⚠ **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the monthly premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.fideliscare.org or call 1-888-FIDELIS (1-888-343-3547). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.fideliscare.org or call 1-888-FIDELIS (1-888-343-3547) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$600 individual / $1,200 Family**	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 services covered before you meet your deductible?	Yes – Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. Copayments or coinsurance may still apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at: https://www.healthcare.gov/coverage/preventive-care-benefits/
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
What is the out-of-pocket limit for this plan?	**$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**.
Will you pay less if you use a network provider?	Yes – This plan does not cover most services provided out of network	It is important to make sure your provider is in-network, otherwise your claim might not be covered. This plan covers emergency services out of network.
Do you need a referral to see a specialist?	No	You can see the in-network **specialist** you choose without permission from this plan.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit after deductible	Not covered	None.
	Specialist visit	$40 copay per visit after deductible	Not covered	None.
	Preventive care/screening/ immunization	No charge	Not covered	No cost-sharing applies for services provided according to the guidelines outlined in section 2713 of the Affordable Care Act (ACA).
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay per visit after deductible	Not covered	Prior authorization required for diagnostic radiology except x-ray.
	Imaging (CT/PET scans, MRIs)	$40 copay per visit after deductible	Not covered	Prior authorization is required for certain blood work and diagnostic imaging except x-ray.
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 copay/prescription (retail), $25 copay/prescription (mail order)	Not covered	Covers up to 30 day supply at retail and up to 90 day supply through mail order. Prior authorization/step therapy may be required. Covered through CVS/Caremark. For questions, please call: 1-888-FIDELIS (1-888-343-3547) Retail: 30 day supply Mail Order: 90 day supply Diabetic medication and supplies are subject to the primary care provider copayment.
	Preferred brand drugs	$35 copay/prescription (retail), $87.50 copay/prescription (mail order)	Not covered	
	Non-preferred brand drugs	$70 copay/prescription (retail), $175 copay/prescription (mail order)	Not covered	
	Specialty drugs	$70 copay/prescription (retail)	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.fideliscare.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay after deductible	Not covered	Prior authorization is required.
	Physician/surgeon fees	$100 copay after deductible	Not covered	Prior authorization required. One copay is charged per surgery and applies only to surgeries performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters (does not apply to office surgeries).
If you need immediate medical attention	Emergency room care	$150 copay per visit after deductible	$150 copay per visit after deductible	Copay is waived if you are admitted as an inpatient (including an observation stay) directly from the ER.
	Emergency medical transportation	$150 copay after deductible	$150 copay after deductible	None.
	Urgent care	$60 copay per visit after deductible	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay per admission after deductible	Not covered	Prior authorization is required for elective hospitalizations.
	Physician/surgeon fees	$100 copay per surgery after deductible	Not covered	Prior authorization is required for elective hospitalizations.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit after deductible	Not covered	Prior authorization is required.
	Inpatient services	$1,000 copay per admission after deductible	Not covered	Prior authorization is required except for emergency admissions.
If you are pregnant	Office visits	$25 copay per visit after deductible	Not covered	None.
	Childbirth/delivery professional services	$100 copay per visit after deductible	Not covered	Prior authorization is required.
	Childbirth/delivery facility services	$1,000 copay per admission after deductible	Not covered	Prior authorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$ 25 copay per visit after deductible	Not covered	Up to 40 home health care visits are covered per condition per year.
	Rehabilitation services	$30 copay per visit after deductible	Not covered	Up to 60 visits are covered per condition per year.
	Habilitation services	$30 copay per visit after deductible	Not covered	Up to 60 visits are covered per condition per year.
	Skilled nursing care	$1,000 copay per admission after deductible	Not covered	Up to 200 days are covered per year. Copay is waived if direct transfer from inpatient hospital setting or skilled nursing facility to hospice facility.
	Durable medical equipment	20% coinsurance after deductible	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 services	$25 copay per visit after deductible	Not covered	Prior authorization required. Up to 210 days covered / year. Inpatient hospice is subject to inpatient hospital cost-sharing.
If your child needs dental or eye care	Children's eye exam	$25 copay per visit after deductible	Not covered	1 per 12-month period for children under the age of 19. If you have questions, please call Davis Vision at: 1-800-999-5431
	Children's glasses	20% coinsurance after deductible	Not covered	Eyewear coinsurance applies to the combined cost of lenses and frame, also applies to contact lenses – Limits may apply. Covered for children under the age of 19. If you have questions, please call Davis Vision at: 1-800-999-5431
	Children's dental check-up	$25 copay per visit after deductible	Not covered	1 per 6-month period for children under the age of 19. If you have questions, please call Dentaquest at: 1-800-516-9615

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Private duty nursing	• Long-term care
• Routine foot care	• Routine dental care (adult)	• Routine eye care (adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• Chiropractic care
• Fitness center reimbursement

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

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

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, contact: Fidelis Member Services at 1-888-FIDELIS, or visit www.nystateofhealth.ny.gov or call 1-855-355-5777.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
E-mail: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov
1-800-206-8125

New York State Department of Financial Services
Consumer Assistance Unit

* For more information about limitations and exceptions, see the plan or policy document at www.fideliscare.org.

One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov
1-800-342-3736

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-FIDELIS (1-888-343-3547)
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-FIDELIS (1-888-343-3547)
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-FIDELIS (1-888-343-3547)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-FIDELIS (1-888-343-3547)

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	**$600**
■ **Specialist copayment**	**$40**
■ **Hospital (facility) copayment**	**$1,000**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$13,115**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$1,810
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,470**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$600**
■ **Specialist copayment**	**$40**
■ **Hospital (facility) copayment**	**$1,000**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,906**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$1,685
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,686**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$600**
■ **Specialist copayment**	**$40**
■ **Hospital (facility) copayment**	**$1,000**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,009**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$730
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,337**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.