FORTRESS GOLD HSA PPO

*** PLEASE REFER TO YOUR SBC FOR MORE DETAILED PLAN INFORMATION**

Services	In-Network	Out-of-Network
Calendar Year Deductible	**$1,350 Single / $2,700 Family**	**$5,000 Single / $10,000 Family**
Out-of-Pocket Max	$3,000 Single / $6,000 Family	$5,000 Single / $10,000 Family
Primary Care Physician	$25 Copay after Deductible	50% after Deductible
Specialist Visit	$25 Copay after Deductible	50% after Deductible
Preventive Care	No Charge	50% after Deductible
Lab, X-Ray & Diagnostic	No Charge after Deductible	50% after Deductible
Imaging (MRI/CT/PET) (non-hospital based)	No Charge after Deductible	50% after Deductible
Imaging (MRI/CT/PET) (hospital based)	20% after Deductible**	50% after Deductible**
Inpatient Hospital	$150 /day (3 days) after Deductible**	$200 /day (3 days)**
Outpatient Surgery	$200 Copay + 20% after Deductible**	50% after Deductible**
Urgent Care	$35 per visit after Deductible	50% after Deductible
Emergency Room	$200 Copay + 20% after Deductible	20% after Deductible
Ambulance Services	$250 after Deductible	$250 after Deductible
Chiropractic/Acupuncture ($400 Annual Benefit Maximum)	$35 Copay after Deductible	50% after Deductible
Calendar Year Deductible	**$1,350 Single / $2,700 Family**	**$5,000 Single / $10,000 Fam.**
Generic Drugs(31 Days)	$25 Copay after Deductible	N/A
Preferred Drugs(31 Days)	$40 Copay after Deductible	N/A
Non-Preferred Drugs(31 Days)	$55 Copay after Deductible	N/A
Specialty Drugs(31 Days)	$25/$40/$55 after Deductible	N/A
Mail Order	2x Retail (90 Days)	N/A
Vision Exam, Lenses Frames, Contact Lens, fitting: $250 per year per covered member		

Note: All cost-sharing applies after Deductible is satisfied
** Pre-authorization is required

	Per Pay Period
EE only	$0
EE + 1	$0
FAM	$0