

# VACE HEALTH INSURANCE PROGRAM

## *VACE CIGNA \$3,000 / \$4,000 OAP Plan Option*

BENEFITS	IN-NETWORK		OUT-OF-NETWORK	
<b>Calendar Year Deductible</b> Individual Family	\$3,000 \$6,000	\$4,000 \$8,000	\$5,000 \$10,000	\$8,000 \$16,000
<b>Out-of-Pocket Maximum (includes deductible)</b> Individual Family	\$3,000 \$6,000	\$4,000 \$8,000	\$5,000 \$10,000	\$8,000 \$16,000
<b>Lifetime Maximum</b>	Unlimited		\$1,000,000	
<b>Doctor Visits</b> Primary Specialist	\$30 copay \$50 copay		100% after deductible* 100% after deductible*	
<b>Preventive Care</b> Routine Preventive Care Well Woman Care Mammogram	No Charge No Charge No Charge		Not Covered Not Covered 100% after deductible*	
<b>Inpatient Hospital</b>	\$150 copay then 100% after deductible		\$150 copay then 100% after deductible*	
<b>Outpatient Facility Services</b>	\$75 copay then 100% after deductible		\$75 copay then 100% after deductible*	
<b>Emergency Room</b> Doctor's Office Emergency Room (must meet definition of emergency)	Office copay \$150 copay (waived if admitted)		Office copay \$150 copay (waived if admitted)	
<b>Prescription Drugs (30 to 90 day supply)</b> <b>Mail Order Drugs (90 day supply)</b> Brand Name Generic Out-of-Pocket Maximum Individual Family	50% coinsurance \$3.00 (\$9.00 for 90 day supply)  \$2,500 \$5,000		In-Network Coverage Only Mail Order - TelDrug Only   N/A N/A	

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
<b>Skilled Nursing Facility</b> (Up to 60 days per calendar year)	100% after deductible	100% after deductible*
<b>Lab and X-ray Services</b>	100% after deductible	100% after deductible*
<b>Outpatient Short-Term Rehabilitation (60 visits all therapies combined per calendar year / Chiropractic Unlimited)</b>		
Facility/Hospital Outpatient	100% after deductible	100% after deductible*
Doctors Office	Office copay	100% after deductible*
<b>Home Health Care</b> (Up to 40 visits per calendar year)	100% after deductible	100% after deductible*
<b>Hospice</b>	100% after deductible	100% after deductible*
<b>Maternity</b>		
Initial Visit to Confirm Pregnancy	Office copay	100% after deductible*
Delivery Charges/Including Pre & Post natal visits	\$150 admission copay per confinement then 100% after deductible	\$150 admission copay per confinement then 100% after deductible*
<b>Durable Medical Equipment</b> (Unlimited annual maximum)	100% after deductible	100% after deductible*
<b>External Prosthetic Devices</b> (Unlimited annual maximum)	100% after deductible	100% after deductible*
<b>Mental Health / Substance Abuse</b>		
Inpatient	\$150 admission copay then 100% after deductible	\$150 admission copay then 100% of charges*
Outpatient	Office copay	100% of charges*
<b>Employee Assistance Plan (EAP)</b>	1-3 visits @ 100%	In-Network Coverage Only
<b>Routine Vision</b> (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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