Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 2023

Vault Bronze

Coverage for: Plan Participants | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.AllThingsVault.com/2022MEC. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall **deductible**?	$0 individual / $0 family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your **deductible**?	Yes. Preventative care, genericpreventative drugs and $0 Copay Telemedicine services are covered.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. Forexample, this plan covers certain preventative services without cost-sharing and before you meet your deductible. See a list of covered preventative services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other **deductibles** for specific services?	No.	You don't have to meet deductibles for specific services.
What is the **out-of-pocketlimit** for this **plan**?	$8,550 individual/ $17,100 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the **out-of-pocket limit**?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a **network provider**?	Yes. See www.multiplan.com or call 1-877-952-7427for a list of network providers.	This plan uses a provider network. In office services are only covered when you use a provider in the plan's network. If you use an out-of- network provider, you will likely receive a bill from a provider for services (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a **referral** to seea **specialist**?	No.	Specialist services must be provided by an in-network provider, per visit co-payment will apply.

All copayment and coinsurance costs shown in this chart are after your deductible has been met if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injuryor illness	$25 copay	Not covered	Not covered if provided at a hospital. Limited to 8 visits per plan year.
	Specialist visit	$50 copay	Not covered	Not covered if provided at a hospital. Limited to 8 visits per plan year.
	Preventative care/screening/ immunization	No charge	Not covered	Not covered if provided at a hospital. Plan pays 100% of covered preventative and wellness services. You may have to pay for servicesthat aren't preventative. Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay	Not covered	Not covered if services are provided at a hospital. Combined limit of 3 visits per plan year for Laboratory Services and Radiology.
	Imaging (CT/PET scans, MRIs)	$350 copay (Subject to Reference Based Pricing)	Not covered	Not covered if services are provided at a hospital. Limited to 1 per plan year. Preauthorization is required.
If you need drugs to treatyour illness or condition More information about **prescription drug coverage** is available at www.AllThingsVault.com/2022MEC	Generic drugs	Covered 100% for preventative, co-payments apply for other generic drugs, see formulary	Not covered	Limited to preventative generic drugs. See Formulary posted online at www.AllThingsVault.com/2022MEC
	Preferred brand drugs	See Formulary posted online at www.AllThingsVault.com/2022MEC	Not covered	See Formulary posted online at www.AllThingsVault.com/2022MEC
	Non-preferred brand drugs	See Formulary posted online at www.AllThingsVault.com/2022MEC	Not covered	See Formulary posted online at www.AllThingsVault.com/2022MEC
	Specialty drugs	See Formulary posted online at www.AllThingsVault.com/2022MEC	Not covered	See Formulary posted online at www.AllThingsVault.com/2022MEC

* For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay	$350 copay	Limited to 2 visits per plan year. Preauthorization is required.
	Physician/surgeon fees	Covered	Covered	Included in Inpatient Hospitalization or Outpatient Hospital or Free-Standing Facility Services and Surgery Copay.
If you need immediate medical attention	Emergency room care	$350 copay.	$350 copay	Emergency room stay over 24 hours will be considered inpatient hospitalization. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Limited to 1 visit per plan year.
	Emergency medical transportation	$250 copay. (Subject to Reference Based Pricing)	$250 copay. (Subject to Reference Based Pricing)	By land only. Limited to 1 transport per plan year.
	Urgent care	$50 copay	Not covered	Not covered if provided at a hospital. Limited to 2 visit per plan year.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay per admission	$350 copay per admission	This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Combined limit of 5 days per plan year. Neonatal Intensive Care (NICU) is not covered. Preauthorization is required. Coverage limited to facility fees. Limited to 5 days per plan year.
	Physician/surgeon fees	Included in Inpatient Hospitalization copay	Included in Inpatient Hospitalization copay	Limited to 5 days per plan year.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per day	Not covered	Not covered if provided at a hospital. Considered a specialist visit. Limited to mental & behavioral health or substance abuse. Preventative services are covered for mental, behavioral health or substance abuse. Cost sharing does not apply for preventative services. Partial hospitalization is not covered.
	Inpatient services	$350 copay per day (Subject to Reference Based Pricing)	$350 copay per day (Subject to Reference Based Pricing)	Not covered if services are provided at a hospital. Treatment for Chemical Abuse & Dependency only. Limited to 7 days per plan year. Preventative services are covered for mental, behavioral health or substance abuse. Cost sharing does not apply for preventative services. Preauthorization is required. Limited to 5 days per plan year.
If you are pregnant	Office visits	Considered a specialist visit.	Not covered	Refer to specialist visit section.
	Childbirth/delivery professional services	Not covered	Not covered	Not covered
	Childbirth/delivery facility services	Not covered	Not covered	Not covered

* For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$25 copay	Not covered	Limited to 10 visits per plan year.
	Rehabilitation services	Not covered	Not covered	Not covered
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered	Not covered
	Hospice services	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	One vision screening for children 3-5 years is covered as a preventative service. Cost sharing does not apply for preventativeservices.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Dental caries fluoride application for infants and children up to 5 years are covered as preventative services. Cost sharing does notapply for preventative services.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

This plan is a limited medical plan and excludes the following: Acupuncture, Infertility Treatment, Weight Loss Programs, Bariatric Surgery, Long Term Care, Chiropractic Care, Non-emergency care when traveling outside the U.S., Cosmetic Surgery, Private Duty Nursing, Dental Care (except as noted above), Vision Services (expect as noted above), Durable Medical Devices, Routine Foot Care, and other Voluntary Procedures.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- None

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-877-813-2685.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-813-2685.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-813-2685.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-813-2685.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-813-2685.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Bridget is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		**Managing Doug's type 2 Diabetes** (a year of routine in-network care of a well- controlled condition)		**Blaine's Simple Fracture** (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$0	■ The plan's overall deductible	$0	■ The plan's overall deductible	$0
■ Specialist [*copay*]	$25	■ Specialist [*copay*]	$25	■ Specialist [*copay*]	$25
■ Hospital (facility) [*copay*]	$350	■ Hospital (facility) [*copay*]	$350	■ Hospital (facility) [*copay*]	$350
■ Other [*cost sharing*]	0%	■ Other [*cost sharing*]	0%	■ Other [*cost sharing*]	0%
This EXAMPLE event includes services like: Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)		This EXAMPLE event includes services like: Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)		This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)	
Total Example Cost	**$13,252**	**Total Example Cost**	**$8,056**	**Total Example Cost**	**$1,984**
In this example, Bridget would pay:		In this example, Doug would pay:		In this example, Blaine would pay:	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$1,300	Copayments (for generic drugs, see formulary)	$925	Copayments	$1,075
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$132	Limits or exclusions	$5,962	Limits or exclusions	$721
The total Bridget would pay is	$1,432	The total Doug would pay is	$6,887	The total Blaine would pay is	$1,796

The plan would be responsible for the other costs of these EXAMPLE covered services.