

PARTNERS in Benefits



VACE CIGNA \$1,250 / \$2,500 OAP Plan Options

BENEFITS	IN-NETWORK		OUT-OF-NETWORK	
Calendar Year Deductible				
Individual	\$1,250	\$2,500	\$3,000	\$4,000
Family	\$2,500	\$5,000	\$6,000	\$8,000
Out-of-Pocket Maximum (Includes deductible and coinsurance)				
Individual	\$4,000	\$4,000	\$8,000	\$8,000
Family	\$8,000	\$8,000	\$16,000	\$16,000
Lifetime Maximum	Unlimited		\$1,000,000	
Doctor Office Visits				
Primary	\$30 copay		40% after deductible*	
Specialist	\$50 copay		40% after deductible*	
Preventive Care				
Routine Preventive Care	No charge		Not Covered	
Well Woman Care	No charge		Not Covered	
Mammogram	No charge		40% after deductible*	
Inpatient Hospital	\$150 admission copay per confinement then 20% after deductible		\$150 admission copay per confinement then 40% after deductible*	
Inpatient Doctor Visits	20% after deductible		40% after deductible*	
Outpatient Facility Services	\$75 copay then 20% after deductible		\$75 copay then 40% after deductible*	
Emergency Care				
Doctor's Office	Office copay		Office copay	
Emergency Room (must meet CIGNA's definition of emergency)	\$150 copay (waived if admitted)		\$150 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. 01/2010

*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 Office 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	Office copay \$150 admission copay per confinement then 20% after deductible	40% after deductible* \$150 admission copay per confinement then 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	\$150 admission copay then 20% after deductible Office copay	\$150 admission copay then 40% after deductible* 40% after deductible*
Employee Assistance Plan (EAP)	1-3 visits @ 100%	In-Network Coverage Only
Prescription Drugs (30 to 90 day supply)		In-Network Coverage Only
Mail Order Drugs (90 day supply)		Mail Order - TelDrug Only
Brand Name	50% coinsurance	
Generic	\$3.00 (\$9.00 for 90 day supply)	
Out-of-Pocket Maximum		
Individual	\$2,500	N/A
Family	\$5,000	N/A
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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