2019

FIDELIS CARE®

BENEFITS	Fidelis Care Catastrophic	Fidelis Care Bronze*+	Fidelis Care Silver*+	Fidelis Care Gold*+	Fidelis Care Platinum*+
	For those under Age 30 Only		Cost Sharing Reduction Options Available		
Monthly Premium	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)	$7,900	$4,000	$1,700	$600	$0
Max. Out of Pocket per Individual (Family Max. is 2x Individual)	$7,900	$7,600	$7,500	$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% Coinsurance after deductible	$30 Copay after deductible	$25 Copay after deductible	$15 Copay
Specialist Doctor Visit	100% Covered 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 X-ray/MRI/CT Scan/ PET Scan	100% Covered after deductible 100% Covered after deductible	50% Coinsurance after deductible 50% Coinsurance after deductible	$50 Copay per visit after deductible $50 Copay per visit after deductible	$40 Copay per visit after deductible $40 Copay per visit after deductible	$35 Copay per visit $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	$100 Copay after deductible	$100 Copay after deductible	$100 Copay
Surgeon	100% Covered after deductible	50% Coinsurance after deductible	$100 Copay after deductible	$100 Copay after deductible	$100 Copay
Inpatient Hospital – Acute Inpatient Hospital – Mental Health	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
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	$250 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% 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	50% Coinsurance 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% 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 Preferred Brand – Tier 2 Non Preferred Brand – Tier 3 Mail Order	 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

Utica/Watertown

Metal Level	Platinum	Gold	Silver	Bronze	Catastrophic
HIOS ID	25303NY0040001	25303NY0030001	25303NY0020001	25303NY0010001	25303NY0090001
Individual	$764.47	$630.95	$528.49	$371.76	$186.01
Ind+Sp	$1,528.95	$1,261.91	$1,056.99	$743.53	$372.01
Ind+Ch(ren)	$1,299.61	$1,072.62	$898.44	$632.00	$316.21
Family	$2,178.75	$1,798.21	$1,506.21	$1,059.53	$530.12