Summary of Benefits & Coverages

Vault Small Employer Captive (Sub-Groups w/ embedded Dental & Vision)

V5000 Model Plan Design - $5,000/$10,000

- 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	 $ 5,000 $10,000
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)	 $ 5,000 $10,000
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.

Vision and Dental Benefits

Vision Benefit	In-Network Benefits	Out-of-Network Reimbursement
Vision Examination	Covered in full after $10 copay	$35.00
Contact Lens Fit and Follow-up	Standard - $50 member out-of-pocket maximum	N/A N/A
Frame Allowance	Covered in full after copay	
Copay	$25	Up to $45
Retail Value	$130	
Standard Spectacle Lenses		
Single Vision	Covered in full	Up to $25
Bifocal	Covered in full	Up to $40
Trifocal	Covered in full	Up to $50
Lenticular	Covered in full	Up to $80
Specialty Lenses (high-index, etc.)	Corresponding standard lens reimbursement	Corresponding standard lens reimbursement
Lens Options		
Adult Polycarbonate	Up to $44 copay	N/A
Standard Scratch-Resistant Coating	Up to $17 copay	N/A
Ultra-Violet Screening	Up to $15 copay	N/A
Standard Tint	Up to $17 copay	N/A
Standard Anti-Reflective Coating	Up to $45 copay	N/A
Level 1 Progressives	Up to $75 copay	N/A
Level 2 Progressives	Up to $110 copay	N/A
Transitions® (single focus/Multi-focus)	Up to $80 copay	N/A
Polarized	Up to $75 copay	N/A
Contact Lenses (in lieu of frame and specitacle lenses)		
Elective Allowance	$130	$110.50
Lenses or Contact Lenses	Covered in full	$250
Frequancy		
Eye Examination	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frame	Once every 24 months	Once every 24 months
Providers accessed through Avesis https://www.avesis.com/Commercial3/ProviderSearch_Gen.aspx Vision benefits administered by Aveis Third Party Adminstrators, Inc. See Exclusions and Limitations		

Dental Benefit	Member Pays	Limitations*
Preventative/Diagnostic Services		
Periodic and Initial Oral Examinations	$0	1 per consecutive 6 month period
Cleanings Adult/Child	$0	1 per consecutive 6 month period
Fluoride Treatment (Up to age 18)	$0	1 per consecutive 6 month period
Sealants (Permanent 1st and 2nd mol	$0	1 placement per tooth per consecutive 36 month period
Bitewing X-rays	$0	1 set per consecutive 12 month period
Basic Services		
Full mouth series x-ray or panoramic	20% Coinsurance	1 service per consecutive 48 month period
Restorative Amalgam or Composite (	20% Coinsurance	no limitations
Simple Tooth Extraction	20% Coinsurance	no limitations
Major Resortative Services		
Endodontics	50% Coinsurance	no limitations
Periodontics (Surgical and non-surgic	50% Coinsurance	no limitations
Full or Partial Dentures	50% Coinsurance	1 set per arch per consecutive 60 month period
Crowns	50% Coinsurance	1 placement per tooth per consecutive 60 month period
Core Buildup (D2950)	50% Coinsurance	1 placement per tooth per consecutive 60 month period
Post/Core (D2954)	50% Coinsurance	1 placement per tooth per consecutive 60 month period
Bridges	50% Coinsurance	1 placement per tooth per consecutive 60 month period
Surgical Extractions	50% Coinsurance	no limitations
Local Anesthesia	50% Coinsurance	no limitations
Inlays/Onlays	50% Coinsurance	1 placement per tooth per consecutive 60 month period
Implants	50% Coinsurance	1 placement per tooth per consecutive 60 month period

* Annual Individual Maximum Benefit $1,500/Family $3,000
Providers accessed through the Dentemax provider network. Provider look up available at https://www.dentemax.com/clients/find-a-dentist
Dental Benefits Administerd by VAULT Admin Services, LLC Powered by AMPS

Vision & Dental
Exclusions and Limitations

Notice: Starting January 1, 2022 Vision and Dental benefits are incorporated in the VAULT Small Employer reimbursement contract and the recommended Plan Documents.

Dental

1. Procedures which are not necessary and which do not have uniform endorsement.
2. Procedures for which a charge would not have been made in the absense of coverage or for which the covered person is not legally required to pay.
3. Replacement of lost or stolen appliances or dentures.
4. Replacement of teeth beyond the normal complement of 32.
5. Orthodontic treatment.
6. Charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies.
7. Charges for travel time, transportation costs or professional advice given on the phone.
8. Any charge for any treatment performed outside the United States other than for emergency treatment.
9. Oral hygiene, plaque control, tobacco and diet instructions, broken appointments, completion of claim forms, personal supplies (water pick, tootbrush, floss holder, etc.), duplication of x-rays and exams required by a third party.
10. Services or appliances which restore or alter occlusion or vertical dimension.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Fixed or removable appliances for correction of harmful habits.
13. Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
14. Brush biopsy
15. Nitrous Oxide
16. Prosthodontics to replace missing teeth are covered only for teeth that are lost while plan participant is covered by this plan.
17. Any item or procedure not specifically covered under the Schedule of Benefits

Vision

1. Out-of-Network Providers: Members who elect to use out-of-network provider must pay the provider in full at the time of service and submit a claim to Avesis for reimbursement. Reimbursement levels are in accordance with the out-of-network reimbursement schedule previously listed. Out-of-network benefits are subject to the same eligibility, availability, fequency of benefits, and limitations and exclusions provisions of the plan, and are in lieu of services provided by participating Avesis provider. Out-of-network claim forms can be obtained by contacting Avesis Customer Center or by visiting www.avesis.com.

2. Limitations & Exclusions: Some provisions, benefits, exclusions, or limitations listed may vary depending on your state of residence.
Limitations: This plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should you select options that are not covered under the plan, as shown in the schedule of benefits, you will pay a discounted fee to the participating Avesis provider. Benefits are payable only for services recieved while your coverage is in force.

Exclusions: There are no benefits under the plan for professional services or materials connected with and arising from:
a) Orthoptics or vision training;
b) Subnormal vision aids and any supplemental testing, aniseikonic lenses;
c) Plano (non-prescription) lenses, sunglasses;
d) Two pair of glasses in lieu of bifocal lenses;
e) Any medical or surgical treatment of eye or supporting structures;
f) Replacement of lost or broken lenses, contact lenses, or frames, except when normally eligible for services;
g) Any eye examination or corrective eyewear required by an employer as a condition of employment and safety eyewear;
h) Services or materials provided as a result of Workers' Compensation Law, or similar legislation, required by any governement agency whether Federal, State, or subdivision thereof.

Refractive Surgery Vision Benefit Exclusions: Benefits are not payable for any of the following:
a) Routine vision examinations or corrective vision materials, including corrective eyeglasses, fittings, lenses, frames, or contact lenses; or
b) Medical or surgical procedures, services, or treatments:
   i) not specifically covered in the plan document
   ii) provided free of charge in the absense of insurance
   iii) payable under any Worker's Compensation law or similar statutory authority
   iv) payable under government plan or program, whether Federal, state, or subdivision thereof.

3. Notes and Disclaimer: The contact lense allowance may be used all at once or throughout the plan year as needed or may be applied toward contact lenses only. Reftactive Laser Surgery is considered an elective procedure, and may involve potential risks to patients. Avesis and VAULT Captive are not responsible for the outcomes of any refractive surgery. Discounts on materials are not available at Walmart locations. You may not use your contact lens allowance toward fitting fees at Walmart and are responsible for any out-of-pocket fees associated with fittings there. Discounts on materials are not available at Costco locations. ID cards are not required for services.