



**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.evergreenmd.org/](http://www.evergreenmd.org/) or by calling 410-844-0701.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<p><b><u>In-Network</u></b>: \$1,350 person/ \$2,700 family</p> <p><b><u>Out-of-Network</u></b>: \$6,000 person/ \$12,000 family</p> <p>Does not apply to preventive care and prenatal and postnatal care, which are provided at no cost. Certain drugs which fall under the preventive Preferred Generics category are provided at the specified copay with waived deductible.</p>	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan agreement to see when the <b><u>deductible</u></b> 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 <b><u>deductible</u></b> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <b><u>deductibles</u></b> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	<p>Yes, for <b><u>In-Network</u></b>: \$2,700 person/ \$5,400 family</p> <p><b><u>Out-of-Network</u></b>: None</p> <p>If you have family coverage and one family member meets the in-network individual coverage <b><u>out-of-pocket limit</u></b>, no further <b><u>coinsurance</u></b> or <b><u>copayments</u></b> will be required of that member in that plan year for covered services rendered by <b><u>in-network providers</u></b>.</p>	The <b><u>out-of-pocket limit</u></b> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.

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<p><b>Does this plan use a network of providers?</b></p>	<p>Yes. For a list of <b>network providers</b>, see <a href="https://www.evergreenmd.org/tools-resources/find-a-doctor/">https://www.evergreenmd.org/tools-resources/find-a-doctor/</a> or call 410-844-0701.</p>	<p>If you use an in-network doctor or other health care <b>provider</b>, 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 <b>provider</b> for some services. Plans use the term <b>in-network</b> or <b>network</b> for providers in their <b>network</b>. See the chart starting on page 3 for how this plan pays different kinds of <b>providers</b>.</p>
<p><b>Do I need a referral to see a specialist?</b></p>	<p>No.</p>	<p>You can see the <b>specialist</b> you choose without permission from this plan.</p>
<p><b>Are there services this plan doesn't cover?</b></p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about <b>excluded services</b>.</p>

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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 **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20/visit	\$30/visit	50% after Deductible	None.
	Specialist visit	No Tier 1 Providers Available	\$50/visit	50% after Deductible	<b>Preauthorization</b> is required for podiatry services.
	Other practitioner office visit	No Tier 1 Providers Available	\$50/visit	50% after Deductible	Chiropractic care is limited to 20 visits per condition per plan year. <b>Preauthorization</b> is required for chiropractic care.
	Preventive care/screening/immunization	No Charge	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	\$30 Copayment	\$60 Copayment	50% after Deductible	<b>Preauthorization may be required.</b> Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	20% after Deductible	30% after Deductible	50% after Deductible	<b>Preauthorization</b> is required.

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Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="https://www.evergreenmd.org/healthformulary">https://www.evergreenmd.org/healthformulary</a>.</p>	Preferred Generic drugs	No Tier 1 Providers Available	\$5 Copayment/script (up to a 30-day supply); \$15 Copayment/script (up to a 90-day supply)	50% after Deductible	<p>Certain preventive Preferred Generics will be covered with waived deductible.</p> <p>Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). <b>Network provider</b> contraceptives are not subject to a copay.</p> <p><b>Preauthorization</b> may be required for certain drugs.</p>
	Non-Preferred Generic drugs	No Tier 1 Providers Available	\$15 Copayment/script (up to a 30-day supply); \$45 Copayment/script (up to a 90-day supply)	50% after Deductible	<p>Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). <b>Network provider</b> contraceptives are not subject to a copay.</p> <p><b>Preauthorization</b> may be required for certain drugs.</p>
	Preferred brand drugs	No Tier 1 Providers Available	\$30 Copayment/script (up to a 30-day supply); \$90 Copayment/script (up to a 90-day supply)	50% after Deductible	
	Non-preferred brand drugs	No Tier 1 Providers Available	60% after Deductible	60% after Deductible	

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Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Generic & Preferred brand Specialty drugs	No Tier 1 Providers Available	15% after Deductible	50% after Deductible	Up to a \$150 max per 30-day supply per script.
	Non-Preferred Specialty drugs	No Tier 1 Providers Available	30% after Deductible	50% after Deductible	<b><u>Preauthorization</u></b> may be required for certain drugs.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	<b><u>Preauthorization</u></b> may be required. Refer to your plan agreement.
	Physician/surgeon fees	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	None.
<b>If you need immediate medical attention</b>	Emergency room services	No Tier 1 Providers Available	\$200 Copayment per visit	\$200 Copayment per visit	None.
	Emergency medical transportation	No Tier 1 Providers Available	20% after Deductible	20% after Deductible	None.
	Urgent care	No Tier 1 Providers Available	\$50/visit	\$50/visit	<b><u>Out-of-Network Providers</u></b> are covered out of the service area.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	<b><u>Preauthorization</u></b> is required.
	Physician/surgeon fee	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	None.

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Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	<b><u>Preauthorization</u></b> may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	<b><u>Preauthorization</u></b> is required.
	Substance use disorder outpatient services	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	<b><u>Preauthorization</u></b> may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	<b><u>Preauthorization</u></b> is required.
<b>If you are pregnant</b>	Prenatal and postnatal care	No Charge	No Charge	Not Covered	<b><u>Preauthorization</u></b> is required for genetic testing during pregnancy.
	Delivery and all inpatient services	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	None.

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Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	<b><u>Preauthorization</u></b> is required.
	Rehabilitation services	No Tier 1 Providers Available	\$20/visit	50% after Deductible	For adults (19 and older) limited to 30 visits per member per plan year for each of the following therapies: physical, speech, and occupational therapy. <b><u>Preauthorization</u></b> is required.
	Habilitation services	No Tier 1 Providers Available	\$20/visit	50% after Deductible	For adults (19 and older), limited to 30 visits per member per plan year for physical, speech, and occupational therapy. For members under 19, there are no visit limits.
	Skilled nursing care	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	Limited to 100 days per plan year. <b><u>Preauthorization</u></b> is required.
	Durable medical equipment	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	<b><u>Preauthorization</u></b> may be required. Refer to your plan agreement.
	Hospice service	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	<b><u>Preauthorization</u></b> is required.
<b>If your child needs dental or eye care</b>	Eye exam	No Tier 1 Providers Available	\$50/visit	50% after Deductible	Limited to 1 exam per plan year.
	Glasses	No Tier 1 Providers Available	20% after Deductible	50% after Deductible	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per plan year under age 19.
	Dental check-up	No Tier 1 Providers Available	No Charge	Not Covered	Limited to members under age 19. Diagnostic services and preventive services included at no extra cost. Refer to your plan agreement for limitations.

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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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine foot care
- Weight loss programs

### 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.)

- Bariatric Surgery
- Chiropractic Care (with limits)
- Hearing aids (with limits)
- Infertility Treatment (limits apply)
- Routine eye care (for adults, limited to one exam every plan year)

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **410-844-0701**. You may also contact your state insurance department at [www.mdinsurance.state.md.us](http://www.mdinsurance.state.md.us).

## 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: [www.mdinsurance.state.md.us](http://www.mdinsurance.state.md.us).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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*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 \$4,880
- Patient pays \$2,660

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,350
Copays	\$10
Coinsurance	\$1,150
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,660</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$3,290
- Patient pays \$2,110

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,350
Copays	\$370
Coinsurance	\$310
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,110</b>

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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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