Fidelity Health Plan: Fidelity Investments

Coverage for: Individual/Family Plan Type: Self-funded PPO

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 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.NetBenefits.com/Fidelity or call 1-800-835-5099. 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-800-835-5099 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,500 Individual / $3,000 Family Non-Network: $3,000 Individual / $6,000 Family Deductibles cross-apply. Does not apply to services listed below as "No Charge".	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
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 annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific service, 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?	Network: $2,000 Individual / $4,000 Family Non-Network: $4,000 Individual / $8,000 Family Out-of-pockets cross-apply	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limits must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover. Penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Note: Out of Network services that are not pre-approved and are not medically necessary will not be paid by the plan and will be your responsibility.
Will you pay less if you use a network provider?	Yes. See member.Accolade.com or call 1-844-287-3861 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% Coinsurance	30% Coinsurance	
	Specialist visit	10% Coinsurance	30% Coinsurance	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	Frequency of services may be limited. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	30% Coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com. For preventive drug coverage information, call CVS Caremark at 800-446-3709.	Generic Drugs (Tier 1)	10% co-insurance Preventive copay $10 Retail $20 Mail Order	30% co-insurance Preventive copay $10 Retail $20 Mail Order	Retail – 30 day supply Mail order – 84-90 day supply
	Preferred brand drugs (Tier 2)	10% co-insurance Preventive copay $20 Retail $40 Mail Order	30% co-insurance Preventive copay $20 Retail $40 Mail Order	Retail – 30 day supply Mail order – 84-90 day supply
	Non-preferred brand drugs (Tier 3)	10% co-insurance Preventive copay $40 Retail $80 Mail Order	30% co-insurance Preventive copay $40 Retail $80 Mail Order	Retail – 30 day supply Mail order – 84-90 day supply
	Specialty drugs (Tier 4)	Specialty drugs will be processed as Generic, Formulary, Non-Formulary. This plan does not have a specific level of coverage for specialty drugs.		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	None
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	None
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	48-hour emergency notification required if admitted to the hospital.
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	None
	Urgent care	10% Coinsurance	30% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	$500 out of network non-notification penalty.
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% Coinsurance	30% Coinsurance	None
	Inpatient services	10% Coinsurance	30% Coinsurance	$500 out-of-network non-notification penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
If you are pregnant	Office visits	10% Coinsurance	30% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). $500 out of network non-notification penalty.
	Childbirth/delivery professional services	10% Coinsurance	30% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	30% Coinsurance	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	30% Coinsurance	200 visit limit per year combined with Skilled Nursing Care (outpatient, in the home only). Failure to preauthorize may result in a denial or reduction in benefits. $500 out of network non-notification penalty.
	Rehabilitation services	10% Coinsurance	30% Coinsurance	Occupational and Physical Therapy limited to 100 visits combined for each type of therapy per calendar year, in and out-of-network. Speech therapy limited to 52 visits per member per calendar year, in- and out-of-network combined.
	Habilitation services	10% Coinsurance	30% Coinsurance	
	Skilled nursing care	10% Coinsurance	30% Coinsurance	100 days per calendar year for network and non-network combined. $500 out of network non-notification penalty.
	Durable medical equipment	10% Coinsurance	30% Coinsurance	Prior authorization is required if expenses are greater than $750.
	Hospice services	10% Coinsurance	30% Coinsurance	$500 out of network non-notification penalty.
If your child needs eye care	Children's eye exam	No Charge	30% Coinsurance	Limited to one routine eye exam per year; diagnostic eye exams are subject to deductible/coinsurance.
	Children's glasses	10% Coinsurance	Not Covered	Only covered as a result of accidental injury, or 1 pair eyeglasses or contacts after cataract surgery.
	Children's dental	Not Covered	Not Covered	

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 • Dental Care (Adult/child) • Long-term care	• Non-emergency care when traveling outside the U.S • Out-of-network services which are not pre-approved and are not medically necessary.	• Private duty nursing (inpatient) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture – up to 20 visits per calendar year, in and out-of-network combined. • Bariatric Surgery (prior authorization and use of COE; additional requirements may apply)	• Chiropractic care – up to 20 visits per calendar year, in and out-of-network combined • Hearing aids ($1500 per ear, every 36 months)	• Infertility treatment (lifetime maximum of $30,000 medical and $15,000 for pharmacy, prior authorization is required) • Private-duty nursing (Outpatient) • Routine eye care (Adult)

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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, visit www.HealthCare.gov/ or call 1-800-318-2596.

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:

- Accolade at 1-844-287-3861
- Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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.

For more information about limitations and exceptions, see the plan or policy document at www.FMRbenefits.com

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-287-3861.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-287-3861.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-844-287-3861.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-287-3861.

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	$1,500
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,060

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

■ The plan's overall deductible	$1,500
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,430
Copayments	$260
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,750

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

■ The plan's overall deductible	$1,500
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,540