

VACE HEALTH INSURANCE PROGRAM

VACE CIGNA \$3,500 OAP Plan Option (HSA Compatible)

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible Individual Family	\$3,500 (medical and/or drugs) \$7,000 (medical and/or drugs)	\$7,000 (medical and/or drugs) \$14,000 (medical and/or drugs)
Out-of-Pocket Maximum (includes deductible and drug coinsurance) Individual Family	\$5,000 (medical and drug) \$10,000 (medical and drug)	\$10,000 (medical and drug) \$20,000 (medical and drug)
Lifetime Maximum	Unlimited	\$1,000,000
Doctor Visits	20% after deductible	40% after deductible*
Preventive Care Routine Preventive Care Well Woman Care Mammogram	No Charge 100%	In-Network Coverage Only 40% after deductible*
Inpatient Hospital	20% after deductible	40% after deductible*
Outpatient Surgery	20% after deductible	40% after deductible*
Emergency Room	20% after deductible	40% after deductible*
Prescription Drugs (30 to 90 day supply) Mail Order Drugs (90 day supply) Generic/Brand Name Out-of-Pocket Maximum Preventive Drugs	50% coinsurance (after \$3,500 deductible) 50% coinsurance (after \$3,500 deductible) Plan Out-of-Pocket Applies 50% coinsurance (no deductible)	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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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	20% after deductible	40% after deductible*
Doctors Office	20% 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	20% after deductible	40% after deductible*
Delivery Charges/Including Pre & Post natal visits	20% after deductible	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	20% after deductible	40% after deductible* (30 day max)
Outpatient	20% after deductible	40% after deductible* (20 visit max)
Employee Assistance Plan (EAP)	1-3 visits @ 100%	In-Network Coverage Only
Routine Vision	Not Included	Not Included

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