



**FIDELIS CARE®**

	Fidelis Care Catastrophic	Fidelis Care Bronze*+	Fidelis Care Silver*+	Fidelis Care Gold*+	Fidelis Care Platinum*+
<b>BENEFITS</b>	For those under Age 30 Only		Cost Sharing Reduction Options Available		
<b>Monthly Premium</b>	Varies by Rating Region	Varies by Rating Region	Varies by Rating Region	Varies by Rating Region	Varies by Rating Region
<b>Deductible per Individual (Family Deductible 2x Individual)</b>	\$8,150	\$4,425	\$1,300	\$600	\$0
<b>Max. Out of Pocket per Individual (Family Max. is 2x Individual)</b>	\$8,150	\$8,150	\$7,900	\$4,000	\$2,000
<b>Preventive Care**</b>	\$0	\$0	\$0	\$0	\$0
<b>Primary Care Doctor Visit</b>	First three in a year covered in full, then 100% Covered after deductible	First three in a year covered in full, then 50% Coinsurance after deductible	\$30 Copay after deductible	\$25 Copay after deductible	\$15 Copay
<b>Specialist Doctor Visit</b>	100% Covered after deductible	50% Coinsurance after deductible	\$50 Copay after deductible	\$40 Copay after deductible	\$35 Copay
<b>Annual Physical Exam</b>	\$0	\$0	\$0	\$0	\$0
<b>Clinical/Diagnostic Lab X-ray/MRI/CT Scan/ PET Scan</b>	100% Covered after deductible	50% Coinsurance after deductible	\$50 Copay per visit after deductible	\$40 Copay per visit after deductible	\$35 Copay per visit
	100% Covered after deductible	50% Coinsurance after deductible	\$50 Copay per visit after deductible	\$40 Copay per visit after deductible	\$35 Copay per visit
<b>Radiation Therapy</b>	100% Covered after deductible	50% Coinsurance after deductible	\$30 Copay per visit after deductible	\$25 Copay per visit after deductible	\$15 Copay per visit
<b>Outpatient Facility - Surgery</b>	100% Covered after deductible	50% Coinsurance after deductible	\$150 Copay after deductible	\$100 Copay after deductible	\$100 Copay
<b>Surgeon</b>	100% Covered after deductible	50% Coinsurance after deductible	\$150 Copay after deductible	\$100 Copay after deductible	\$100 Copay
<b>Inpatient Hospital – Acute Inpatient Hospital – Mental Health</b>	100% Covered after deductible	50% Coinsurance after deductible	\$1,500/admission after deductible \$1,500/ admission after deductible	\$1,000/admission after deductible \$1,000/ admission after deductible	\$500 per admission \$500 per admission
<b>Outpatient Mental Health</b>	100% Covered after deductible***	50% Coinsurance after deductible***	\$30 Copay after deductible	\$25 Copay after deductible	\$15 Copay
<b>Skilled Nursing Facility</b>	100% Covered after deductible	50% Coinsurance after deductible	\$1,500/admission after deductible	\$1,000/admission after deductible	\$500 per admission
<b>Emergency Room</b>	100% Covered after deductible	50% Coinsurance after deductible	\$250 Copay after deductible	\$150 Copay after deductible	\$100 Copay
<b>Urgent Care</b>	100% Covered after deductible	50% Coinsurance after deductible	\$70 Copay after deductible	\$60 Copay after deductible	\$55 Copay
<b>Ambulance</b>	100% Covered after deductible	50% Coinsurance after deductible	\$150 Copay after deductible	\$150 Copay after deductible	\$100 Copay
<b>PT/OT/ST</b>	100% Covered after deductible	50% Coinsurance after deductible	\$30 Copay after deductible	\$30 Copay after deductible	\$25 Copay
<b>Chiropractor</b>	100% Covered after deductible	50% Coinsurance after deductible	\$50 Copay after deductible	\$40 Copay after deductible	\$35 Copay
<b>Pediatric Eye Exams</b>	100% Covered after deductible	50% Coinsurance after deductible	\$30 Copay after deductible	\$25 Copay after deductible	\$15 Copay
<b>Pediatric Dental</b>	100% Covered after deductible	50% Coinsurance after deductible	\$30 Copay after deductible	\$25 Copay after deductible	\$15 Copay
<b>Durable Medical Equipment(DME)</b>	100% Covered after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	20% Cost Sharing after deductible	10% Coinsurance
<b>Diabetic Supplies</b>	100% Covered after deductible	50% Coinsurance after deductible	\$30 Copay, 30 Day Supply after deductible	\$25 Copay, 30 Day Supply after deductible	\$15 Copay, 30 Day Supply
<b>Hearing Aids</b>	100% Covered after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance
<b>Eyewear (Pediatric Only)</b>	100% Covered after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance
<b>Prescription Drugs: Generic – Tier 1 Preferred Brand – Tier 2 Non Preferred Brand – Tier 3 Mail Order</b>	100% Covered after deductible 100% Covered after deductible 100% Covered after deductible	\$10 Copay after deductible \$35 Copay after deductible \$70 Copay after deductible 90 Day Supply, 2.5x Retail Copay after deductible	\$10 Copay \$35 Copay \$70 Copay 90 Day Supply, 2.5x Retail Copay	\$10 Copay \$35 Copay \$70 Copay 90 Day Supply, 2.5x Retail Copay	\$10 Copay \$30 Copay \$60 Copay 90 Day Supply, 2.5x Retail Copay

\*Native American Option: A Native American who can show required documentation and earns less than 300% of the federal poverty level can choose a Silver, Gold, Platinum, or Bronze plan with no cost sharing.

+Child Only option available for this plan. Products not available in all areas. Please check with your Fidelis Care representative or visit fideliscare.org for information on products available in your area.

\*\*For some preventive care visits and services, as defined under section 2713 of the Affordable Care Act, there is 100% coverage with no cost sharing.

\*\*\*Prior authorization is required. Visits included in the free PCP visit benefit.

## FIDELIS CARE PRODUCT NOTES

**-Summary Only:** This is a plan summary and is not intended to be comprehensive. Please review the Summary Plan Description and Plan Document to get all of the details for your plan of choice. In the event of differences between this summary and the Summary Plan Description or Plan Document, the Plan Document will govern.

**-Primary Care Doctor Selection Not Required:** Selection of a primary care doctor to enroll in the Essential Plan or a Qualified Health Plan is not required. However, we strongly encourage you to pick a primary care doctor to assist you in managing your health.

**-Network-Only Benefits:** Members enrolled in one of these products must use a doctor or hospital that has a contract with Fidelis Care. These are known as “network providers.” There are no benefits paid for medical services delivered by out-of-network providers, except in the case of an emergency.

**-Annual Open Enrollment Period:** Enrollment in the plan is confined to an annual Open Enrollment Period. In 2019-2020, that period is from November 1, 2019 through January 31, 2020. New applicants can enroll as early as November 1, 2019. Applications for coverage after this period are possible with certain qualifying events.

**-Effective Date of Coverage:** Applications prior to the 15<sup>th</sup> of the month will be effective the first of the following month. Applications after the 15<sup>th</sup> of the month will be effective the first of the second month after application.

**-Telemedicine Program:** Starting January 1, 2020, covered services provided through Fidelis Care’s new Telemedicine program will be covered in full with no cost-sharing.

Fidelis Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Fidelis Care cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Fidelis Care 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-343-3547 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-343-3547 (TTY: 711)。

**1-888-FIDELIS (1-888-343-3547)**  
TTY: 711 • fideliscare.org

## BENEFIT COMPARISON 2020

# Qualified Health Plans

Catastrophic | Bronze | Silver | Gold | Platinum



**FIDELIS CARE®**