Summary of Benefits & Coverages Vault Small Employer Captive V2500 Model Plan Design - \$2,500/\$5,000

- ➤ All payable benefits are subject to the applicable exclusions and maximum eligible expense provisions. See the Summary Plan Document for additional details.
- ➤ The Benefit Period ends on December 31 of each year and renews benefit limits on January 1 of each year. Deductibles do not carry over from calendar year to calendar year. No expenses from prior plans (or periods) will count toward this deductible.
- ➤ Your employer has contracted with a preferred provider network. However, all providers are accepted by this plan as "in network." For assistance finding a provider please contact (800) 425-9374.
- ➤ The Covered Person is responsible for 100% of the cost of Outpatient Prescription Drug Out-of-Pocket Eligible Expenses until the applicable Deductible Amount(s) per Covered Person is (are) satisfied. The Copayment amounts and Coinsurance Percentages listed are payable by the Covered Individual in each Calendar Year after the applicable Deductible Amount(s) per Covered Individual is (are) satisfied.
- ➤ The Copayment amounts and Coinsurance Percentages listed are payable by the Covered Person in each Calendar Year after the applicable Deductible Amount(s) per Covered Person is (are) satisfied.
- ➤ Pre-Authorization (Pre-Certification) is required prior to some services and may be subject to the Edison Health Second Opinion Program. It is the Member's responsibility to follow the Pre-Certification procedures, failure to do so may result in the reduction or non-payment of benefits. Contact the Third-Party Administrator prior to scheduling any of the services listed here:
 - Transplants
 - Facility Admissions Inpatient
 - Outpatient hospital services
 - Inpatient/Outpatient Surgery (not in the doctor's office)
 - Cancer Treatment
 - Advanced Imaging CT scans, MRIs, Nuclear Imaging

Schedule of Benefits

General Provisions -		
DEDUCTIBLE (Combined with Pharmacy Benefit)		
Per Covered Person per Benefit Period	\$2,500	
Per Family per Benefit Period	\$5,000	
BENEFIT PERCENTAGE		
After satisfaction of Deductible / Out-of-Pocket	100%	
Maximum)		
OUT-OF-POCKET MAXIMUM		
Per Covered Person per Benefit Period	\$2,500	
Per Family per Benefit Period	\$5,000	
Patient responsibility for Pharmacy co-pay and		
co-insurance continues after reaching OUT-OF-		
POCKET MAXIMUM. (see pharmacy tiers below)		
Type of Service / Limitations	Benefit/Coverage	
Acupuncture	Not Covered	
Allergy Injections	100% after Deductible	
Ambulance Service - As described in Article 6.1	100% after Deductible	
Ambulatory Surgical Center	100% after Deductible	
Anesthesia	100% after Deductible	
Bariatric Surgery	Not Covered	
Biofeedback	Not Covered	
Birthing Center	100% after Deductible	
Brachytherapy	100% after Deductible	
Cardiac Rehabilitation – As described in Article 6.1	100% after Deductible	
Chemotherapy – Outpatient	100% after Deductible	
Chiropractic Care	100% after Deductible	
Colonoscopy - Diagnostic Colonoscopy	100% after Deductible	
Routine Colonoscopy (1 every 10 years over	100% Deductible Waived	
age 50)		
Contraceptives (Pharmacy or Devices)	100% after Deductible	
Cosmetic Surgery	Not Covered	
Dental Services (Covered only if result of Accidental	100% after Deductible	
Injury unless identified as additional benefits, below)	10070 and Boadonsio	
Diabetic Education	100% after Deductible	
Diagnostic Tests - Outpatient	100% after Deductible	
Dialysis Treatments - Outpatient	100% after Deductible	
Medical Equipment	100% after Deductible	
Education	Not Covered	
Eyeglasses	Not Covered	
Experimental Services	Not Covered	
Home Health Care	100% after Deductible	
Hospice Care (1 benefit period – 6 months max or per	100% after Deductible	
pre-authorized Hospice Care Plan)		
Hospital Services	100% after Deductible	
Infertility Treatment	Not Covered	
Infusion Services/IV Therapy - Outpatient	100% after Deductible	
njections 100% after Deductible		
ong-term care Not Covered		
_aboratory 100% after Deductible		
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Mammograms - Diagnostic Mammogram	100% after Deductible	
Routine Mammogram (1 per year over the age of 40)	100% Deductible Waived	
Maternity Services (during pregnancy)	100% after Deductible	
Medical Supplies provided by Hospital or Physician	100% after Deductible	
Mental Health - Office visits and inpatient facility	100% after Deductible	
services		
Non-Emergency Care Outside of the US	Not Covered	
Occupational Therapy - Outpatient	100% after Deductible	
Orthotics	Not Covered	
Physical Therapy - Outpatient	100% after Deductible	
Physician Services	100% after Deductible	
Preventive Care – as defined at	100% Deductible Waived	
https://www.healthcare.gov/coverage/preventive-care-benefits/		
Private Duty Nursing	Not Covered	
Prosthetic Appliances	100% after Deductible	
Radiation Therapy – Outpatient*	100% after Deductible	
Radiology / Imaging (X-Ray, MRI, CT, PET, etc)	100% after Deductible	
Respiratory Therapy - Outpatient	100% after Deductible	
Sleep Studies (medically necessary)	100% after Deductible	
Speech Therapy - Outpatient	100% after Deductible	
Sterilization Procedures	100% after Deductible	
Substance Abuse (Alcohol/Chemical)	100% after Deductible	
- Office visits and inpatient facility services		
Surgery - Office	100% after Deductible	
Surgery – Inpatient / Outpatient	100% after Deductible	
TMJ / Jaw Disorders	Not Covered	
Urgent Care Services	100% after Deductible	
Transplant Services	100% after Deductible	
Vision Services (Covered only if result of Accidental	100% after Deductible	
Injury unless identified as additional benefits, below)		
Vision Therapy	Not Covered	
/eight Loss Programs Not Covered		

The Covered Individual is responsible for 100% of the cost of many Outpatient Prescription Drug Out-of-Pocket Eligible Expenses until the applicable Deductible Amount(s) per Covered Individuals (are) satisfied.

The Copayment amounts and Coinsurance Percentages listed are payable by the Covered Individual in each Calendar Year after the applicable Deductible Amount(s) per Covered Individuals (are) satisfied.

Tier	Retail Copayment	Mail Order Copayment
	(Maximum 30-day supply)	(Maximum 90-day supply)
Tier 1: Preventive Drugs:	\$0.00 (Prior to and after	\$0.00 (Prior to and after
	meeting the deductible)	meeting the deductible)
Tier 2: Preferred Generics	100% prior to meeting	100% prior to meeting
	deductible	deductible \$30.00 (after
	\$15.00 (after deductible)	deductible)
Tier 3: Preferred Brand &	100% prior to meeting	100% prior to meeting
non-preferred generics:	deductible \$50.00 (after	deductible \$100.00 (after
	deductible)	deductible)
Tier 4: Non-Preferred	100% prior to meeting	100% prior to meeting
Brand:	deductible \$100 (after	deductible \$200 (after
	deductible)	deductible)
Tier 5: Specialty Drugs	100% prior to meeting deductible	
	35% copayment after meeting deductible	
	Max 30-day supply	
Tier 6: Non-formulary &	100% copay – not covered	
excluded drugs		

The Current Pharmacy Formulary and Tier List can be found at https://www.AllThingsVault.com/CaptiveSmallEmployer. The formulary and tier list is subject to change from time to time, without notice.

Additional Benefits:

Telemedicine and Virtual Behavioral Health Benefits. The Plan includes unlimited access for Covered Individuals to VaultTeleMed, for zero Co-Pay virtual Medical Benefits and a limited number of zero Co-Pay Behavioral Health consults. Telephone and video services are provided by board certified professionals licensed in your state. A welcome packet will be sent to employees with instructions for accessing services. Or visit https://portal.vaulttelemed.com/ for additional information. Using virtual services is a great way to reduce the cost of benefits for you and your plan, please consider these options when services are needed.