Summary of Benefits and Coverages
V10000 Plan Design ($10,000 Ind. / $20,000 Family)

See the Summary Plan Document for a more detailed explanation of benefits and coverages.

This plan is administered by VAULT Admin Services, LLC. In cooperation with NBFSA Administrative Solutions and Advanced Medical Pricing Solutions. Some plan benefits are subject to approval by the Edison Health Second Opinion program.

Verification of Benefits - (800) 425-9374
Claim) Submission Questions - (800) 425-9374
Medical - Member Services & Questions - (800) 425-9374
Pharmacy Services & Questions - (888) 424-4186
Billing Questions - (877) 403-4919

- All benefits payable are subject to the applicable exclusions and maximum eligible expense provisions.
- The Copayment amounts and Coinsurance Percentages listed are payable by the Covered Person in each Calendar Year after the applicable Deductible Amount(s) per Covered Person is (are) satisfied.
- *Pre-Authorization is required on some services and are subject to the Edison Health Second Opinion Program, and/or Pre-Authorization processes provided by Advanced Medical Pricing Solutions.

General Provisions – **Refer to your Summary Plan Document for Deductible and Out of Pocket Maximums. (Combined with Pharmacy Benefit)**	
Type 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
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 Visit Services (Maximum 26 visits per year) Inpatient Facility Services (Maximum 31 days)	 100% after Deductible 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 Visit Services (Maximum 26 visits per year) Inpatient Facility Services (Maximum 31 days)	 100% after Deductible 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	100% after Deductible
Vision Therapy	Not Covered
Weight Loss Programs	Not Covered

OUTPATIENT PRESCRIPTION DRUG COVERAGE

The Covered Person is responsible for 100% of the cost of Outpatient Prescription Drug Out-of-Pocket Eligible Expenses until the applicable Deductible Amount(s) per Covered Person is (are) satisfied.

The Copayment amounts and Coinsurance Percentages listed are payable by the Covered Person in each Calendar Year after the applicable Deductible Amount(s) per Covered Person is (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 (after deductible)	100% prior to meeting deductible $30.00 (after deductible)
Tier 3: Preferred Brand & non-preferred generics:	100% prior to meeting deductible $50.00 (after deductible)	100% prior to meeting deductible $100.00 (after deductible)
Tier 4: Non-Preferred Brand:	100% prior to meeting deductible $100 (after deductible)	100% prior to meeting deductible $200 (after deductible)
Tier 5: Specialty Drugs	100% prior to meeting deductible 35% copayment after meeting deductible Max 30-day supply	
Tier 6: Non-formulary & excluded drugs	100% copay – not covered	