



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 \$2,000 individual / \$4,000 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 1 st). 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?	\$5,500 individual / \$11,000 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 <i>specific</i> 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 some 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 .

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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	\$30	Not covered	-----none-----
	Specialist visit	\$50	Not covered	-----none-----
	Other practitioner office visit	\$30	Not covered	-----none-----
	Preventive care/screening/immunization	\$0	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)	\$50	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$50	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.fideliscare.org	Generic drugs	\$10	Not covered	Rx through Caremark. For questions, please call: 1-888-FIDELIS
	Preferred brand drugs	\$35	Not covered	
	Non-preferred brand drugs	\$70	Not covered	Retail: 30-day supply Mail Order: 90-day supply
	Specialty drugs	\$70	Not covered	-----none-----

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Fidelis Care Silver

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

Coverage Period: 01/01/2014-12/31/2014

Coverage for: Individual/Family | Plan Type: HMO

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100	Not covered	Precertification is required
	Physician/surgeon fees	\$100	Not covered	Precertification 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	Not covered	Copay is waived if patient is admitted as an inpatient (including as an observation stay) directly from the ER
	Emergency medical transportation	\$150	Not covered	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	\$70	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,500 per admission	Not covered	Precertification is required for elective hospitalizations
	Physician/surgeon fee	\$100	Not covered	Precertification is required for elective hospitalizations

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Fidelis Care Silver

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

Coverage Period: 01/01/2014-12/31/2014

Coverage for: Individual/Family | Plan Type: HMO

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	\$30	Not covered	Precertification is required
	Mental/Behavioral health inpatient services	\$1,500	Not covered	Precertification is required
	Substance use disorder outpatient services	\$30	Not covered	Precertification is required
	Substance use disorder inpatient services	\$1,500	Not covered	Precertification is required
If you are pregnant	Prenatal and postnatal care	\$0	Not covered	Copay is based on the type of physician performing the service
	Delivery and all inpatient services	\$1,500	Not covered	Precertification is required
If you need help recovering or have other special health needs	Home health care	\$30	Not covered	Coverage for up to 40 home health care visits per condition, per lifetime.
	Rehabilitation services	\$30	Not covered	Covered for up to 60 visits per condition, per lifetime.
	Habilitation services	\$30	Not covered	Covered for up to 60 visits per condition, per lifetime.
	Skilled nursing care	\$1,500	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	30% 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	\$30	Not covered	Precertification is required
If your child needs dental or eye care	Eye exam	\$30	Not covered	
	Glasses	30% coinsurance	Not covered	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames; also applies to contact lenses
	Dental check-up	Not Covered	Not covered	See stand-alone dental provider

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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
- Routine dental care (Adult)
- Interruption of pregnancy
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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 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.

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, kwijigo holne' 1-888-FIDELIS

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

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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 \$ 3,520**
- **Patient pays \$ 4,020**

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	\$2,000
Copays	\$1,870
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$4,020

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$2,570**
- **Patient pays \$ 2,830**

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	\$2,000
Copays	\$480
Coinsurance	\$270
Limits or exclusions	\$80
Total	\$2,830

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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.

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