Summary of Benefits & Coverages

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 Vault Admin Services Program, and/or Pre-Authorization processes provided by 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 50)	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

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% 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
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 – 100% Copay	

The Current Pharmacy Formulary and Tier List can be found here. The formulary and tier list are 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 Clever Health for zero copay virtual Medical Benefits and a limited number of zero copay 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. 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 Benefits

Vision Benefit	In-Network Benefits	Out-of-Network Reimbursement
Vision Examination	Covered in full after $10 copay	$35
Contact Lens Fit and Follow-up	Standard - $50-member out-of-pocket maximum	N/A
Frame Allowance	Covered in full after copay	Up to $45
Copay	$25	
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 spectacle lenses)		
Elective Allowance	$130	$110.50
Lenses or Contact Lenses	Covered in full	$250
Frequency		
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

NOTE:
Providers can be accessed through Avesis at by **clicking here**. Vision benefits administered by Avesis Third Party Administrators, Inc. See Exclusions and Limitations

Vision Exclusions and Limitations

Vision benefits are incorporated in the VAULT Small Employer reimbursement contract and the recommended Plan Documents.

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, frequency 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 received 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, aniseikonia 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 government 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 absence 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 lens allowance may be used all at once or throughout the plan year as needed or may be applied toward contact lenses only. Refractive 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.