Medical Benefits Schedule

- All benefits payable are subject to the applicable exclusions and maximum eligible expense provisions. And the Selected Deductible/Out-of-Pocket Maximums ($2,500, $5,000, or $10,000)

- 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.

**Pre-Authorization is required on some services and are subject to the Edison Health Second Opinion Program, and/or Pre-Authorization processes provided Vault Admin Services.*

General Provisions	
Types of Service/Limitations	**Benefit/Coverage**
Acupuncture	Not Covered
Allergy Injections	100% after Deductible
Allergy Testing / Serums	100% after Deductible
Ambulance Service	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	100% after Deductible
Brachytherapy	100% after Deductible
Cardiac Rehabilitation – Outpatient	100% after Deductible
Chemotherapy – Outpatient*	100% after Deductible
Chiropractic Care	100% after Deductible
Colonoscopy – Diagnostic Colonoscopy (Routine Colonoscopy: 1 every 10 years over age 45)	100% after Deductible 100% **Deductible Waived**
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	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

Summary of Benefits & Coverages

VAULT CAPTIVE

General Provisions	
Types of Service/Limitations	**Benefit/Coverage**
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	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
Orthopedic Devices	100% after Deductible
Orthotics	Not Covered
Physical Therapy - Outpatient	100% after Deductible
Physician Services	100% after Deductible
Preventive Care	100% after Deductible
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
Skilled Nursing Facility	Not Covered
Sleep Studies	Not Covered
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 Exams (Covered only if result of Accidental Injury)	100% after Deductible
Vision Therapy	Not Covered
Weight Loss Programs	Not Covered

Pharmacy Benefits Schedule

This Pharmacy Benefits Schedule is a snapshot of the terms and conditions of the Pharmacy Benefits portion of the Plan. It is not intended to be comprehensive. Detail regarding each of these items is in the later text.

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 copay, after deductible	100% prior to meeting deductible; $30.00 copay, after deductible
Tier 3: Preferred Brand & non-preferred generics:	100% prior to meeting deductible; $50.00 copay, after deductible	100% prior to meeting deductible; $100.00 copay, after deductible
Tier 4: Non-Preferred Brand:	100% prior to meeting deductible; $100.00 copay, after deductible	100% prior to meeting deductible; $200.00 copay, after deductible
Tier 5: Specialty Drugs	Not Covered – Defined as any drug that costs more than $1,000 Per script fill	
Tier 6: Non-formulary & excluded drugs	Not Covered – Defined as any drug that costs more than $1,000 Per script fill	