

VACE HEALTH INSURANCE PROGRAM

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

BENEFITS	IN-NETWORK		OUT-OF-NETWORK	
	3000	4000	3000	4000
Calendar Year Deductible Individual Family	\$3,000 \$6,000	\$4,000 \$8,000	\$5,000 \$10,000	\$8,000 \$16,000
Out-of-Pocket Maximum (includes deductible) Individual Family	\$3,000 \$6,000	\$8,000 \$16,000	\$5,000 \$10,000	\$16,000 \$32,000
Lifetime Maximum	Unlimited		\$1,000,000	
Doctor Visits Primary Specialist	\$30 copay \$50 copay	\$30 copay \$50 copay	100% after deductible* 100% after deductible*	40% after deductible* 40% after deductible*
Preventive Care Routine Preventive Exam Well Woman (including Paps) Routine Mammogram Routine Colonoscopy Routine Lab Work	No Charge No Charge No Charge No Charge No Charge		100% after deductible* Not Covered 40% after deductible* Not Covered Not Covered	Not Covered Not Covered 40% after deductible* Not Covered Not Covered
Inpatient Hospital	\$150 copay then 100% after deductible 20% after deductible		\$150 copay then 100% after deductible* 40% after deductible*	
Outpatient Facility Services	\$75 copay then 100% after deductible 20% after deductible		\$75 copay then 100% after deductible* 40% after deductible*	
Emergency Room Doctor's Office Emergency Room (must meet definition of emergency)	Office copay \$150 copay (waived if admitted)		Office copay \$150 copay (waived if admitted)	
Prescription Drugs (30 to 90 day supply) Mail Order Drugs (90 day supply) 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 - CIGNA Home Delivery 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

01/2011

Please Turn Over

VACE CIGNA \$3,000 / \$4,000 OAP Plan Options

BENEFITS	IN-NETWORK		OUT-OF-NETWORK	
	3000	4000	3000	4000
Skilled Nursing Facility (Up to 60 days per calendar year)	100% after deductible	20% after deductible	100% after deductible*	40% after deductible*
Lab and X-ray Services	100% after deductible	20% after deductible	100% after deductible*	40% after deductible*
Outpatient Short-Term Rehabilitation (60 visits all therapies combined per calendar year / Chiropractic Unlimited)				
Facility/Hospital Outpatient	100% after deductible	20% after deductible	100% after deductible*	40% after deductible*
Doctors Office		Office copay	100% after deductible*	40% after deductible*
Home Health Care (Up to 40 visits per calendar year)	100% after deductible	20% after deductible	100% after deductible*	40% after deductible*
Hospice	100% after deductible	20% after deductible	100% after deductible*	40% after deductible*
Maternity				
Initial Visit to Confirm Pregnancy		Office copay	100% after deductible*	40% after deductible*
Delivery Charges/Including Pre & Post natal visits	\$150 admission copay per confinement then 100% after deductible	20% after deductible	\$150 admission copay per confinement then 100% after deductible*	40% after deductible*
Durable Medical Equipment (Unlimited annual maximum)	100% after deductible	20% after deductible	100% after deductible*	40% after deductible*
External Prosthetic Devices (Unlimited annual maximum)	100% after deductible	20% after deductible	100% after deductible*	40% after deductible*
Mental Health / Substance Abuse				
Inpatient	\$150 admission copay then 100% after deductible	20% after deductible	\$150 admission copay then 100% after deductible*	40% of charges
Outpatient		Office copay	100% after deductible*	40% of charges
Employee Assistance Plan (EAP)		1-3 visits @ 100%	In-Network Coverage Only	

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

01/2011

Please Turn Over