BENEFITS	Fidelis Care Catastrophic	Fidelis Care Bronze*+		Fidelis Care Silver*+	Fidelis Care Gold*+	Fidelis Care Platinum*+
	For those under Age 30 Only	Standard	HSA-Compatible	Cost Sharing Reduction Options Available; Enhanced Plan Option with Adult Dental and Vision Available	Enhanced Plan Option with Adult Dental and Vision Available	
Monthly Premium	Varies by Rating Region	Varies by Rating Region	Varies by Rating Region	Varies by Rating Region	Varies by Rating Region	Varies by Rating Region
Deductible per Individual (Family Deductible 2x Individual)	$8,550	$4,700	$6,100	$1,300	$600	$0
Max. Out of Pocket per Individual (Family Max. is 2x Individual)	$8,550	$8,550	$6,900	$8,500	$4,000	$2,000
Preventive Care**	$0	$0		$0	$0	$0
Primary Care Doctor Visit	First three in a year covered in full, then 100% covered after deductible	$50 Copay for first three, then $50 Copay after deductible	50% Coinsurance after deductible	$30 Copay after deductible	$25 Copay after deductible	$15 Copay
Specialist Doctor Visit	100% Covered after deductible	$75 Copay after deductible	50% Coinsurance after deductible	$50 Copay after deductible	$40 Copay after deductible	$35 Copay
Annual Physical Exam	$0	$0		$0	$0	$0
Clinical/Diagnostic Lab	100% Covered after deductible	50% Coinsurance after deductible		$50 Copay per visit after deductible	$40 Copay per visit after deductible	$35 Copay per visit
X-ray/MRI/CT Scan/ PET Scan	100% Covered after deductible	50% Coinsurance after deductible		$75 Copay per visit after deductible	$40 Copay per visit after deductible	$35 Copay per visit
Radiation Therapy	100% Covered after deductible	50% Coinsurance after deductible		$30 Copay per visit after deductible	$25 Copay per visit after deductible	$15 Copay per visit
Outpatient Facility – Surgery	100% Covered after deductible	50% Coinsurance after deductible		$150 Copay after deductible	$100 Copay after deductible	$100 Copay
Surgeon	100% Covered after deductible	50% Coinsurance after deductible		$150 Copay after deductible	$100 Copay after deductible	$100 Copay
Inpatient Hospital – Acute	100% Covered after deductible	50% Coinsurance after deductible		$1,500/admission after deductible	$1,000/admission after deductible	$500 per admission
Inpatient Hospital – Mental Health				$1,500/admission after deductible	$1,000/admission after deductible	$500 per admission
Outpatient Mental Health	100% Covered after deductible	50% Coinsurance after deductible		$30 Copay after deductible	$25 Copay after deductible	$15 Copay
Skilled Nursing Facility	100% Covered after deductible	50% Coinsurance after deductible		$1,500/admission after deductible	$1,000/admission after deductible	$500 per admission
Emergency Room	100% Covered after deductible	50% Coinsurance after deductible		$300 Copay after deductible	$150 Copay after deductible	$100 Copay
Urgent Care	100% Covered after deductible	50% Coinsurance after deductible		$70 Copay after deductible	$60 Copay after deductible	$55 Copay
Ambulance	100% Covered after deductible	50% Coinsurance after deductible		$150 Copay after deductible	$150 Copay after deductible	$100 Copay
PT/OT/ST	100% Covered after deductible	$50 Copay after deductible	50% Coinsurance after deductible	$30 Copay after deductible	$30 Copay after deductible	$25 Copay
Chiropractor	100% Covered after deductible	50% Coinsurance after deductible		$50 Copay after deductible	$40 Copay after deductible	$35 Copay
Pediatric Eye Exams	100% Covered after deductible	Visits 1-3 covered, then $75 after deductible		$30 Copay after deductible	$25 Copay after deductible	$15 Copay
Pediatric Dental	100% Covered after deductible	50% Coinsurance after deductible		$30 Copay after deductible	$25 Copay after deductible	$15 Copay
Durable Medical Equipment (DME)	100% Covered after deductible	50% Coinsurance after deductible		30% Coinsurance after deductible	20% Cost Sharing after deductible	10% Coinsurance
Diabetic Supplies	100% Covered after deductible	$50 Copay 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
Hearing Aids	100% Covered after deductible	50% Coinsurance after deductible		30% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance
Eyewear (Pediatric Only)	100% Covered after deductible	50% Coinsurance after deductible		30% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance
Prescription Drugs:						
Generic – Tier 1	100% Covered after deductible	$10 Copay after deductible		$10 Copay	$10 Copay	$10 Copay
Preferred Brand – Tier 2	100% Covered after deductible	$35 Copay after deductible		$35 Copay	$35 Copay	$30 Copay
Non Preferred Brand – Tier 3	100% Covered after deductible	$70 Copay after deductible		$70 Copay	$70 Copay	$60 Copay
Mail Order (90-Day Supply)		2.5x Retail Copay after deductible		2.5x Retail Copay	2.5x Retail Copay	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.

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 2020-2021, that period is from November 1, 2020 through January 31, 2021. New applicants can enroll as early as November 1, 2020. Applications for coverage after this period are possible with certain qualifying events.

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

-**Telemedicine Program with Babylon:** Covered services provided through Fidelis Care's telemedicine program with Babylon 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).

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BENEFIT COMPARISON 2021

Qualified Health Plans

Catastrophic | Bronze | Bronze HSA | Silver | Gold | Platinum

FIDELIS CARE®