The Essential Plans are offered through the NY State of Health Marketplace and were designed to bridge the gap between Medicaid and Qualified Health Plans. These plans are designed to provide more affordable healthcare and expand Marketplace enrollment. They include all of the essential health benefits covered by the Qualified Health Plans offered on the Marketplace, with no annual deductible and low out-of-pocket costs.

<table>
<thead>
<tr>
<th>Provider Call Center</th>
<th>Fidelis Care Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-888-FIDELIS (1-888-343-3547), then follow the prompts</td>
</tr>
<tr>
<td>Member Services</td>
<td></td>
</tr>
<tr>
<td>Fidelis Care Website</td>
<td><a href="http://www.fideliscare.org">www.fideliscare.org</a></td>
</tr>
</tbody>
</table>

PLANS SUMMARY

- Fidelis Care offers 4 Essential Plans. Premiums, cost sharing and benefits vary slightly by plan.
- Primary care provider (PCP) not required
- Referrals not required for specialist visits
- In-Network benefits only
- Prior authorization is required for certain services
- No out-of-pocket cost to the members for preventative services
- Continuous enrollment: Applicants can enroll all year long and renewal will be 12 (twelve) months from initial enrollment

COVERED SERVICES

- Ambulatory Services
- Audiology and Hearing Aid Services
- Durable Medical Equipment
- Emergency Services
- Emergency Transportation
- Gym Reimbursement
- Home Health Services
- Hospice
- Inpatient Hospital Services
- Laboratory Services
- Maternity and Newborn Care
- Mental Health and Substance Abuse Services
- Nurse Practitioner Services
- Physician Services
- Prescription Coverage
- Preventative Health Services
- Prosthetics
- Radiology Services
- Rehabilitation Services
- Second Medical Surgical Opinion
- Short-term Residential Health Care Facility Services
- Smoking Cessation
- Specialist Services
- Wellness Services
- Family Planning Services - Beginning January 1, 2019, coverage for family planning and reproductive health benefits has transitioned to Fidelis Care. There are no changes to members’ covered family planning and reproductive health benefits. Members do not need a referral from their PCP to obtain these services. Fidelis Care covers family planning services, which consists of contraceptive drugs or devices, counseling on the use of contraceptives and related topics, sterilization procedures for women, and vasectomies. Fidelis Care covers medically necessary abortions and elective abortions allowing for one (1) procedure per Member, per Plan Year. Fidelis Care does not cover services related to the reversal of elective sterilizations. Starting 1/1/2019, members should use their Fidelis Care member ID card when they obtain these services and claims should be submitted directly to Fidelis Care. Copayments, deductibles and coinsurance may apply based on the member's plan.
- Claims for dates of service prior to 1/1/2019, should continue to be submitted to:
  Unified Independent Practice Association, LLC* (Essential Plans 1 and 2), and New York State Medicaid Fee for Service (Essential Plans 3 & 4).

*Unified, IPA can be reached at 1-800-342-2641.

VERIFYING MEMBER ELIGIBILITY These suggestions are not a guarantee of coverage

Check the member’s ID card and log on to Fidelis Care’s Provider Access Online through https://providers.fideliscare.org or contact the Fidelis Care Provider Call Center and use the automated eligibility tool at 1-888-FIDELIS (1-888-343-3547) and follow the prompts.
• Essential Plans 1 & 2: Individuals who are ineligible for Medicaid or Child Health Plus due to income levels and who do not have access to affordable employer coverage. Income will determine which plan they are enrolled in.

• Essential Plans 3 & 4: Individuals who would be eligible for Medicaid due to income, but who cannot qualify because of immigration status. Income will determine which plan they are enrolled in. Plans 3 and 4 cover the same benefits as plans 1 and 2, but have additional benefits such as vision and dental.

AUTHORIZATIONS

Pre-authorization requests are processed by the Fidelis Care's Quality Health Care Management (QHCM) Department. We recommend that requests be sent at least five (5) calendar days before the anticipated date of service. Standard Requests are responded to within three (3) business days, as long as additional information is not necessary. Please refer to the authorization grid in the Metal-Level Products and Essential Plans Provider Manual (Appendix I) or visit the Fidelis Care website at http://www.fideliscare.org/en-us/providers/authorizationgrid.aspx to determine which services require authorization.

Provider submission of service authorization requests can be accomplished as follows:

• Telephonically: 1-888-FIDELIS (1-888-343-3547) • Fax: 1-718-896-1784 (Behavioral Health)
• Fax: 1-800-860-8720 (Medical) • Fax: 1-877-533-2405 (Pharmacy)

CLAIMS

• All claims submitted to Fidelis Care must include the appropriate CPT and ICD-10 diagnosis codes.

• All claims must be submitted within ninety (90) days from the date of service. Claims are processed within thirty (30) days after receipt of a clean claim submitted electronically and forty-five (45) days after receipt of a clean paper claim (Note: A "Clean Claim" is a claim for healthcare services that contains all required data elements).

• To obtain the status of a claim, please visit Provider Access Online at https://providers.fideliscare.org or contact the Provider Call Center at 1-888-FIDELIS (1-888-343-3547), Monday through Friday, 8:30 AM to 5:00 PM.

• Claims Remittances are available through Fidelis Care’s Provider Access Online at https://providers.fideliscare.org or through a HIPAA-mandated 835 Electronic Remittance Advice.

• Grace Period - Members who fail to pay their premiums are given a 30-day grace period to pay their outstanding amount. If the member fails to pay the amount owed by the end of the grace period, their coverage will terminate. During the grace period members are considered eligible for services and Fidelis Care will continue to pay claims for dates of service within the grace period.

• If payment is not received within the allotted grace period, the member’s policy will be cancelled and subsequent claims will be denied. Providers may seek payment from members for claims denied due to coverage termination for nonpayment.

• Reimbursement rates may vary between Essential Plans 1 & 2 and Essential Plans 3 & 4 members.

<table>
<thead>
<tr>
<th>Claim Submission Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electronic Claims</strong></td>
</tr>
<tr>
<td>Fidelis Care Payer ID # 11315 - For more information, visit fideliscare.org</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Paper Claims</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional - CMS1500</td>
</tr>
<tr>
<td>Facility – UB04</td>
</tr>
</tbody>
</table>

APPEALS AND REQUESTS FOR ADMINISTRATIVE REVIEWS

Medical Necessity Standard Appeals

Appeals must be received within sixty (60) business days of the remittance advice and should be mailed to:

Attn: Appeals Department, Fidelis Care, 490 CrossPoint Parkway, Getzville, NY 14068, Phone: 718-896-6500 ext. 13159, Fax: 718-393-6779

Requests for Administrative Review of Previously Processed Claim

Requests for claims reconsiderations must be submitted within sixty (60) calendar days of the date of the remittance advice. Requests for administrative review must be sent to the following address:

Attn: Claims Reconsideration, Fidelis Care, 480 CrossPoint Parkway, Getzville, NY 14068

Please visit Fidelis Care's website, fideliscare.org, for a complete Fidelis Care Provider Manual, Authorization Grids, educational resources, announcements, participating provider search engine, and other helpful tools.