

PARTNERS in Benefits



VACE CIGNA \$600 / \$1,000 / \$2,500 OAP Plan Options

BENEFITS	IN-NETWORK			OUT-OF-NETWORK		
Calendar Year Deductible						
Individual	\$600	\$1,000	\$2,500	\$1,500	\$3,000	\$4,000
Family	\$1,200	\$2,000	\$5,000	\$3,000	\$6,000	\$8,000
Out-of-Pocket Maximum (Includes deductible and coinsurance)						
Individual	\$3,000	\$4,000	\$4,000	\$6,000	\$8,000	\$8,000
Family	\$6,000	\$8,000	\$8,000	\$12,000	\$16,000	\$16,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	\$1,000,000	\$1,000,000	\$1,000,000
Doctor Office Visits - Injury or Illness	\$25 copay	\$25 copay	\$25 copay	40% after deductible*		
Preventive Care						
Routine Preventive Care	\$25 copay	\$25 copay	\$25 copay	Not Covered	Not Covered	Not Covered
Well Woman Care	\$25 copay	\$25 copay	\$25 copay	Not Covered	Not Covered	Not Covered
Mammogram	No charge	No charge	No charge	40% after deductible*		
Inpatient Hospital	\$100 admission copay per confinement then 20% after deductible			\$100 admission copay per confinement then 40% after deductible*		
Inpatient Doctor Visits	20% after deductible			40% after deductible*		
Outpatient Facility Services	\$50 copay then 20% after deductible			\$50 copay then 40% after deductible*		
Emergency Care						
Doctor's Office	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay
Emergency Room (must meet CIGNA's definition of emergency)	\$100 copay (waived if admitted)			\$100 copay (waived if admitted)		

Note: This is a summary of benefits for your CIGNA OAP plan. All plan maximums and services, specific maximums (dollar and occurrence) cross-accumulate between In and Out-of-Network unless otherwise noted. The specific terms of coverage, exclusions, and limitations, including legislative benefits, are contained in the Plan Description. 01/2008

*Subject to reasonable and customary charge limitations for out-of-network services

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility (Up to 60 days per calendar year)	20% after deductible	40% after deductible*
Lab and X-ray Services	20% after deductible	40% after deductible*
Outpatient Short-Term Rehabilitation (60 visits all therapies combined per calendar year / Chiropractic Unlimited) Facility/Hospital Outpatient Doctors Office	20% after deductible \$25 copay	40% after deductible* 40% after deductible*
Home Health Care (Up to 40 visits per calendar year)	20% after deductible	40% after deductible*
Hospice	20% after deductible	40% after deductible*
Maternity Initial Visit to Confirm Pregnancy Delivery Charges/Including Pre & Post natal visits	\$25 copay 20% after deductible	40% after deductible* 40% after deductible*
Durable Medical Equipment (Unlimited annual maximum)	20% after deductible	40% after deductible*
External Prosthetic Devices (Unlimited annual maximum)	20% after deductible	40% after deductible*
Mental Health / Substance Abuse Inpatient Outpatient	\$100 admission copay and 20% after deductible \$25 copay	\$100 admission copay & 40% after deductible* (30 day max) 40% after deductible* (20 visit max)
Employee Assistance Plan (EAP)	1-3 visits @ 100%	In-Network Coverage Only
Prescription Drugs (30 to 90 day supply) Mail Order Drugs (TelDrug) (90 day supply) Includes Preventive Drugs	50% coinsurance with, Out of Pocket Maximum Per Year of Individual \$2,000 and Family \$4,000	In-Network Coverage Only Mail Order - TelDrug Only
Routine Vision (Benefits Same In or Out of Network) - benefit is once every 24 months Eye Examination \$20; Lenses: Single Lens \$15; Bifocals \$30; Trifocals \$42; Lenticular \$54; Contact Lenses \$72 (medically necessary) / \$30 (elective); Frames \$15		

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