

**DANVILLE AREA COMMUNITY COLLEGE**  
**2011-2012 Health Plan Employee Options**

	<i>Option One (0501)</i>		<i>Option Two (0502)</i>		<i>Option Three (0505)</i>		<i>Option Four (0506)</i>	
	<i>PPO Providers</i>	<i>NonPPO Providers</i>	<i>PPO Providers</i>	<i>NonPPO Providers</i>	<i>PPO Providers</i>	<i>NonPPO Providers</i>	<i>PPO Providers</i>	<i>NonPPO Providers</i>
<b>Deductible/Out-of-Pocket</b>								
Lifetime Maximum Benefit	Unlimited	No Coverage		Unlimited		Unlimited		Unlimited
Per Confinement Deductible	-----	No Coverage	None	\$200				
Plan Year Deductible	None	No Coverage		\$200	\$500 (\$1000 Family)	\$1000 (\$2000 Family)	\$500 (\$1500 Family)	\$1000 (\$3000 Family)
Out-of-Pocket Maximum								
Individual	None	No Coverage	\$800	\$3,000	\$2,000	\$4,000	\$2,000	\$4,000
Family	None	No Coverage	\$2,000	\$7,000	\$4,000	\$8,000	\$6,000	\$12,000
<b>Special Coverages</b>								
Second Surgical Opinion	100% after a \$10 co-pay	No Coverage			80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Voluntary	-----			80% No Deductible	-----		-----	
Required	-----			100% No Deductible	-----		-----	
Well Child Care (through age 6)								
Office Visits	100% after a \$10 co-pay	No Coverage		80% No Deductible	100% after a \$20 copay	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Immunizations/Routine Lab Work	100%	No Coverage		100% No Deductible	100% after a \$20 copay	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
School Health Exams (grades 5 and 8)								
Office Visits	100% after a \$10 co-pay	No Coverage		80% No Deductible	100% after a \$20 copay	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Immunizations/Routine Lab Work	100%	No Coverage		100% No Deductible	100% after a \$20 copay	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Adult Physicals (age 19 and over)								
Office Visits	100% after a \$10 co-pay	No Coverage		80% No Deductible	100% after a \$20 copay	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Immunizations/Routine Lab Work	100%	No Coverage		100% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Pap Smear	100%	No Coverage		100% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Related Exam	100% after a \$10 co-pay	No Coverage		100% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Related Professional charges	100%	No Coverage		80% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Mammograms	100%	No Coverage		100% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Related Professional charges	100%	No Coverage		80% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Sigmoidscopy	100%	No Coverage		80% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Fecal Occult Blood Testing	100%	No Coverage		100% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Related Professional charges	100%	No Coverage		80% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
PSA Test	100%	No Coverage		100% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Related Exam	100% after a \$10 co-pay	No Coverage		80% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Related Professional charges	100%	No Coverage		80% No Deductible	100% No Deductible	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
<b>Physician and Office Services</b>								
Office Visits	100% after a \$10 co-pay	No Coverage		80% Deductible Applies	100% after a \$20 copay	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Surgeon	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Diagnostic X-ray & Lab	100%	No Coverage		100% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Independent Lab, Radiologist & Pathologist	100%	No Coverage		100% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Allergy Injections	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Allergy Testing	100%	No Coverage		100% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Acupuncture for treatment of chronic pain	100% after a \$10 co-pay	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Christian Science Practitioner	100% after a \$10 co-pay	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Nurse Practitioner	100% after a \$10 co-pay	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Dietician Services/Consultation	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Chemotherapy	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Physical, Occupational & Speech Therapy	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Chiropractic Services	100% after a \$10 co-pay	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Podiatric Services					50% after the deductible up to 15 visits		50% after the deductible up to 15 visits	
Office Visits	100% after a \$10 co-pay	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Surgery	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
X-ray & Lab	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Orthotics	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Infertility Services								
Physician Charges	100% after a \$10 co-pay	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Lab/X-ray	100%	No Coverage		100% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Other Covered Services				80% Deductible Applies				
<b>Outpatient Hospital &amp; Ambulatory Surgical Center</b>								
Facility	100%	No Coverage	90% Deductible Applies	65% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Surgi-Center/Ambulatory Surgicenter (Facility Fee Only)	-----		90% Deductible and Network OOP Applies		-----		-----	
Emergency Room	100% after a \$150 co-pay	No Coverage	80% after a \$200 per visit co-pay, Deductible Applies		100% after a \$150 co-pay	100% after a \$150 co-pay	80% (\$50 penalty for non-emergencies)	60% (\$50 penalty for non-emergencies)
Urgent Care Facility	100% after a \$10 co-pay	No Coverage			100% after a \$150 co-pay	100% after a \$150 co-pay	80% Deductible Applies	60% Deductible Applies
Non-Emergency Care	-----			80% Deductible Applies	-----		-----	
Emergency Care	-----			100% Deductible Applies	-----		-----	
Lab/X-ray	-----			100% Deductible Applies	-----		-----	
Diagnostic X-ray & Lab	100%	No Coverage		100% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Pre-Admission Testing	100%	No Coverage	90% Deductible Applies	65% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Surgeon	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Physical, Occupational & Speech Therapy	100%	No Coverage	90% Deductible Applies	65% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Chemotherapy & Radiation Therapy	100%	No Coverage	90% Deductible Applies	65% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Assistant Surgeon, Anesthesiologist, & Consulting Physician	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Pathologist, Radiologist	100%	No Coverage		100% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Other Covered Services	100%	No Coverage	90% Deductible Applies	65% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
<b>Inpatient Hospital</b>								
Room, Board & Miscellaneous	100% after a \$150 co-pay	No Coverage	90% Deductible Applies	65% Deductible Applies	80% after a \$150 co-pay	60% after a \$150 co-pay	80% Deductible Applies	60% Deductible Applies
Nursery	100% after a \$150 co-pay	No Coverage	90% Deductible Applies	65% Deductible Applies	80% after a \$150 co-pay	60% after a \$150 co-pay	80% Deductible Applies	60% Deductible Applies
Diagnostic X-ray & Lab	100%	No Coverage	90% Deductible Applies	65% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Surgeon	100% after a \$10 co-pay	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Physician Visits	100% after a \$10 co-pay	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Private Duty Nursing	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies

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Assistant Surgeon, Anesthesiologist, & Consulting Physician	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Other Covered Services	100%	No Coverage	90% Deductible Applies		80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
<b>Other Covered Services</b>								
Extended Care Facility	100% after a \$150 co-pay	No Coverage		80% Deductible Applies	80% after a \$150 co-pay	60% after a \$150 co-pay	80% Deductible Applies	60% Deductible Applies
Home Health Care	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Hospice Care	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Rbereavement Counseling	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Ambulance	100%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Durable Medical Equipment	80%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Prosthetic Appliances	80%	No Coverage		80% Deductible Applies	80% Deductible Applies	60% Deductible Applies	80% Deductible Applies	60% Deductible Applies
Smoking Cessation Program	100% up to \$600	No Coverage		100% up to \$600	100% up to \$600	100% up to \$600	100% up to \$600	100% up to \$600
<b>Prescription Drug Plan</b>								
Retail Prescription Plan								
Brand	100% after a \$10 co-pay	No Coverage		\$24	100% after a \$40 co-pay	No Coverage	100% after a \$40 co-pay	No Coverage
Formulary	100% after a \$10 co-pay	No Coverage		\$12	100% after a \$20 co-pay	No Coverage	100% after a \$20 co-pay	No Coverage
Generic	100% after a \$5 co-pay	No Coverage		\$6	100% after a \$10 co-pay	No Coverage	100% after a \$10 co-pay	No Coverage
Mail Order Prescripion Plan								
Brand	100% after a \$20 co-pay	No Coverage		\$48	100% after a \$80 co-pay	No Coverage	100% after a \$80 co-pay	No Coverage
Formulary	100% after a \$20 co-pay	No Coverage		\$24	100% after a \$40 co-pay	No Coverage	100% after a \$40 co-pay	No Coverage
Generic	100% after a \$10 co-pay	No Coverage		\$12	100% after a \$20 co-pay	No Coverage	100% after a \$20 co-pay	No Coverage
Purchased Outside the Plan	No Coverage	No Coverage	100% of the discounted amount minus the appropriate co-		No Coverage	No Coverage	No Coverage	No Coverage
<b>Dental Benefits</b>								
Plan Year Maximum Benefit		\$1,200		\$1,200		No coverage		\$1,200
Prosthetic, Periodontic, Surgical Extraction & Related Anesthesia		\$2,000		\$2,000		No Coverage		\$2,000
Orthodontia Lifetime Maximum		\$1,500		\$1,500		No Coverage		\$1,500
Plan Year Deductible		\$50 per person		\$50 per person		No Coverage		\$50 per person
<b>VSP</b>								
Eye Care Wellness								
Exam	Covered in Full	up to \$25 every 24 months	Covered in Full	up to \$25 every 24 months		No coverage	Covered in Full	up to \$25 every 24 months
Lenses	Single Vision, Lined Bifocal, Lined Trifocal lenses are covered in full	up to \$30 (\$35 bifocal & \$45 trifocal) every 24 months	Single Vision, Lined Bifocal, Lined Trifocal lenses are covered in full	up to \$30 (\$35 bifocal & \$45 trifocal) every 24 months		No Coverage	Single Vision, Lined Bifocal, Lined Trifocal lenses are covered in full	up to \$30 (\$35 bifocal & \$45 trifocal) every 24 months
Frames	VSP fully covers a wide selection of frames	up to \$45	VSP fully covers a wide selection of frames	up to \$45		No Coverage	VSP fully covers a wide selection of frames	up to \$45
Contact Lenses	Covered in Full after a \$50 co-pay	up to \$250 after a \$50 co-pay every 24 months	Covered in Full after a \$50 co-pay	up to \$250 after a \$50 co-pay every 24 months		No Coverage	Covered in Full after a \$50 co-pay	up to \$250 after a \$50 co-pay every 24 months
<b>2011-2012</b>								
	<b>College Contributes</b>	<b>Employee Contributes</b>	<b>College Contributes</b>	<b>Employee Contributes</b>	<b>College Contributes</b>	<b>Employee Contributes</b>	<b>College Contributes</b>	<b>Employee Contributes</b>
Single Employee + One	<b>\$839.00</b>	<b>\$210.00</b>	<b>\$954.00</b>	<b>\$238.00</b>	<b>\$817.00</b>	<b>\$0.00</b>	<b>\$817.00</b>	<b>\$0.00</b>
Family	<b>\$839.00</b>	<b>\$1,212.00</b>	<b>\$954.00</b>	<b>\$1,371.00</b>	<b>\$817.00</b>	<b>\$825.00</b>	<b>\$817.00</b>	<b>\$825.00</b>
	<b>\$839.00</b>	<b>\$1,804.00</b>	<b>\$954.00</b>	<b>\$2,076.00</b>	<b>\$817.00</b>	<b>\$1,020.00</b>	<b>\$817.00</b>	<b>\$1,020.00</b>

**Dental and Vision benefits are available optional coverages. Rates for Dental benefits are \$21 for Single, \$37 for Employee + One, and \$70 for Family coverage. Rates for Vision benefits are \$10 for Single, \$15 for Employee + One, and \$26 for Family coverage.**