Following the implementation of the Patient Protection and Affordable Care Act (ACA), Fidelis Care made the decision to offer products covering the Essential Health Benefits as required by the ACA and the New York State health care exchange, known as the New York State of Health (NYSOH). Fidelis Care continues to offer an approved set of products that are briefly described below in the PLANS SUMMARY section. Members can enroll through the NYSOH (also known as "on-exchange") or directly with Fidelis Care (also known as “off-exchange”). Metal-Level Products are standardized and approved by NYSOH and have different cost sharing levels and prices based on their "metal" level. These metal levels are: Platinum, Gold, Silver, Bronze, and Catastrophic.

<table>
<thead>
<tr>
<th>Fidelis Care Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Call Center</td>
</tr>
<tr>
<td>Member Services</td>
</tr>
<tr>
<td>Fidelis Care Website</td>
</tr>
</tbody>
</table>

**PLANS SUMMARY**

Fidelis Care offers standard products at each metal level: Platinum, Gold, Silver (Plus 3 additional Silver tiers available for lower income individuals, on-exchange only), Bronze, and Catastrophic. Premiums and cost sharing vary by plan, but the benefit structure is consistent across all Metal-Level Products:

- Primary care provider (PCP) not required
- Referrals not required for specialist visits
- In-Network benefits only
- Prior authorization required for certain services
- No out-of-pocket cost to the members for preventative services
- Annual open enrollment period: November 15 - February 15

**COVERED SERVICES**

- Ambulatory Services
- Audiology and Hearing Aid Services
- Durable Medical Equipment
- Emergency Services
- Emergency Transportation
- EPSDT/(Child Teen Health Program)
- Eye Care and Low Vision Services
- Home Health Services
- Hospice
- Inpatient Hospital Services
- Laboratory Services
- Maternity and Newborn Care
- Mental Health and Substance Abuse Services
- Nurse Practitioner Services
- Pediatric Dental and Vision Services
- Physician Services
- Prescription Coverage
- Preventive Health Services
- Prosthetics
- Radiology Services
- Rehabilitation Services
- Second Medical Surgical Opinion
- Short-term Residential Health Care Facility Services
- Smoking Cessation
- Specialist Services
- Wellness Services

As of January 1, 2019, coverage for family planning and reproductive health benefits will transition from Unified IPA, LLC to Fidelis Care. There are no changes to members’ covered family planning and reproductive health benefits. Members should use their Fidelis Care member ID card and claims should be billed directly to Fidelis Care. Claims with dates of service prior to 1/1/2019 will continue to be handled by Unified IPA. Their contact information is, Unified Independent Practice Association, LLC 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 at https://providers.fideliscare.org or contact the Fidelis Care Provider Call Center and to use the automated eligibility tool at 1-888-FIDELIS (1-888-343-3547) and follow the prompts.
AUTHORIZATIONS
Pre-authorization requests are processed by 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. We respond to standard requests within three (3) business days, as long as additional information is not necessary.

Please refer to the authorization grid in the Metal-Level Products 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 prior authorization.

Provider submission of service authorization requests can be accomplished as follows:
- Telephonically: 1-888-FIDELIS (1-888-343-3547)
- Fax: 1-800-860-8720 (Medical)
- Fax: 1-1-718-896-1784 (Behavioral Health)
- Fax: 1-1-757-533-2405 (Pharmacy)

CLAIMS
- All claims submitted to Fidelis Care must include the appropriate CPT and ICD10 diagnosis code.
- 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 call the Provider Call Center at 1-888-FIDELIS (1-888-343-3547), Monday through Friday, 8:30 AM to 5 PM.
- Claims Remittances are available through Fidelis Care’s Provider Access Online at https://providers.fideliscare.org. Remittances are also available through transaction.
- Providers should only collect a member's copayment at the time of service. Providers may bill members for applicable coinsurance and deductible amounts only after claims have been adjudicated by Fidelis Care. The provider's remittance advice will indicate the member’s financial responsibility.
- Grace Period for Government Subsidized Plans - Members receiving an Advance Premium Tax Credit (APTC) are entitled to a ninety (90) day grace period before coverage is terminated for premium delinquency. During the first thirty (30) days following nonpayment, claims for services will be processed and paid. Claims for services rendered during the subsequent sixty (60) days will be pended by Fidelis Care. Providers will be notified in writing if claims are pended for premium nonpayment.
- Grace Period for Nonsubsidized Plans - Members who do not qualify for an APTC are entitled to a thirty (30) day grace period before coverage is terminated for premium delinquency. During the first thirty (30) days following nonpayment, claims for services will be pended by Fidelis Care.

If payment is not received within the allotted grace period, APTC and non-APTC member policies will be cancelled and pended claims will be denied. Providers may seek payment from members for claims denied due to coverage termination for nonpayment.

<table>
<thead>
<tr>
<th>Claim Submission Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper Claims</td>
</tr>
</tbody>
</table>
| Fidelis Care – Metal-Level Products PO Box 724 Amherst, NY 14226-0724 | • Fidelis Care Payer ID: 11315
|                          | • For more information, visit fideliscare.org |

APPEALS AND REQUESTS FOR ADMINISTRATIVE REVIEWS
All requests must be submitted within sixty (60) business days of the provider receiving the remittance advice.

Standard Appeals - If Fidelis Care denies payment for a claim due to a lack of medical necessity, appeals may be sent to: Fidelis Care Appeals Department, 490 CrossPoint Parkway, Getzville, NY 14068.

Reconsideration Request - Requests for claims reconsiderations may be sent to: Attn: Claims Reconsideration, Fidelis Care, 480 CrossPoint Parkway, Getzville, NY 14068.

For additional information, please visit fideliscare.org for a complete Fidelis Care Provider Manual, educational resources, announcements and other helpful tools.