Revolution Health Plans: *Fortress Series*

Concord II

Schedule of Benefits		You Pay
Preventive Care Under PPACA	Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.	No Deductible, No Copay
Virtual Care / Telemedicine Full Virtual Primary, Urgent and Behavioral Health. See enrollment materials for details.	With Virtual Primary Care (VPC), members and their families receive access to a dedicated physician. Virtual Preventive, Urgent, and Behavioral Health are covered at a $0 Copay when using a Recuro provider.	No Deductible, No Copay
Plan Year Deductible Individual Family	No deductible applies to any covered service. Please see applicable copays.	 N/A N/A
Out of Pocket Maximum Individual Family	The maximum out of pocket will be met when the accumulated In-Network copays have reached the maximum amount. In-Network covered services will then be provided at 100%.	 $1,500 in Copays $3,000 in Copays
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Use Disorder	These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately.	 $30 Copay $50 Copay $30 Copay
Office Based Diagnostic Tests, Labs & X-Ray	Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.	$30 Copay
Outpatient Surgical, Diagnostic & Therapeutic Procedures Medical Services Facility Charges	Includes outpatient services, such as miscellaneous medical procedures and supplies, diagnostic and therapeutic procedures and surgery at a physician's office, freestanding surgical center or hospital (when approved).	 NOT COVERED NOT COVERED
Vision Annual Exam Only	Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.	NOT COVERED
Short Term Rehabilitation Services	Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).	$30 Copay
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	$250 penalty for non-emergency use of a hospital emergency room. ER covered services include facility and physician charges only and do not include charges for diagnostic, surgical, or medical procedures. Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.	 $500 Copay $30 Copay $100 Copay
Allergy Treatment Testing & Injections Serum		 $50 Copay $100 Copay
Prescription Drug Coverage Tier 1 Tier 2 Tier 3 Tier 4	Up to a 34-day supply may be purchased at retail for the listed copay. Up to a 90-day supply may be purchased at retail or by mail order for 2 copays.	 $0 Copay for Generics $25 Copay for Preferred NOT COVERED NOT COVERED
Inpatient Hospitalization Medical Services & Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Use Disorder		 NOT COVERED NOT COVERED NOT COVERED
Home Health Care & Skilled Nursing Facilities		NOT COVERED
Durable Medical Equipment		NOT COVERED

Benefit Reduction for Non-Network Providers - when receiving care from non-network providers you are responsible for all expenses except under certain conditions discussed in this Summary Plan Description. THE CONCORD II PLAN PROVIDES IN-NETWORK BENEFITS ONLY. Please refer to the Summary Plan Description (SPD) for details. The SPD is the final determination of all benefits.