Summary of Benefits & Coverages

Vault Small Employer Captive

V10000 Model Plan Design - $10,000/$20,000

- 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 Per Family per Benefit Period	 $10,000 $20,000
BENEFIT PERCENTAGE After satisfaction of Deductible / Out-of-Pocket Maximum)	 100%
OUT-OF-POCKET MAXIMUM Per Covered Person per Benefit Period Per Family per Benefit Period Patient responsibility for Pharmacy co-pay and co-insurance continues after reaching OUT-OF-POCKET MAXIMUM. (see pharmacy tiers below)	 $10,000 $20,000
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 • Routine Colonoscopy (1 every 10 years over age 50)	100% after Deductible 100% **Deductible Waived**
Contraceptives (Pharmacy or Devices)	100% after Deductible
Cosmetic Surgery	Not Covered
Dental Services (Covered only if result of Accidental Injury unless identified as additional benefits, below)	100% after Deductible
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 pre-authorized Hospice Care Plan)	100% after Deductible
Hospital Services	100% after Deductible
Infertility Treatment	Not Covered
Infusion Services/IV Therapy - Outpatient	100% after Deductible
Injections	100% after Deductible
Long-term care	Not Covered
Laboratory	100% after Deductible

Mammograms – Diagnostic Mammogram Routine Mammogram (1 per year over the age of 40)	100% after Deductible 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 services	100% after Deductible
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 https://www.healthcare.gov/coverage/preventive-care-benefits/	100% Deductible Waived
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) - Office visits and inpatient facility services	100% after Deductible
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 Injury unless identified as additional benefits, below)	100% after Deductible
Vision Therapy	Not Covered
Weight 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 (Maximum 30-day supply)	Mail Order Copayment (Maximum 90-day supply)
Tier 1: Preventive Drugs:	$0.00 (Prior to and after meeting the deductible)	$0.00 (Prior to and after meeting the deductible)
Tier 2: Preferred Generics	100% prior to meeting deductible $15.00 (after deductible)	100% prior to meeting deductible $30.00 (after deductible)
Tier 3: Preferred Brand & non-preferred generics:	100% prior to meeting deductible $50.00 (after deductible)	100% prior to meeting deductible $100.00 (after deductible)
Tier 4: Non-Preferred Brand:	100% prior to meeting deductible $100 (after deductible)	100% prior to meeting deductible $200 (after deductible)
Tier 5: Specialty Drugs	100% prior to meeting deductible 35% copayment after meeting deductible Max 30-day supply	
Tier 6: Non-formulary & excluded drugs	100% copay – not covered	

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 **http://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.