

VACE HEALTH INSURANCE PROGRAM

VACE CIGNA \$3,000 OAP Plan Option

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible Individual Family	\$3,000 \$6,000	\$5,000 \$10,000
Out-of-Pocket Maximum (includes deductible) Individual Family	\$3,000 \$6,000	\$5,000 \$10,000
Lifetime Maximum	Unlimited	\$1,000,000
Doctor Visits	\$30 copay	100% after deductible*
Preventive Care Routine Preventive Care Well Woman Care Mammogram	\$30 copay \$30 copay No Charge	Not Covered Not Covered 100% after deductible*
Inpatient Hospital	\$100 copay then 100% after deductible	\$100 copay then 100% after deductible*
Outpatient Facility Services	\$50 copay then 100% after deductible	\$50 copay then 100% after deductible*
Emergency Room Doctor's Office Emergency Room (must meet CIGNA's definition of emergency)	\$30 copay \$100 copay (waived if admitted)	\$30 copay \$100 copay (waived if admitted)
Prescription Drugs (30 to 90 day supply) Mail Order Drugs (90 day supply) Generic/Brand Name Out-of-Pocket Maximum Individual Family Includes Preventive Drugs	50% coinsurance 50% coinsurance \$2,000 \$4,000	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

01/2008

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Skilled Nursing Facility (Up to 60 days per calendar year)	100% after deductible	\$100 per admission then 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	\$30 copay	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	\$30 copay	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 admission copay & 100% after deductible	\$100 admission copay then 100% of charges* (30 day max)
Outpatient	\$30 copay	100% of charges* (30 visit max)
Employee Assistance Plan (EAP)	1-3 visits @ 100%	In-Network Coverage 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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