Fidelis Care Gold

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017-12/31/2017

Coverage for: Individual/Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.fideliscare.org or by calling 1-888-FIDELIS.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$600** individual / **$1,200** family. Doesn't apply to in-network preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers
Is there an out–of–pocket limit on my expenses?	$4,000 individual / $8,000 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.fideliscare.org or call 1-888-FIDELIS	If you use an in-network doctor or other health care **provider**, this plan will pay come or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-FIDELIS or visit us at www.fideliscare.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.fideliscare.org or call 1-888-FIDELIS to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	Not covered	----------none----------
	Specialist visit	$40 copay	Not covered	----------none----------
	Other practitioner office visit	$25 copay	Not covered	----------none----------
	Preventive care/screening/immunization	No Charge	Not covered	For preventive care visits/services as defined in section 2713 of ACA no deductible or cost sharing applies. Otherwise, PCP/Specialist copay per visit applies to all services in this benefit service category.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	$40 copay	Not covered	----------none----------
If you need drugs to treat your illness or condition More information about **prescription**	Generic drugs	$10 Retail/$25 Mail copay	Not covered	Rx through Caremark. For questions, please call: 1-888-850-8243 Retail: 30-day supply Mail Order: 90-day supply
	Preferred brand drugs	$35 Retail/$88 Mail copay	Not covered	
	Non-preferred brand drugs	$70 Retail/$175 Mail copay	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
drug coverage is available at www.fideliscare.org	Specialty drugs	$70 copay	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay	Not covered	Prior Authorization is required.
	Physician/surgeon fees	$100 copay	Not covered	Prior Authorization is required. One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery.
If you need immediate medical attention	Emergency room services	$150 copay	$150 copay	Copay is waived if patient is admitted as an inpatient (including as an observation stay) directly from the ER
	Emergency medical transportation	$150 copay	$150 copay	Covered in-network, subject to meeting "emergency" criteria. When services are delivered by an out-of-network land ambulance provider that is not licensed under the NY Public Health Law, you may be required to pay up to the difference between the reasonable and customary allowed amount and the provider's total charges.
	Urgent care	$60 copay	Not covered	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay per admission	Not covered	Prior Authorization is required for elective hospitalizations
	Physician/surgeon fee	$100 copay	Not covered	Prior Authorization is required for elective hospitalizations

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay	Not covered	Prior Authorization is required.
	Mental/Behavioral health inpatient services	$1,000 copay	Not covered	Prior Authorization is required.
	Substance use disorder outpatient services	$25 copay	Not covered	Prior Authorization is required.
	Substance use disorder inpatient services	$1,000 copay	Not covered	Prior Authorization is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not covered	----------none----------
	Delivery and all inpatient services	$1,000 copay (Inpatient) $100 copay (Delivery)	Not covered	Prior Authorization is required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$25 copay	Not covered	Coverage for up to 40 home health care visits per condition, per lifetime.
	Rehabilitation services	$30 copay	Not covered	Covered for up to 60 visits per condition, per lifetime.
	Habilitation services	$30 copay	Not covered	Covered for up to 60 visits per condition, per lifetime.
	Skilled nursing care	$1,000 copay	Not covered	Coverage for up to 200 days. Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility
	Durable medical equipment	20% coinsurance	Not covered	Repairs and replacements are covered when necessary due to normal wear and tear. Repairs and replacements that result from misuse or abuse are not covered.
	Hospice service	$25 copay	Not covered	Up to 210 days per year. Inpatient hospice care is subject to the inpatient hospital cost share. Prior Authorization is required.
If your child needs dental or eye care	Eye exam	$25 copay	Not covered	Covered through Davis Vision for children under the age of 19. 1 per 12-month period
	Glasses	20% coinsurance	Not covered	Covered through Davis Vision for children under the age of 19. Eyewear coinsurance cost sharing applies to combined cost of lenses and frames; also applies to contact lenses
	Dental check-up	$25 copay	Not covered	Covered through DentaQuest for children under the age of 19. One per 6-month period

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Private-Duty Nursing
- Interruption of Pregnancy
- Long-Term Care
- Routine Foot Care
- Routine Dental Care (Adult)
- Routine Eye Care (Adult)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at Fidelis Member Services Department – 1-888-FIDELIS.
You may also contact your state insurance department at:

Department of Financial Service
Consumer Assistance Unit
One Commerce Plaza
Albany, New York 12257
Fax: (212) 480-6282

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Fidelis Member Services Department – 1-888-FIDELIS.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-FIDELIS.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-FIDELIS.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-FIDELIS.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-FIDELIS.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,400
- **Patient pays** $2,140

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$600
Copays	$1,390
Coinsurance	$0
Limits or exclusions	$150
Total	**$2,140**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,770
- **Patient pays** $1,630

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$600
Copays	$740
Coinsurance	$210
Limits or exclusions	$80
Total	**$1,630**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.