

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. Preventive care and generic preventive drugs 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive 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-pocket limit for this plan ? | N/A | There is no out-of-pocket limit is the most you could pay in a year for covered services. |
| What is not included in the out-of-pocket limit ? | Premiums , balance-billing charges, and health care this plan doesn't cover. | This plan does not have an out-of-pocket limit on your expenses. |
| Will you pay less if you use a network provider ? | Yes. See www.Findvaultproviders.com or call 1-866-244-7796 for 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 see a specialist ? | No. | Specialist services are not covered by this plan. |

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 injury or illness | Telemedicine Visits only covered 100% | Not covered | Call the telemedicine phone number on your Medical ID Card for services. |
| | Specialist visit | Not covered | Not covered | Not covered |
| | Preventive care/screening/immunization | No charge | Not covered | Not covered if provided at a hospital. Plan pays 100% of covered preventive and wellness services . You may have to pay for services that aren't preventive. Deductible does not apply. |
| If you have a test | Diagnostic test (x-ray, blood work) | Not covered | Not covered | Not covered. |
| | Imaging (CT/PET scans, MRIs) | Not covered | Not covered | Not covered |
| If you need drugs to treat your illness or condition More information about prescription drug coverage | Generic drugs | Covered 100% for preventive, co-payments apply for other generic drugs, see formulary | Not covered | Limited to preventive generic drugs. See Formulary posted online at www.AllThingsVault.com/2022MEC |
| is available 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) | Not covered | Not covered | Not covered |
| | Physician/surgeon fees | Not covered | Not covered | Not covered |
| If you need immediate medical attention | Emergency room care | Not covered | Not covered | Not covered |
| | Emergency medical transportation | Not covered | Not covered | Not covered |
| | Urgent care | Not covered | Not covered | Not covered |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Not covered | Not covered | Not covered |
| | Physician/surgeon fees | Not covered | Not covered | Not covered |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Not covered | Not covered | Not covered |
| | Inpatient services | Not covered | Not covered | Not covered |
| If you are pregnant | Office visits | Not covered | Not covered | Not covered |
| | 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 | Not covered | Not covered | Not covered |
| | 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 | Not covered |
| | Children's glasses | Not covered | Not covered | Not covered |
| | Children's dental check-up | Not covered | Not covered | Not covered |

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 (except 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: 1-866-298-9848.

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? No

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 1-866-298-9848

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-298-9848

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1866-298-9848

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijijigo holne' 1-866-298-9848

----- 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 [<i>cost sharing</i>] | \$0 | ■ Specialist [<i>cost sharing</i>] | \$0 | ■ Specialist [<i>cost sharing</i>] | \$0 |
| ■ Hospital (facility) [<i>cost sharing</i>] | 0% | ■ Hospital (facility) [<i>cost sharing</i>] | 0% | ■ Hospital (facility) [<i>cost sharing</i>] | 0% |
| ■ Other [<i>cost sharing</i>] | 0% | ■ Other [<i>cost sharing</i>] | 0% | ■ Other [<i>cost sharing</i>] | 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: | | |
| <i>Cost Sharing</i> | | | <i>Cost Sharing</i> | | | <i>Cost Sharing</i> | | |
| Deductibles | \$0 | | Deductibles | \$0 | | Deductibles | \$0 | |
| Copayments | \$0 | | Copayments (for generic drugs, see formulary) | \$1,230 | | Copayments | \$0 | |
| Coinsurance | \$0 | | Coinsurance | \$0 | | Coinsurance | \$0 | |
| <i>What isn't covered</i> | | | <i>What isn't covered</i> | | | <i>What isn't covered</i> | | |
| Limits or exclusions | \$13,252 | | Limits or exclusions | \$6,041 | | Limits or exclusions | \$1,984 | |
| The total Bridget would pay is | \$13,252 | | The total Doug would pay is | \$7,271 | | The total Blaine would pay is | \$1,984 | |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.