Summary of Benefits and Coverages
V2500 Plan - $2,500/$5,000 (VSSE 01)

(to be distributed to eligible individuals)

- All benefits payable are subject to the applicable exclusions and maximum eligible expense provisions.
- 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 not contracted with a preferred provider network. 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. (See the Outpatient Prescription Drug Coverage section of this document)
- 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.

General Provisions	Benefit
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 Maximum	100%
OUT-OF-POCKET MAXIMUM (Combined with Pharmacy Benefit)	
Per Covered Person per Benefit Period	$2,500
Per Family per Benefit Period	$5,000

This plan is administered by VAULT Admin Services, LLC. In cooperation with NBFSA Administrative Solutions and Advanced Medical Pricing Solutions.

Verification of Benefits - (800) 425-9374
Claim Submission Questions - (800) 425-9374
Medical - Member Services & Questions - (800) 425-9374
Pharmacy Services & Questions - (888) 424-4186
Billing Questions - (877) 403-4919
General Program Questions – (309) 244-4629

Some plan benefits are subject to approval by the Edison Health Second Opinion program.

See the Summary Plan Document for a more detailed explanation of benefits and coverages, available at https:/AllThingsVAULT.com/garplans

Type of Service / Limitations	Benefit/Coverage
Acupuncture	Not Covered
Allergy Injections	100% after Deductible
Allergy Testing / Serums	100% after Deductible
Ambulance Service Air Ambulance Ground Ambulance	 100% after Deductible 100% after Deductible
Ambulatory Surgical Center	100% after Deductible
Anesthesia	100% after Deductible
Audiological Services • 0 – 18 years of age	100% after Deductible
Bariatric Surgery	Not Covered
Biofeedback	Not Covered
Birthing Center Facility Services Professional Services	 100% after Deductible 100% after Deductible
Brachytherapy	100% after Deductible
Cardiac Rehabilitation – Outpatient	100% after Deductible
Chemotherapy – Outpatient* Facility Services Professional Services	 100% after Deductible 100% after Deductible
Chiropractic Care	100% after Deductible
Colonoscopy Routine Colonoscopy • **1 every 10 years over age 50** Diagnostic Colonoscopy	 100% **Deductible Waived** 100% after Deductible
Contraceptives (Devices)	100% after Deductible
Cosmetic Surgery	Not Covered
Dental Services Covered only if result of Accidental Injury	 100% after Deductible
Diabetic Education	100% after Deductible
Diagnostic Tests - Outpatient Facility Services Professional Services	 100% after Deductible 100% after Deductible
Dialysis Treatments - Outpatient	100% after Deductible
Durable Medical Equipment	100% after Deductible
Education	Not Covered
Eyeglasses	Not Covered
Experimental Services	Not Covered
Hearing Aids	100% after Deductible
Home Health Care	100% after Deductible
Hospice Care (1 benefit period per year – 6 months max)	100% after Deductible
Hospital Services* Inpatient Facility Services Inpatient Professional Services Outpatient Facility Services (26 annual visits max) Outpatient Professional Services	 100% after Deductible 100% after Deductible 100% after Deductible 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 Routine Mammogram • 1 per year over the age of 40 Diagnostic Mammogram	 100% **Deductible Waived** 100% after Deductible
Maternity Services (during pregnancy) Office Visit (Initial / not part of global fee) Inpatient Facility Services Inpatient Professional Services Outpatient Facility Services Outpatient Professional Services	 100% after Deductible 100% after Deductible 100% after Deductible 100% after Deductible 100% after Deductible
Medical Supplies	100% after Deductible
Mental Health Office Visit Services (Maximum 26 visits per year) Inpatient Facility Services (Maximum 31 days) Inpatient Professional Services (same as other services) Outpatient Facility Services (same as other services) Outpatient Professional Services (same as other services)	 100% after Deductible 100% after Deductible 100% after Deductible 100% after Deductible 100% after Deductible
Non-Emergency Care Outside of the US	Not Covered
Occupational Therapy - Outpatient	100% after Deductible
Orthopedic Devices	100% after Deductible
Orthotics	Not Covered
Physical Therapy - Outpatient	100% after Deductible
Physician Services Office Visits Outpatient Visits Retail Health Clinic Visits Online Medical Visits (Telehealth) Inpatient Visits Home Visits Specialist Visit	 100% after Deductible 100% after Deductible 100% after Deductible 100% after Deductible 100% after Deductible 100% after Deductible 100% after Deductible
Preventive Care	100% Deductible Waived
Private Duty Nursing	Not Covered
Prosthetic Appliances	100% after Deductible
Radiation Therapy – Outpatient* Facility Services Professional Services	 100% after Deductible 100% after Deductible
Radiology / Imaging (X-Ray, MRI, CT, PET, etc…)	100% after Deductible
Respiratory Therapy - Outpatient Facility Services Professional Services	 100% after Deductible 100% after Deductible
Skilled Nursing Facility	Not Covered

Service	Benefit
Sleep Studies	Not Covered
Speech Therapy - Outpatient	100% after Deductible
Sterilization Procedures	
Female Sterilization Procedures	100% after Deductible
Vasectomy	100% after Deductible
Substance Abuse (Alcohol/Chemical)	
Office Visit Services (Maximum 26 visits per year)	100% after Deductible
Inpatient Facility Services (Maximum 31 days)	100% after Deductible
Inpatient Professional Services (same as other services)	100% after Deductible
Outpatient Facility Services (same as other services)	100% after Deductible
Outpatient Professional Services (same as other services)	100% after Deductible
Surgery – Office	100% after Deductible
Surgery – Inpatient / Outpatient*	
Facility Services	100% after Deductible
Professional Services	100% after Deductible
TMJ / Jaw Disorders	Not Covered
Urgent Care Services	100% after Deductible
Transplant Services*	100% after Deductible
Vision Exams	100% after Deductible
Vision Therapy	Not Covered
Weight Loss Programs	Not Covered

Note * Pre-certification is required for Services and are subject to the Edison Health Second Opinion Program, and/or pre-auth processes provided by Advanced Medical Pricing Solutions. If Pre-certification is not obtained the charge could be denied if the service, treatment, or supply is found to be not Medically Necessary when the claim is submitted. Payment of benefits may be subject to the Edison Health contracted rates available through an accredited Center of Excellence.

Benefit applies to all expenses in connection with any eligible procedure. Services subject to the benefit limits include, but are not limited to: evaluation, surgery and post-surgery care including organ donor search, procurement and retrieval, complications related to the procedure and follow up care received during the 12-month period from date of transplant surgery.

OUTPATIENT PRESCRIPTION DRUG COVERAGE

Deductible Amounts, Coinsurance Percentages and Maximum Days Supply

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 Person in each Calendar Year after the applicable Deductible Amount(s) per Covered Person is (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 deducible $15.00 (after deductible)	100% prior to meeting deducible $30.00 (after deductible)
Tier 3: Preferred Brand & non-preferred generics:	100% prior to meeting deducible $50.00 (after deductible)	100% prior to meeting deducible $100.00 (after deductible)
Tier 4: Non-Preferred Brand:	100% prior to meeting deducible $100 (after deductible)	100% prior to meeting deducible $200 (after deductible)
Tier 5: Specialty Drugs	100% prior to meeting deducible 35% copayment after meeting deductible Max 30 day supply	
Tier 6: Non-formulary & excluded drugs	100% copay – not covered	

Maximum Amount of Coinsurance Out-of-Pocket Eligible Expense

If, during the same Calendar Year, a Covered Person incurs $2,500 of Out-of-Pocket Eligible Expense under the Major Medical Expense Coverage and the Outpatient Prescription Drug Coverage combined, any additional Outpatient Prescription Drug Coverage Eligible Expense incurred by the Covered Person in the remainder of the Calendar Year is payable at 100% Coinsurance less the copayment amounts and coinsurance amounts listed under Deductible Amounts, Coinsurance Percentages and Maximum Days supply, subject to any Maximum Benefit shown in this Schedule of Benefits.