VAULT HEALTH PLAN

	ELITE MEC	MEC VISIT	PREMIUM HEALTH
Deductible	$0 Individual / $0 Family	$0 Individual / $0 Family	$0 Individual / $0 Family
Out-of-Pocket Max	N/A	N/A	N/A
Preventative & Wellness Office Visits	✔ $0 Copay	✔ $0 Copay	✔ $0 Copay
Telemedicine	✔ $0 Consult Fee	✔ $0 Consult Fee	✔ $0 Consult Fee
Primary Care Office Visit		✔ $25 Copay (2 visits)	✔ $35 Copay
Specialist Office Visit		✔ $75 Copay (1 panel/test)	✔ $75 Copay
Laboratory Services		✔ $50 Copay (1 per visit)	✔ $150 Copay
Radiology			✔ $65 Copay
Imaging (CT/MRI/MRA/PET Scans)			✔ $600 Copay/image (limit 3)
Urgent Care			✔ $85 Copay
Emergency Room Services			
Hospital Inpatient Room & Board			
Preventative Prescriptions (Generic)	✔ $0 Copay	✔ $0 Copay	✔ $0 Copay
Preferred Prescription Drugs (amount shown or less)		✔ Tier 1 = $0; Tier 2 = $10 Tier 3 = $25; Tier 4 = $50	✔ Tier 1 = $0; Tier 2 = $10 Tier 3 = $25; Tier 4 = $50
Inpatient Hospitalization & Surgery			
Outpatient or Free-Standing Facility			
Treatment: Chemical Abuse/Dependency			
Home Health Care			
Pregnancy Benefits			

✔ Included in Plan
*After deductible
Disclaimer: If plan comparison differs from the Schedule of Benefits, the Schedule of Benefits will govern. Refer to the Schedule of Benefits for a list of Benefits Coverage, Limitations, and Exclusions.

VAULT HEALTH PLAN

	BASIC	PRO
Deductible	✔ $250 Individual / $500 Family	✔ $0 Individual / $0 Family
Out-of-Pocket Max	✔ $7,500 Individual / $15,000 Family	✔ $4,000 Individual / $8,000 Family
Preventative & Wellness Office Visits	✔ $0 Copay	✔ $0 Copay
Telemedicine	✔ $0 Consult Fee	✔ $0 Consult Fee
Primary Care Office Visit	✔ $20 Copay	✔ $10 Copay
Specialist Office Visit	✔ $40 Copay (Limit 8/year)*	✔ $20 Copay (Limit 10/year)
Laboratory Services	✔ $50 Copay (Limit 3/year)*	✔ $50 Copay (Limit 3/year)
Radiology Imaging (CT/MRI/MRA/PET Scans)	✔ $350 Copay/image (Limit 1/year)*	✔ $350 Copay/image (Limit 2/year)
Urgent Care	✔ $40 Copay	✔ $40 Copay
Emergency Room Services	✔ $350 Copay + 50% Coins (Limit 1/year)*	✔ $350 Copay + 50% Coins (Limit 1/year)
Inpatient Hospitalization	✔ $350 Copay (Limit 7 days/year)*	✔ $350 Copay (Limit 9 days/year)
Preventative Prescriptions (Generic)	✔ $0 Copay	✔ $0 Copay
Preferred Prescription Drugs (amount shown or less)	✔ Tier 1 = $0; Tier 2 = $10; Tier 3 = $25; Tier 4 = $50	✔ Tier 1 = $0; Tier 2 = $10; Tier 3 = $25; Tier 4 = $50
Inpatient Surgery	✔ $350 Copay + 20% Coins (Limit 2 surgeries/year)*^	✔ $350 Copay + 20% Coins (Limit 3 surgeries/year)^
Outpatient or Free-Standing Facility	✔ $350 Copay + 20% Coins (Limit 1 surgery/year)*^	✔ $350 Copay + 20% Coins (Limit 1 surgery/year)^
Treatment: Chemical Abuse/Dependency	✔ Outpatient: $350 Copay (1 admission/year)*^ Inpatient: $350 Copay/admission (Limit 7 days)*^; *(See plan documents; Precertification required)*	✔ Outpatient: $350 Copay (1 admission/year)^ Inpatient: $350 Copay/admission (Limit 9 days)^; *(See plan documents; Precertification required)*
Home Health Care	✔ $25 Copay (Limit 10/year)*	✔ $20 Copay (Limit 10/year)
Pregnancy Benefits		✔ $350 Copay + 50% Coins (Childbirth/Delivery);^ $350 Copay (Professional Services)^

✔ Included in Plan

*After deductible; then plan pays 100% of the PPO Amount or Allowed Amount.

^Subject to a 12 month waiting period.

If plan comparison differs from the Schedule of Benefits, the Schedule of Benefits will govern. Refer to the Schedule of Benefits for a list of Benefits Coverage, Limitations, and Exclusions.