10***	**$722.36**	**$758.45**	**$849.45**
Member & Spouse	**$974.52**	**$1,331.93**	**$1,412.48**	**$1,481.81**
Member & Child(ren)	**$1,074.65**	**$1,216.45**	**$1,298.39**	**$1,449.44**
Family	**$1,324.66**	**$1,820.10**	**$1,855.85**	**$2,105.61**

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Plans utilize the Cigna PPO Network. Plans are not insured by Cigna

FAQ: Frequently Asked Questions

1. ***How do I know what to save for retirement? How much goes into my HSA vs 401-k?***
   Our one-one one advisors will walk you through the entire process.

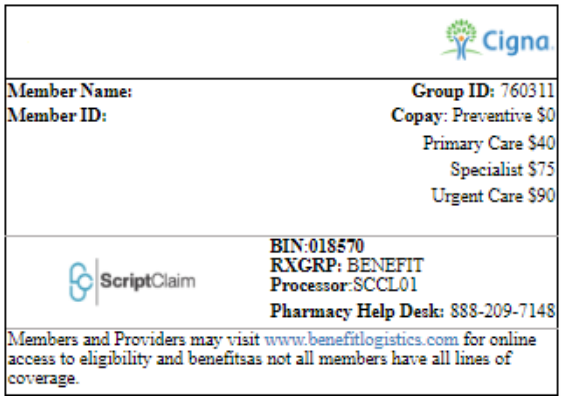
2. ***How will I know if a medical, dental, or vision provider is in-network?***
   Please check our online provider directory for an in-network specialist or provider.

3. ***What pharmacies can members use for prescriptions?***
   All plans use preferred pharmacies that include Publix, Walgreens, Walmart, Winn-Dixie, CVS, and many other local pharmacies. Members pay less when they use preferred pharmacies to fill prescriptions.

4. ***Should I go to Urgent Care or the Emergency Room?***
   Most medical conditions can be treated at an Urgent Care facility, and your cost may be greatly reduced. However, if you are experiencing an extreme medical condition such as a stroke, a 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.

5. ***Why Should I Consider a High Deductible Plan with "First Dollar" Supplemental Coverage?***
   - On average, only 1 in 100 (1%) Americans will spend more than $5,000 on healthcare expenses, and only 1 in 20 (5%) will spend more than $1,700 in medical expenses. That means 95% of people spend less than $1,700 in out-of-pocket medical expenses
   - Lower Premiums: Lowering premiums with first dollar coverage with supplemental products will save 99% of Americans 36% on their premiums (on average $2,845/year per employee)

6. ***What will my ID Cards look like?***



7. ***My card has a maintenance schedule so what can I do to maintain my health?***
   For adult health (19+), please review the table on the next page for recommended frequency and age regarding check-ups, screenings, immunizations, etc. For child and adolescent health (Birth-18 years), please review the table on page 8 for this information.