



Summary of benefits and coverage

MEDICAL BENEFITS SCHEDULE

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Copays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of the SPD for more details.

Benefits listed in this Schedule of Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of the SPD for more details. In the event of a conflict or inconsistency between the Schedule of Benefits and any other section of the Summary Plan Description (SPD), the terms and provisions set forth in the detailed sections of the SPD shall control.

Important: Prior Authorization may be required before benefits will be considered for payment. Failure to obtain Prior Authorization may result in a penalty or increased out-of-pocket costs. If there is an “*” next to a listed benefit, it requires prior-authorization. Contact the Third-Party Administrator for assistance securing a prior-authorization. Some benefits may require a second-opinion and/or the use of a designated facility, please contact the Third-Party Administrator for no-cost to You, programs.

Third-Party Administrator	Vault Admin Services, LLC
Website	allthingsvault.com
Customer Service Phone Number	877- 958 - 2109
Email	integritysupport@allthingsvault.com
Hours of Operation	8:00 AM – 5:00 PM CST
Medical Network	UnitedHealthcare Choice Plus

Coverage Overview		
Type	In-Network	Out-of-Network
Annual Deductible: Individual Family	See cover page of SPD Two Times Individual	Two Times In-Network Individual Two Times Out-of-Network Individual
Annual Total Out-of-Pocket Maximum: Individual Family	See cover page of SPD Two Times Individual	Two Times In-Network Individual Two Times Out-of-Network Individual
Plan Participation (after Deductible)	Plan pays 100% of the Negotiated Rate	Plan pays 60% of the Plan Allowable Amount

Deductible and Out-of-Pocket Maximum Options: The Individual In-Network Deductible and Out-of-Pocket Maximum elected by the Plan Sponsor and shown on the cover page of the SPD is \$2,500, \$5,000, or \$10,000. The corresponding Individual Out-of-Network Deductible and Out-of-Pocket Maximum is two times the In-Network amount (\$5,000, \$10,000, or \$20,000, respectively). Family amounts are two times the applicable Individual amount.

Embedded Deductible and Out-of-Pocket Maximum: If You have family coverage, any combination of covered family members may help meet the family Deductible and out-of-pocket maximum; however, no one person will pay more than their embedded individual amount.

Accumulation: The In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums are separate. Amounts applied at one benefit level do not count toward the other. Exception: cost sharing for services that applicable law requires to be covered at In-Network cost sharing (including Emergency services, Emergency air ambulance, and certain services by

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Summary of benefits and coverage cont.

Out-of-Network providers at In-Network facilities under the No Surprises Act) and other services the Plan covers at the In-Network benefit level as described in the SPD is treated as In-Network and counts toward the In-Network Deductible and Out-of-Pocket Maximum.

Provider Billing: In-Network Providers have agreed to accept the Negotiated Rate as payment in full and may not bill You for amounts above Your Deductible or other cost sharing. For Out-of-Network services not protected by the No Surprises Act, Out-of-Network Providers may bill You for amounts above the Plan Allowable Amount; those amounts are not covered and do not count toward any Deductible or Out-of-Pocket Maximum.

Preventive Services		
Type	In-Network	Out-of-Network
Preventive/Routine Care Benefits (see Glossary of Terms for definition)	100% Deductible waived	After deductible, plan pays 60%
Preventive/Routine Physical Exams (Age Appropriate)	100% Deductible waived	After deductible, plan pays 60%
Preventive Immunizations	100% Deductible waived	After deductible, plan pays 60%
Preventive/Routine Diagnostic Tests, Lab and X-Rays per ACA	100% Deductible waived	After deductible, plan pays 60%
Preventive/Routine Mammograms and Breast Exams	100% Deductible waived	After deductible, plan pays 60%
Preventive/Routine Pelvic Exam and Pap Test	100% Deductible waived	After deductible, plan pays 60%
Preventive/Routine PSA Test and Prostate Exam (Age Appropriate)	100% Deductible waived	After deductible, plan pays 60%
Pediatric Preventive/Routine Hearing Exams (Age Appropriate per ACA)	100% Deductible waived	After deductible, plan pays 60%
Pediatric Preventive/Routine Eye Exams (Age Appropriate per ACA)	100% Deductible waived	After deductible, plan pays 60%
Well-Woman Visits	100% Deductible waived	After deductible, plan pays 60%
Flu and Pneumonia Immunizations	100% Deductible waived	After deductible, plan pays 60%
Pediatric Immunizations	100% Deductible waived	After deductible, plan pays 60%
Regular Well-Baby and Well-Child Visits	100% Deductible waived	After deductible, plan pays 60%
Mammograms (Age Appropriate)	100% Deductible waived	After deductible, plan pays 60%
Colonoscopies (Age Appropriate)	100% Deductible waived	After deductible, plan pays 60%
Contraceptive Methods and Contraceptive Counseling Approved by the FDA for Men and Women	100% Deductible waived	After deductible, plan pays 60%
Breast Pumps One pump per delivery; reimbursement is capped at \$150 per pump	100% Deductible waived	After deductible, plan pays 60%
Routine Prenatal Services	100% Deductible waived	After deductible, plan pays 60%

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Summary of benefits and coverage cont.

Preventive Services		
Type	In-Network	Out-of-Network
Preventive/Routine Counseling for Alcohol or Substance Use Disorder, Tobacco/Nicotine Use, Obesity, Diet and Nutrition	100% Deductible waived	After deductible, plan pays 60%
PrEP Preventive Services	100% Deductible waived	After deductible, plan pays 60%

Ambulance Transportation (Ground or Air)		
Prior Authorization required for non-emergency inter-facility transportation; no Prior Authorization required for Emergency transport.		
Type	In-Network	Out-of-Network
Ground Ambulance	After deductible, plan pays 100%	After deductible, plan pays 60%
Emergency Air Ambulance	After deductible, plan pays 100%	Covered at In-Network level
Non-Emergency Air Ambulance	Not covered	Not covered

Physician Office Visit		
Type	In-Network	Out-of-Network
Primary Care Physician Visit	After deductible, plan pays 100%	After deductible, plan pays 60%
Specialist Visit	After deductible, plan pays 100%	After deductible, plan pays 60%
Services Performed in a Physician Office	After deductible, plan pays 100%	After deductible, plan pays 60%
Pediatric Office Visits	After deductible, plan pays 100%	After deductible, plan pays 60%
OBGYN	After deductible, plan pays 100%	After deductible, plan pays 60%
Injections*	After deductible, plan pays 100%	After deductible, plan pays 60%

Urgent Care/Emergency Services		
Type	In-Network	Out-of-Network
Urgent Care	After deductible, plan pays 100%	After deductible, plan pays 60%
Walk-In Retail Health Clinics	After deductible, plan pays 100%	After deductible, plan pays 60%
Emergency Room Only	After deductible, plan pays 100%	Covered at In-Network level
Emergency Physicians Only	After deductible, plan pays 100%	Covered at In-Network level

Facility Based Services		
Type	In-Network	Out-of-Network
Pre-Admission Testing	After deductible, plan pays 100%	After deductible, plan pays 60%
Inpatient Admissions/Inpatient Physician Charges*	After deductible, plan pays 100%	After deductible, plan pays 60%

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Summary of benefits and coverage cont.

Facility Based Services		
Type	In-Network	Out-of-Network
Inpatient Surgery*	After deductible, plan pays 100%	After deductible, plan pays 60%
Outpatient Services/Outpatient Physician Charges	After deductible, plan pays 100%	After deductible, plan pays 60%
Outpatient Surgery/Facility*	After deductible, plan pays 100%	After deductible, plan pays 60%
Outpatient Surgery/Professional Services	After deductible, plan pays 100%	After deductible, plan pays 60%
Physician Clinic Visits in an Outpatient Hospital Setting	After deductible, plan pays 100%	After deductible, plan pays 60%
Cardiac Implants	After deductible, plan pays 100%	After deductible, plan pays 60%
LVAD/RVAD Implants	After deductible, plan pays 100%	After deductible, plan pays 60%
Extended Care Facility Benefits, such as Skilled Nursing, Convalescent or Subacute Facility	After deductible, plan pays 100%	After deductible, plan pays 60%
Inpatient/Outpatient Orthopedic Services	After deductible, plan pays 100%	After deductible, plan pays 60%
Anesthesia*	After deductible, plan pays 100%	After deductible, plan pays 60%
Inpatient Diagnostic Lab/X-Ray*	After deductible, plan pays 100%	After deductible, plan pays 60%
Transplant* \$10,000 per transplant	After deductible, plan pays 100%	After deductible, plan pays 60%

Maternity Services		
Type	In-Network	Out-of-Network
Non-Routine Prenatal Services	After deductible, plan pays 100%	After deductible, plan pays 60%
Postnatal Care	After deductible, plan pays 100%	After deductible, plan pays 60%
Delivery in a Facility	After deductible, plan pays 100%	After deductible, plan pays 60%

Mental Health and Substance Use		
Type	In-Network	Out-of-Network
Therapy Services 40 visits per Calendar Year	After deductible, plan pays 100%	After deductible, plan pays 60%
Inpatient Services*	After deductible, plan pays 100%	After deductible, plan pays 60%
Residential Treatment	After deductible, plan pays 100%	After deductible, plan pays 60%
Outpatient or Partial Hospitalization Services and Physician Charges	After deductible, plan pays 100%	After deductible, plan pays 60%

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Summary of benefits and coverage cont.

Imaging Services		
Type	In-Network	Out-of-Network
3D Mammograms for Diagnosis/Treatment of a Covered Medical Benefit*	After deductible, plan pays 100%	After deductible, plan pays 60%
Pediatric/Routine Diagnostic Tests, Labs, X-Rays	After deductible, plan pays 100%	After deductible, plan pays 60%
Routine/Diagnostic Tests in a Physician Office Labs, X-Rays	After deductible, plan pays 100%	After deductible, plan pays 60%
Advanced Imaging in a Facility (CT/PET Scans, MRIs)*	After deductible, plan pays 100%	After deductible, plan pays 60%
Outpatient Lab and X-Ray in a Facility	After deductible, plan pays 100%	After deductible, plan pays 60%

Assisted Living/Hospice Care		
Type	In-Network	Out-of-Network
Hospice Services*	After deductible, plan pays 100%	After deductible, plan pays 60%
Bereavement Counseling Immediate family only, max 3 visits	After deductible, plan pays 100%	After deductible, plan pays 60%
Home Health Care Benefits* 40 visits per Calendar Year	After deductible, plan pays 100%	After deductible, plan pays 60%
Skilled Nursing Facility Services*	After deductible, plan pays 100%	After deductible, plan pays 60%
Physician Services in a Skilled Nursing Facility*	After deductible, plan pays 100%	After deductible, plan pays 60%
Home IV Therapy*	After deductible, plan pays 100%	After deductible, plan pays 60%

Other Services		
Type	In-Network	Out-of-Network
Chiropractic 40 visits per Calendar Year	After deductible, plan pays 100%	After deductible, plan pays 60%
Physical Therapy 40 visits per Calendar Year	After deductible, plan pays 100%	After deductible, plan pays 60%
Orthopedic Implants*	After deductible, plan pays 100%	After deductible, plan pays 60%
Telehealth Visits Therapy Services and Physical Therapy Services are subject to their respective 40 visit limits	Plan pays 100% with Preferred Vendor; otherwise, after deductible, plan pays 100%, subject to Plan limits	After deductible, plan pays 60%, subject to Plan limits
Custom Molded Foot Orthotics 1 pair	After deductible, plan pays 100%	After deductible, plan pays 60%
Durable Medical Equipment* Plan Year maximum of \$5,000	After deductible, plan pays 100%	After deductible, plan pays 60%

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Summary of benefits and coverage cont.

Other Services		
Type	In-Network	Out-of-Network
Outpatient Habilitative Services 40 visits per Calendar Year	After deductible, plan pays 100%	After deductible, plan pays 60%
Chemotherapy*	After deductible, plan pays 100%	After deductible, plan pays 60%
Radiation Therapy*	After deductible, plan pays 100%	After deductible, plan pays 60%
Dialysis*	After deductible, plan pays 100%	After deductible, plan pays 60%
Sleep Study*	After deductible, plan pays 100%	After deductible, plan pays 60%
Prosthetics*	After deductible, plan pays 100%	After deductible, plan pays 60%
Medical Rehabilitation Center*	After deductible, plan pays 100%	After deductible, plan pays 60%

Heart, Spine, Cancer, Transplant, and Knee and Hip Replacements	
Heart Surgery	Plan pays 100%; limited to Vault Cares Network Centers of Excellence unless granted an exception by the Vault Cares Network
Spine Surgery	Plan pays 100%; limited to Vault Cares Network Centers of Excellence unless granted an exception by the Vault Cares Network
Cancer Surgery and Treatment	Plan pays 100%; limited to Vault Cares Network Centers of Excellence unless granted an exception by the Vault Cares Network
Joint Orthopedic	Plan pays 100%; limited to Vault Cares Network Centers of Excellence unless granted an exception by the Vault Cares Network
Transplant Services	Plan pays 100% when using a Vault Cares Network Center of Excellence
Travel, Lodging and Food Coverage for Heart, Spine, Cancer, Transplant, Knee and Hip Replacement Services listed in this section	Plan pays 100% for travel and lodging costs (coach seat for travel by air or train, or mileage at IRS level for travel by car) for Covered Person plus one companion. A \$75 food per diem per day will be provided for a Covered Person or \$150 per day for a Covered Person plus one companion. Limited to travel, lodging and food coverage as a result of the use and services of the Vault Cares Network Centers of Excellence.

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Summary of benefits and coverage cont.

PHARMACY BENEFITS SUMMARY

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. Pharmacy expenses count toward the Deductible and annual out-of-pocket maximum. Once the applicable out-of-pocket maximum is met, the Plan pays 100% of Covered Expenses through the end of the Plan Year.

Prescription Drugs		
Tier	Retail (30-Day)	Mail Order (90-Day)
Tier 1: Preventive	\$0 Copay	\$0 Copay
Tier 2: Preferred Generics	After deductible, plan pays 100%	After deductible, plan pays 100%
Tier 3: Preferred Brand & Non-Preferred Generics	After deductible, plan pays 100%	After deductible, plan pays 100%
Tier 4: Non-Preferred Brand	After deductible, plan pays 100%	After deductible, plan pays 100%
Tier 5: Specialty Rx	Covered up to \$1,000 per Rx, after deductible	
Tier 6: Non-Formulary & Excluded Drugs	Not covered	

Pharmacy Benefit Manager	
Name	Fairos Rx
Contact	833-464-9600
Website	www.FairosRx.com

Important Tidbits

- Members need to use their ID card at a network pharmacy.
- Members can locate pharmacies through Fairos Rx or Member Services.
- Home delivery is available for maintenance medications, generally allowing up to a 90-day supply.
- Fairos Rx can direct members to a specific pharmacy for certain drugs.
- The formulary/Prescription Drug List can change at any time.
- The member, physician, or pharmacist may need approval from Fairos Rx before the drug is dispensed (prior authorization).
- A medication can ultimately be denied if it does not meet the Plan's coverage requirements.
- Quantity/supply limits may apply. Some drugs have maximum dispensing limits or other restrictions on how much can be filled.

Please review your plan documents carefully for a full list of exclusions and limitations.

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