

VACE HEALTH INSURANCE PROGRAM

VACE CIGNA \$2,450 OAP Plan Option (HSA Compatible)

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible Individual Family	\$2,450 (medical and/or drugs) \$4,900 (medical and/or drugs)	\$5,000 (medical and/or drugs) \$10,000 (medical and/or drugs)
Out-of-Pocket Maximum (includes deductible and drug coinsurance) Individual Family	\$3,450 (medical and drug) \$6,900 (medical and drug)	\$5,000 (medical and drug) \$10,000 (medical and drug)
Lifetime Maximum	Unlimited	\$1,000,000
Doctor Visits	100% after deductible	100% after deductible*
Preventive Care Routine Preventive Care Well Woman Care Mammogram	No Charge No Charge No Charge	In-Network Coverage Only In-Network Coverage Only 100% after deductible*
Inpatient Hospital	100% after deductible	100% after deductible*
Outpatient Surgery	100% after deductible	100% after deductible*
Emergency Room	100% after deductible	100% after deductible*
Prescription Drugs (30 to 90 day supply) Mail Order Drugs (90 day supply) Generic/Brand Name Out-of-Pocket Maximum Individual Family	50% coinsurance (after \$2,450 deductible) 50% coinsurance (after \$2,450 deductible) \$1,000 \$2,000	In-Network Coverage Only Mail Order - TelDrug Only N/A N/A
Preventive Drugs	50% coinsurance (no deductible)	

This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions, limitations, including legislated benefits, are contained in the Plan Description or insurance certificate.

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

01/2010

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility (Up to 60 days per calendar year)	100% after deductible	100% after deductible*
Lab and X-ray Services	100% after deductible	100% after deductible*
Outpatient Short-Term Rehabilitation (60 visits all therapies combined per calendar year / Chiropractic Unlimited)		
Facility/Hospital Outpatient	100% after deductible	100% after deductible*
Doctors Office	100% after deductible	100% after deductible*
Home Health Care (Up to 40 visits per calendar year)	100% after deductible	100% after deductible*
Hospice	100% after deductible	100% after deductible*
Maternity		
Initial Visit to Confirm Pregnancy	100% after deductible	100% after deductible*
Delivery Charges/Including Pre & Post natal visits	100% after deductible	100% after deductible*
Durable Medical Equipment (Unlimited annual maximum)	100% after deductible	100% after deductible*
External Prosthetic Devices (Unlimited annual maximum)	100% after deductible	100% after deductible*
Mental Health / Substance Abuse		
Inpatient	100% after deductible	100% after deductible*
Outpatient	100% after deductible	100% after deductible*
Employee Assistance Plan (EAP)	1-3 visits @ 100%	In-Network Coverage Only
Routine Vision	Not Included	Not Included

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