



Enroll Prime

***ASSOCIATION GROUP
HEALTH PLAN***

Administered by:



CIGNA PPO

MVP Options

Plan	BASIC	FUNDAMENTAL	ENHANCED
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 Copay ¹ (1 per plan year)	\$350 Copay ¹ (2 per plan year)	\$350 Copay ¹ (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)

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.

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			
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	\$40 Copay	\$40 Copay
Non-Preferred Brand-Preventive (Retail)	Not Covered	\$80 Copay	\$80 Copay
Plan	BASIC	FUNDAMENTAL	ENHANCED
Employee	\$580.30	\$624.87	\$659.67
Employee & Spouse	\$881.57	\$979.63	\$1,038.09
Employee & Child(ren)	\$803.31	\$883.55	\$928.61
Family	\$1,129.59	\$1,263.30	\$1,332.03

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