# Vault Bronze

## 2022 Schedule of Medical Benefits

| Lifetime Max: None | Network Providers | Non-Network Providers | Benefit Limits Per Calendar Year |
|---|---|---|---|
| **Annual Deductibles**<br>**Does not include Co-pays.**<br>**In-network and Out-of-network are separate accumulations and do not cross apply** | Individual: $0<br>Family: $0 | None | **Limits are per person per Calendar Year.**<br>**Beginning January 1 and ending December 31.**<br>**All limits and accumulations are per person per plan year.** |
| **Annual Co-pay and Co-Insurance Out of Pocket Maximums**<br>**(Medical and Rx co-pays apply to the annual out of pocket maximums)** | Individual: $8,550<br>Family: $17,100 | None | |
| Office Visits - Primary Care<br>(exam or consultation) | $25 Copay, Plan pays 100% | No Benefit | Limited to **8 visits** per plan year. |
| Office Visits - Specialist<br>(exam or consultation) | $50 Copay, Plan pays 100% | No Benefit | Limited to **8 visits** per plan year. |
| Office Services - basic services with exam<br>(This benefit does not include pain management, chemo, surgical services. See below.) | See below | No Benefit | |
| Telemedicine | Plan pays 100% | | |
| Wellness Care - Adult | Plan pays 100% | No Benefit | |
| Wellness Care - Children | Plan pays 100% | No Benefit | |
| Wellness Care includes, but not limited to: pap smear, mammogram, prostate screening, gynecological exam, routine physical exam, routine vision exam for children, routine hearing exam for children, immunizations and related laboratory blood tests, colonoscopies. Other preventive services as identified by the Patient Protection and Affordable Care Act (PPACA) will be covered. | | | |
| Ambulance | No Benefit | | |
| Birth Control / IUD | Plan pays 100% | No Benefit | |
| Breast Pumps | Plan pays 100% | | One per delivery. Purchase Breast Pump at a local retail store and submit the receipt for reimbursement |
| Chemical Dependency - Inpatient | $250 Copay per day, then Plan pays 100% | No Benefit | Benefits are limited to **7 days** per plan year. |
| Chemical Dependency - Outpatient | $25 Copay per day, Plan pays 100% | No Benefit | Limited to 8 days per plan year. Limit shared with Specialty Office Visits and Mental Health |
| Chemotherapy / Radiation Therapy | No Benefit | | |
| Chiropractic Services | No Benefit | | |
| Colonoscopy (For Medical Reasons) | No Benefit | | |
| Diagnostic Services - Basic labs<br>(related to office visit, LabCorp, etc.) | $50 Copay per panel billed, then Plan pays 100% | No Benefit | Limited to **3** per plan year. |
| Diagnostic Services - Major<br>(MRI, CT, PET, Nuclear Medicine,etc.) | $350 Copay per image billed, then Plan pays 100% | No Benefit | Limited to **1** per plan year. |
| Diagnostic Services - Minor Radiology<br>(x-ray, ultrasound, echography, etc.) | $50 Copay per image billed, then Plan pays 100% | No Benefit | Limited to **3** per plan year. |
| Diabetic Education | No Benefit | | |
| Dialysis | No Benefit | | |
| Durable Medical Equipment<br>(includes orthotics & prosthetics) | No Benefit | | |
| Emergency Room | $350 Copay, then Plan pays 100% | No Benefit | Limited to **1 visit** per plan year. |
| Gastric Bypass Surgery / Lap Banding | No Benefit | | |
| Home Health Care | $25 Copay, then Plan pays 100% | No Benefit | Limited to **10 visits** per plan year. |
| Hospice Care | No Benefit | | |
| Hospital Facility - Inpatient Services | $350 Copay per admission, then Plan pays 100% | No Benefit | Limited to **5 days and 2 surgeries** per plan year. |
| Hospital Facility - Outpatient Services | No Benefit | | For surgery, see Outpatient Surgery below. |
| Infertility Services | No Benefit | | |
| Maternity - Prenatal Office Visits Only<br>(billed separately from total delivery) | No Benefit | | |
| Maternity - (Labs, x-rays, ultrasounds and related covered services) | No Benefit | | |

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|---|---|---|---|
| Maternity - Facility | No Benefit | | |
| Medical Supplies (Including but not limited to: Insulin, Diabetic test strips, Insulin pumps, etc.) | No Benefit | | |
| Mental Health - Inpatient | $250 Copay per day, then Plan pays 100% | No Benefit | Benefits are limited to **7 days** per plan year. |
| Mental Health - Outpatient | $25 Copay per day, Plan pays 100% | No Benefit | Limited to 8 days per plan year. Limit shared with Specialty Office Visits and Mental Health |
| Outpatient Surgery - Facility | $350 Copay, then Plan pays 100% | No Benefit | Limited to **1 surgery** per plan year. |
| Outpatient Surgery performed in an office or urgent care facility | $350 Copay, then Plan pays 100% | No Benefit | |
| Outpatient Therapy<br>Physical, Speech and Occupational | No Benefit | | |
| Skilled Nursing | No Benefit | | |
| Sleep Studies | No Benefit | | |
| Sterilization for Women | Plan pays 100% | No Benefit | |
| Sterilization for Men | No Benefit | | |
| TMJ and Orthognathic | No Benefit | | |
| Transplant - Facility | No Benefit | | |
| Urgent Care Center & 24 Hours | $50 Copay, Plan pays 100% | No Benefit | Limited to **2 visits** per plan year. |

| **Prescription Benefits** | |
|---|---|
| Preventative Prescription Drugs | $0 Copay<br>(Limited to preventative only) |
| Preferred Prescription Drugs | Tier 1: $0 (over 200 drugs)<br>Tier 2: $10 or less<br>Tier 3: $25 or less<br>Tier 4: $50 or less |
| Additional Covered Prescription Drugs | Formulary Generic: $10 Copay<br>Formulary Brand: $30 Copay<br>Subject to a combined separate prescription drug deductible of $1,000 per person / $2,000 per family<br>Subject to a combined separate prescription drug maximum monthly benefit of $1,000 per person / $2,000 per family |

Rural Area is defined as 30 miles. If preventive services are not available within 30 miles of your residence the provider will be paid in network.

If the service is not listed on this Schedule of Benefits it is not covered.

**We believe this coverage is a Non-Grandfathered health plan under the Patient Protection and Affordable Care Act. (PPACA)**

**All claims are subject to Plan provisions at the time of service. Any benefits quoted telephonically or in writing is not a guarantee of payment. Claims are determined upon receipt of the claim and any additional information required to make a benefit determination.**

## PLAN EXCLUSIONS

The following medical services are not a covered benefit unless otherwise stated in the Schedule of Benefits.

1. **Abortion.** Services, supplies, care, or treatment in connection with an abortion.
2. **Acupuncture or Acupressure.**
3. **Adoption.** Any charges associated with Adoption.
4. **Ambulance Charges.**
5. **Bereavement Counseling Services and Supplies.**
6. **Blood or Blood Derivatives.**
7. **Chemotherapy.**
8. **Chiropractic Services/Spinal Adjustments.**
9. **Complications of Non-Covered Treatments.** Care, services, or treatment required as a result of complications from a treatment not covered under the Plan.
10. **Cosmetic Procedures.** A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and /or functions of the body which are lost or impaired due to an illness or injury.
11. **Counseling Services.** Counseling for educational, social, occupational, religious, or other maladjustments. Counseling for treatment of a gambling addiction. Sensitivity or stress management training, self-help training unless specifically stated in the Schedule of Benefits. Counseling services mandated by the PPACA are covered as specifically stated in the Schedule of Benefits.
12. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or Custodial Care.
13. **Day Treatment.** Means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers alternative to Inpatient treatment.
14. **Dental Care.** Services are excluded except those that are accidental and treated as a covered service listed on the Schedule of Benefits.
15. **Dialysis.**
16. **Educational or Vocational Testing.** Services for educational or vocational testing or training, except in regard to education and training for diabetic management.
17. **Error.** This Plan reserves the right to recover any payments made by this Plan that were:
    a. Made in error, or
    b. Made to you or any party on your behalf where this Plan determines the payment to you or any party is greater than the amount payable under this Plan, or
    c. This Plan has the right to recover against you if this Plan has paid you or any other party on your behalf.
18. **Exams or Treatment Required by Third Party.** Physical, psychiatric, and psychological exams or treatments and related services that are required by third parties. For example, exams and tests

that are required for recreational activities, employment, insurance, and school; court-ordered exams and services, except when they are medically necessary services.

19. **Excess Charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Maximum Allowable Charge.

20. **Exercise Programs.** Exercise programs for treatment of any condition.

21. **Experimental.** Care and treatment that is either Experimental or Investigational.

22. **Eye Care.** Radial keratotomy, Lasik surgery, or other eye surgery to correct refractive disorders. Lenses for the eyes and exams for their fitting.

23. **Foot Care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses, toenails, and foot inserts.

24. **Foreign Travel.** Non-emergent care, treatment, or medical supplies obtained outside of the U.S.

25. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

26. **Hair Loss.** Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

27. **Hearing Aids, Including Cochlear Implants and Hearing Examinations.** Charges for services including exams and supplies in connection with hearing aids or cochlear implants.

28. **Hospice Care Services and Supplies or Bereavement Counseling.**

29. **Illegal Acts.** Charges for services received for Injury or Sickness occurring directly or indirectly as a result of active participation in an Illegal Act, or active participation in a riot or public disturbance.

    **a.** It is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment be imposed for this exclusion to apply.

    **b.** Proof beyond a reasonable doubt is not required.

    **c. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.**

    **d.** Services received as a result of illness or injury caused or contributed to by the Covered Person committing or attempting to commit any of the following or engaging in conduct which would amount to any of the following if a charge had been made, regardless of whether a charge was filed or guilt was determined:

        **i.** A felony;

        **ii.** Any illegal occupation;

        **iii.** A misdemeanor or other offense involving theft, fighting, disorderly conduct, or other breach of the peace; or

        **iv.** A misdemeanor or other offense involving the use of alcohol or drugs, including, but not limited to any crime or offense involving driving or being in actual physical control of a motor vehicle or any other means of conveyance propelled in part or in whole by an engine or motor, for example, a boat or ATV, while under the influence of alcohol or drugs.

30. **Illegal Drugs or Medications.** Services, supplies, care, or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of

any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician.

   a. Expenses will be covered for Injured Covered Persons other than the person using controlled substances.

   b. **This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.**

31. **Impotence.** Care, treatment, services, or supplies in connection with treatment for impotence. Some plans may cover medications under the prescription drug benefit.

32. **Infertility.** Care, supplies, services, and treatment for infertility, artificial insemination, or in vitro fertilization, unless listed as covered in the Schedule of Medical Benefits.

33. **Long Term Care.**

34. **Marital, Pre-Marital, or Family Counseling.** These services are not a covered benefit.

35. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

36. **No Obligation to Pay.** Charges incurred for which the Plan has no legal obligation to pay.

37. **No Physician Recommendation.**

   a. Care, treatment, services, or supplies not recommended and approved by a Physician; or

   b. Treatment, services, or supplies when the Covered Person is not under the regular care of a Physician.

      i. **Regular care** means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

38. **Not Specified as Covered.** Non-traditional medical services, treatments, and supplies which are not specified as covered under this Plan.

39. **Obesity.** Care and treatment of obesity, weight loss, or dietary control whether or not it is a part of the treatment plan for another Sickness.

   a. Specifically excluded are charges for Bariatric Surgery, including but not limited to:

      i. Gastric Bypass,

      ii. Stapling and Intestinal Bypass, and

      iii. Lap Band Surgery, including reversals.

      iv. Medically Necessary non-surgical charges for Morbid Obesity will not be covered.

      v. Nutritional counseling will be covered under preventive care.

40. **Occupational.** Care and treatment of an Injury or Sickness that is occupational. Occupational means that it arises from work for wage or profit, including self-employment.

41. **Out of Country Care.**

42. **Plan Design Excludes.** Charges excluded by the Plan design as mentioned in this document.

43. **Private Duty Nursing Care.**

44. **Prosthetic Devices.** Purchase, fitting and repair of fitted prosthetic devices which replace body parts.

45. **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties.

46. **Replacement Braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs.

47. **Residential Treatment Facilities.** Inpatient and outpatient services associated with Mental Health, Chemical Dependency and Substance Abuse.

48. **Respiration Therapy.**

49. **Sales Tax.**

50. **Services Before or After Coverage.** Care, treatment, or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

51. **Sex Changes.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria, or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical, or psychiatric treatment.

52. **Sexual Dysfunction.** Behavioral treatment or drug therapy for sexual dysfunction and sexual function regardless if cause of dysfunction is due to physical or psychological reasons.

53. **Skilled Nursing Facility or Physician Care.**

54. **Sleep Studies.**

55. **Smoking / Tobacco Cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches. Counseling for tobacco use is covered under preventive care.

56. **Speech Therapy.**

57. **Sterilization Services For Men.**

58. **Surgical Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.

59. **Surrogate Pregnancy Services.** Services incurred in connection with an agreement to act as a surrogate mother. This excludes pregnancy-related charges incurred by a Plan Participant who is acting as a surrogate mother as well as pregnancy-related charges incurred by a non-Plan Participant who is acting as a surrogate for a Plan Participant.

60. **TMJ or Orthognathic Services.** Treatment is not covered.

61. **Transplant Services.**

62. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician.

63. **Vision Therapy Services.** Services incurred to treat vision therapy is not covered.

64. **War.** Any loss that is due to a declared or undeclared act of war. Including nuclear reaction or the release of nuclear energy. This exclusion will not apply if the loss is sustained within 90 days of the initial incident. To be covered under the Plan, the loss must be caused by fire, heat, explosion or other physical trauma that is a result of the release of nuclear energy. The covered person must be within a 25-mile radius of the release site at the time of the release or within 24 hours of the start of the release.

65. **Workers Compensation.** Injury or illness that is covered by any Workers Compensation or Occupational Disease law.