Fortress Plans
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
Teladoc	The Teladoc program, while not insurance, is a convenient standalone service that provides access by web, phone, or mobile app to qualified doctors who can treat many common medical conditions.	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	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 Generics Preferred Brand Non-Preferred Brand Expensive Specialty & Injectables	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.

Fortress Plans
Minimum Essential Coverage

Preventive Care Only

The Federal Patient Protection and Affordable Care Act has required that certain health plan provisions must apply to all qualified group health plans offered to employees. In accordance with these provisions, our Minimum Essential Coverage plan is designed to provide minimum benefits required under the law. Those required benefits constitute Minimum Essential Coverage containing the lone federally mandated benefit of 100% coverage for Preventive Health Services without any deductibles, copayments, or other cost sharing provisions.

These benefits are categorized into three major categories, based on recipients of preventive health services: Adults, Women, and Children.

Each of these categories has a series of benefits that are offered by this plan when using an in-network provider. Examples of these types of benefits are as follows:

Adult Preventive Services Examples

- Colorectal Cancer Screening for adults over 50
- Blood Pressure Screening for all adults
- Cholesterol Screening for adults of certain ages or at higher risk
- A variety of vaccinations for adults based upon age and population recommendations

Women's Preventive Services Examples

- Contraception FDA approved as prescribed by a physician with certain exclusions
- Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk
- Breast Cancer Mammography Screening every 1 or two years for women over 40
- Cervical Cancer Screening for sexually active women

Children's Preventive Services Examples

- Behavioral Assessments for children of certain ages
- Autism Screening for children at 10 and 24 months
- Developmental screening for children at specifically scheduled ages
- Hearing Screening for all newborns
- Immunizations as recommended

For a complete list of the 63 covered preventive services, please visit https://www.healthcare.gov/preventive-care-benefits

Always remember to refer to your Summary Plan Description (SPD) for benefits, valid on the date of your plan.
You can acquire a copy of your SPD from your employer or health plan administrator.