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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$0** person/**$0** family **Non-Plan Provider** **Not Covered**	See the chart starting on page 2 for your costs for services this plan covers.
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.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	Not Applicable.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/network providers.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

- **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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	[————none————]
	Specialist visit	No Charge	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	No Charge	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/networkproviders.pdf	Generic drugs	No Charge		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	No Charge		
	Non-preferred brand drugs	No Charge		
	Specialty drugs	No Charge		

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	**Preauthorization** is required.
	Physician/surgeon fees	No Charge	Not Covered	[————none————]
If you need immediate medical attention	Emergency room services	No Charge	No Charge	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	No Charge	Not Covered	**Preauthorization** is required.
	Urgent care	No Charge	Not Covered	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	Not Covered	[————none————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	No Charge	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	No Charge	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	No Charge	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————none————]
	Delivery and all inpatient services	No Charge	Not Covered	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	**Preauthorization** is required.
	Rehabilitation services	No Charge	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	No Charge	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	No Charge	Not Covered	[————none————]
	Hospice service	No Charge	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to 1 exam per benefit year.
	Glasses	No Charge	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $7,390
- **Patient pays** $150

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
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$150**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,320
- **Patient pays** $80

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
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$80**

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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
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Evergreen Health Cooperative: Individual Bronze Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$4,500** person/**$9,000** family **Non-Plan Provider** **$9,000** person/**$18,000** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$6,050** person/**$12,100** family **Non-Plan Provider** **$12,100** person/**$24,200** 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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call **1-855-475-0990** or visit us at http://www.evergreenmd.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% coinsurance	Not Covered	[————none————]
	Specialist visit	40% coinsurance	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	40% coinsurance for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	30% coinsurance	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	50% coinsurance	50% coinsurance	
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	
	Specialty drugs	40% coinsurance (maximum payment of $250 per prescription)	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	[————————none————————]
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	40% coinsurance	50% coinsurance	**Preauthorization** is required.
	Urgent care	40% coinsurance	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay per admission	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	40% coinsurance	50% coinsurance	[————————none————————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	40% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$1,000 copay per admission	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	40% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$1,000 copay per admission	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————————none————————]
	Delivery and all inpatient services	$1,000 copay per admission facility/40% coinsurance professional services	50% coinsurance	[————————none————————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	40% coinsurance	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	40% coinsurance	50% coinsurance	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$1,000 copay per admission	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	40% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	40% coinsurance	50% coinsurance	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	40% coinsurance	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	40% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan agreement for other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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

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?

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.**

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

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** $1,880
- **Patient pays** $5,660

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
Total	**$7,540**

Patient pays:

Deductibles	$4500
Copays	$1,000
Coinsurance	$10
Limits or exclusions	$150
Total	**$5,660**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $570
- **Patient pays** $4,830

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
Total	**$5,400**

Patient pays:

Deductibles	$4,500
Copays	$0
Coinsurance	$250
Limits or exclusions	$80
Total	**$4,830**

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.

Questions: Call **1-855-475-0990** or visit us at http://www.evergreenmd.org.
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Evergreen Health Cooperative: Individual Silver Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** HMO

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$1,300** person/**$2,600** family **Non-Plan Provider** **Not Covered** Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$6,050** person/**$12,100** family **Non-Plan Provider** **Not Covered**	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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/network providers.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

- **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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	Not Covered	[————none————]
	Specialist visit	30% coinsurance	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	30% coinsurance for chiropractic care	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	30% coinsurance		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	30% coinsurance		
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)		
	Specialty drugs	30% coinsurance (maximum payment of $250 per prescription)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	**Preauthorization** is required

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Physician/surgeon fees	30% coinsurance	Not Covered	[————none————]
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	30% coinsurance	Not Covered	**Preauthorization** is required.
	Urgent care	30% coinsurance	Not Covered	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	30% coinsurance	Not Covered	[————none————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	30% coinsurance	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	30% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	30% coinsurance	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————none————]
	Delivery and all inpatient services	30% coinsurance	Not Covered	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	**Preauthorization** is required.
	Rehabilitation services	30% coinsurance	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	30% coinsurance	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	30% coinsurance	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	30% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	30% coinsurance	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	30% coinsurance	Not Covered	Limited to 1 exam per benefit year.
	Glasses	30% coinsurance	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $4,300
- **Patient pays** $3,240

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
Total	**$7,540**

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$1,790
Limits or exclusions	$150
Total	**$3,240**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,830
- **Patient pays** $2,570

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
Total	**$5,400**

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$1,190
Limits or exclusions	$80
Total	**$2,570**

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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

Evergreen Health Cooperative: Individual Silver (73) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** HMO

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$1,000** person/**$2,000** family **Non-Plan Provider** **Not Covered** Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$4,800** person/**$9,600** family **Non-plan Provider** **Not Covered**	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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/networkproviders.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

- **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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	Not Covered	[————none————]
	Specialist visit	30% coinsurance	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	30% coinsurance for chiropractic care	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	30% coinsurance		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	30% coinsurance		
	Non-preferred brand drugs	80% (minimum payment of $60 retail/$180 mail order per prescription)		
	Specialty drugs	30% coinsurance (maximum payment of $250 per prescription)		

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fees	30% coinsurance	Not Covered	[————————none————————]
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	30% coinsurance	Not Covered	**Preauthorization** is required.
	Urgent care	30% coinsurance	Not Covered	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	30% coinsurance	Not Covered	[————————none————————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	30% coinsurance	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	30% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	30% coinsurance	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————————none————————]
	Delivery and all inpatient services	30% coinsurance	Not Covered	[————————none————————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	**Preauthorization** is required.
	Rehabilitation services	30% coinsurance	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	30% coinsurance	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	30% coinsurance	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	30% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	30% coinsurance	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	30% coinsurance	Not Covered	Limited to 1 exam per benefit year.
	Glasses	30% coinsurance	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $4,510
- **Patient pays** $3,030

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
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$1,880
Limits or exclusions	$150
Total	**$3,030**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,040
- **Patient pays** $2,360

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
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$1,280
Limits or exclusions	$80
Total	**$2,360**

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?

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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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Evergreen Health Cooperative: Individual Silver (87) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** HMO

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$500** person/**$1,000** family **Non-Plan Provider** **Not Covered** Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$1,500** person/**$3,000** family **Non-Plan Provider** **Not Covered**	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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/network providers.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

- **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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	Not Covered	[————none————]
	Specialist visit	15% coinsurance	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	15% coinsurance for chiropractic care	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	15% coinsurance		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	15% coinsurance		
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)		
	Specialty drugs	15% coinsurance (maximum payment of $250 per prescription)		

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fees	15% coinsurance	Not Covered	[————none————]
If you need immediate medical attention	Emergency room services	15% coinsurance	15% coinsurance	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	15% coinsurance	Not Covered	**Preauthorization** is required.
	Urgent care	15% coinsurance	Not Covered	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	15% coinsurance	Not Covered	[————none————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	15% coinsurance	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	15% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	15% coinsurance	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————none————]
	Delivery and all inpatient services	15% coinsurance	Not Covered	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	15% coinsurance	Not Covered	**Preauthorization** is required.
	Rehabilitation services	15% coinsurance	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	15% coinsurance	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	15% coinsurance	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	15% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	15% coinsurance	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	15% coinsurance	Not Covered	Limited to 1 exam per benefit year.
	Glasses	15% coinsurance	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $5,870
- **Patient pays** $1,670

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
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$1,020
Limits or exclusions	$150
Total	**$1,670**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,100
- **Patient pays** $1,300

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
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$720
Limits or exclusions	$80
Total	**$1,300**

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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
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Evergreen Health Cooperative: Individual Silver (94) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** HMO

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$0** person/**$0** family **Non-Plan Provider** **Not Covered**	See the chart starting on page 2 for your costs for services this plan covers.
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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$1,000** person/**$2,000** family **Non-Plan Provider** **Not Covered**	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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/network providers.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

- **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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	Not Covered	[————————none————————]
	Specialist visit	10% coinsurance	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	10% coinsurance for chiropractic care	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	10% coinsurance		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	10% coinsurance		
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)		
	Specialty drugs	10% coinsurance (maximum payment of $250 per prescription)		

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fees	10% coinsurance	Not Covered	[————none————]
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	10% coinsurance	Not Covered	**Preauthorization** is required.
	Urgent care	10% coinsurance	Not Covered	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	10% coinsurance	Not Covered	[————none————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	10% coinsurance	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	10% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	10% coinsurance	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————none————]
	Delivery and all inpatient services	10% coinsurance	Not Covered	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	**Preauthorization** is required.
	Rehabilitation services	10% coinsurance	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	10% coinsurance	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	10% coinsurance	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	10% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	10% coinsurance	Not Covered	Limited to 1 exam per benefit year.
	Glasses	10% coinsurance	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan agreement for other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $6,660
- **Patient pays** $880

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
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$730
Coinsurance	$0
Limits or exclusions	$150
Total	**$880**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,790
- **Patient pays** $610

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
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$530
Limits or exclusions	$80
Total	**$610**

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.

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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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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

Evergreen Health Cooperative: Individual Silver Plus Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** HMO

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$3,500** person/**$7,000** family **Non-Plan Provider** **Not Covered** Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$6,050** person/**$12,100** family **Non-Plan Provider** **Not Covered**	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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/network providers.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

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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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	[————————none————————]
	Specialist visit	$60 copay/visit	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$60 copay/visit for chiropractic care	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/networkproviders.pdf	Generic drugs	$10 copay retail/$30 copay mail order		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	$35 copay retail/$105 copay mail order		
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)		
	Specialty drugs	30% coinsurance (maximum payment of $250 per prescription)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	**Preauthorization** is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Physician/surgeon fees	30% coinsurance	Not Covered	[————————none————————]
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	30% coinsurance	Not Covered	**Preauthorization** is required.
	Urgent care	$60 copay/visit	Not Covered	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay per admission	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	Not Covered	[————————none————————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$1,500 copay per admission	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$1,500 copay per admission	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————————none————————]
	Delivery and all inpatient services	$1,500 copay per admission	Not Covered	[————————none————————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$60 copay/visit	Not Covered	**Preauthorization** is required.
	Rehabilitation services	$60 copay/visit	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	$60 copay/visit	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$1,500 copay per admission	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	30% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10 copay/visit	Not Covered	Limited to 1 exam per benefit year.
	Glasses	30% coinsurance	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery (Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $2,370
- **Patient pays** $5,170

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
Total	**$7,540**

Patient pays:

Deductibles	$3,500
Copays	$1,520
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,170**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,460
- **Patient pays** $3,940

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
Total	**$5,400**

Patient pays:

Deductibles	$3,500
Copays	$200
Coinsurance	$160
Limits or exclusions	$80
Total	**$3,940**

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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Evergreen Health Cooperative: Individual Silver Plus (73) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** HMO

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$3,000** person/**$6,000** family **Non-Plan Provider** **Not Covered** Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$4,800** person/**$9,600** family **Non-Plan Provider** **Not Covered**	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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/network providers.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

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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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	[————————none————————]
	Specialist visit	$60 copay/visit	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$60 copay/visit for chiropractic care	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/networkproviders.pdf	Generic drugs	$10 copay retail/$30 copay mail order		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	$35 copay retail/$105 copay mail order		
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)		
	Specialty drugs	30% coinsurance (maximum payment of $250 per prescription)		

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fees	30% coinsurance	Not Covered	[————none————]
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	30% coinsurance	Not Covered	**Preauthorization** is required.
	Urgent care	$60 copay/visit	Not Covered	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay per admission	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	Not Covered	[————none————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$1,500 copay per admission	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$1,500 copay per admission	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————none————]
	Delivery and all inpatient services	$1,500 copay per admission	Not Covered	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$60 copay/visit	Not Covered	**Preauthorization** is required.
	Rehabilitation services	$60 copay/visit	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	$60 copay/visit	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$1,500 copay per admission	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	30% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10 copay/visit	Not Covered	Limited to 1 exam per benefit year.
	Glasses	30% coinsurance	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
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Your Rights to Continue Coverage:

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Does this Coverage Provide Minimum Essential Coverage?

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Does this Coverage Meet the Minimum Value Standard?

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.**

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

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.

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

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
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Copays	$1,510
Coinsurance	$0
Limits or exclusions	$150
Total	**$4,660**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,980
- **Patient pays** $3,420

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
Total	**$5,400**

Patient pays:

Deductibles	$3,000
Copays	$160
Coinsurance	$180
Limits or exclusions	$80
Total	**$3,420**

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.

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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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Evergreen Health Cooperative: Individual Silver Plus (87) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** HMO

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$500** person/**$1,000** family **Non-Plan Provider** **Not Covered** Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$1,000** person/**$2,000** family **Non-Plan Provider** **Not Covered**	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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/networkproviders.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

- **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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	[————————none————————]
	Specialist visit	$60 copay/visit	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$60 copay/visit	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/networkproviders.pdf	Generic drugs	$5 copay retail/$15 copay mail order		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan Provider** contraceptives are not subject to a copay.
	Preferred brand drugs	$35 copay retail/$105 copay mail order		
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)		
	Specialty drugs	20% coinsurance (maximum payment of $250 per prescription)		

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fees	20% coinsurance	Not Covered	[————————none————————]
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	20% coinsurance	Not Covered	**Preauthorization** is required.
	Urgent care	$60 copay/visit	Not Covered	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	Not Covered	[————————none————————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$500 copay per admission	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$500 copay per admission	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————————none————————]
	Delivery and all inpatient services	$500 copay per admission	Not Covered	[————————none————————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$60 copay/visit	Not Covered	**Preauthorization** is required.
	Rehabilitation services	$60 copay/visit	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	$60 copay/visit	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$500 copay per admission	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	20% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10 copay/visit	Not Covered	Limited to 1 exam per benefit year.
	Glasses	20% coinsurance	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $6,300
- **Patient pays** $1,240

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
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$590
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,240**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,030
- **Patient pays** $1,370

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
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$580
Coinsurance	$210
Limits or exclusions	$80
Total	**$1,370**

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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
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Evergreen Health Cooperative: Individual Silver Plus (94) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** HMO

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$0** person/**$0** family **Non-Plan Provider** **Not Covered**	See the chart starting on page 2 for your costs for services this plan covers.
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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$400** person/**$800** family **Non-Plan Provider** **Not Covered**	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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/networkproviders.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

- **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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	[————none————]
	Specialist visit	$60 copay/visit	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$60 copay/visit for chiropractic care	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/networkproviders.pdf	Generic drugs	$3 copay retail/$9 copay mail order		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	$35 copay retail/$105 copay mail order		
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)		
	Specialty drugs	15%coinsurance (maximum payment of $250 per prescription)		

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fees	15% coinsurance	Not Covered	[————————none————————]
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	15% coinsurance	Not Covered	**Preauthorization** is required.
	Urgent care	$60 copay/visit	Not Covered	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay per admission	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	Not Covered	[————————none————————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$250 copay per admission	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$250 copay per admission	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————————none————————]
	Delivery and all inpatient services	$250 copay per admission	Not Covered	[————————none————————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$60 copay/visit	Not Covered	**Preauthorization** is required.
	Rehabilitation services	$60 copay/visit	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	$60 copay/visit	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$250 copay per admission	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	15% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10 copay/visit	Not Covered	Limited to 1 exam per benefit year.
	Glasses	15% coinsurance	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $6,770
- **Patient pays** $770

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
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$620
Coinsurance	$0
Limits or exclusions	$150
Total	**$770**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

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
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$510
Coinsurance	$190
Limits or exclusions	$80
Total	**$780**

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?

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Can I use Coverage Examples to compare plans?

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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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Evergreen Health Cooperative: Individual Silver Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$1,300** person/**$2,600**family **Non-Plan Provider** **$2,600** person/**$5,200** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$6,050** person/**$12,100** family **Non-Plan Provider** **$12,100** person/**$24,200** 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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	Not Covered	[————none————]
	Specialist visit	30% coinsurance	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	30% coinsurance for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreennmd.org/reg/formulary.pdf	Generic drugs	30% coinsurance	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	30% coinsurance	50% coinsurance	
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	
	Specialty drugs	30% coinsurance (maximum payment of $250 per prescription)	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	[————none————]
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	30% coinsurance	30% coinsurance	**Preauthorization** is required.
	Urgent care	30% coinsurance	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	[————none————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	30% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————none————]
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	30% coinsurance	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	30% coinsurance	50% coinsurance	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	30% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	30% coinsurance	50% coinsurance	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	30% coinsurance	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	30% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan agreement for other excluded services.)**		
• Acupuncture • Cosmetic Surgery • Dental Care • Hearing Aids(Adult)	• Long-term Care • Most coverage provided outside the United States. • Non-emergency care when traveling outside the United States	• Private Duty Nursing • Routine eye care (Adult) • Routine foot care • Weight Loss Programs
Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $4,300
- **Patient pays** $3,240

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
Total	**$7,540**

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$1,790
Limits or exclusions	$150
Total	**$3,240**

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

-
- **Amount owed to providers:** $5,400
- **Plan pays** $2,830
- **Patient pays** $2,570

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
Total	**$5,400**

Patient pays:

Deductibles	$1,300
Copays	$0
Coinsurance	$1,190
Limits or exclusions	$80
Total	**$2,570**

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.

Questions: Call 1-855-475-0990 or visit us at www.evergreenmd.org.
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Evergreen Health Cooperative: Individual Silver (73) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$1,000** person/**$2,000**family **Non-Plan Provider** **$2,600** person/**$5,200** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$4,800** person/**$9,600** family **Non-Plan Provider** **$12,100** person/**$24,200** 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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	Not Covered	[————none————]
	Specialist visit	30% coinsurance	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	30% coinsurance for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	30% coinsurance	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	30% coinsurance	50% coinsurance	
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Specialty drugs	30% coinsurance (maximum payment of $250 per prescription)	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	[————none————]
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Urgent care	30% coinsurance	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	[————none————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	30% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————none————]
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	30% coinsurance	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	30% coinsurance	50% coinsurance	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	30% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	30% coinsurance	50% coinsurance	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	30% coinsurance	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	30% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan agreement for other excluded services.)**		
• Acupuncture • Cosmetic Surgery • Dental Care • Hearing Aids(Adult)	• Long-term Care • Most coverage provided outside the United States. • Non-emergency care when traveling outside the United States	• Private Duty Nursing • Routine eye care (Adult) • Routine foot care • Weight Loss Programs
Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $4,510
- **Patient pays** $3,030

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
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$1,880
Limits or exclusions	$150
Total	**$3,030**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,040
- **Patient pays** $2,360

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
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$1,280
Limits or exclusions	$80
Total	**$2,360**

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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Evergreen Health Cooperative: Individual Silver (87) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$500** person/**$1,000**family **Non-Plan Provider** **$2,600** person/**$5,200** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$1,500** person/**$3,000** family **Non-Plan Provider** **$12,100** person/**$24,200** 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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	Not Covered	[————none————]
	Specialist visit	15% coinsurance	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	15% coinsurance for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	50% coinsurance	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	15% coinsurance	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	15% coinsurance	50% coinsurance	
	Non-preferred brand drugs	80% (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	
	Specialty drugs	15% coinsurance (maximum payment of $250 per prescription)	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	15% coinsurance	50% coinsurance	[————————none————————]
If you need immediate medical attention	Emergency room services	15% coinsurance	15% coinsurance	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	15% coinsurance	50% coinsurance	**Preauthorization** is required.
	Urgent care	15% coinsurance	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	15% coinsurance	50% coinsurance	[————————none————————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	15% coinsurance	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	15% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	15% coinsurance	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————————none————————]
	Delivery and all inpatient services	15% coinsurance	50% coinsurance	[————————none————————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	15% coinsurance	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	15% coinsurance	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	15% coinsurance	50% coinsurance	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	15% coinsurance	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	15% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	15% coinsurance	50% coinsurance	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	15% coinsurance	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	15% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $5,870
- **Patient pays** $1,670

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
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$1,020
Limits or exclusions	$150
Total	**$1,670**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,100
- **Patient pays** $1,300

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
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$720
Limits or exclusions	$80
Total	**$1,300**

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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Evergreen Health Cooperative: Individual Silver (94) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$0** person/**$0** family **Non-Plan Provider** **$2,600** person/**$5,200** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$1,000** person/**$2,000** family **Non-Plan Provider** **$12,100** person/**$24,200** 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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	Not Covered	[————none————]
	Specialist visit	10% coinsurance	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	10% coinsurance for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	10% coinsurance	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	10% coinsurance	50% coinsurance	
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Specialty drugs	10% coinsurance (maximum payment of $250 per prescription)	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	[————none————]
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	10% coinsurance	50% coinsurance	**Preauthorization** is required.
	Urgent care	10% coinsurance	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	10% coinsurance	50% coinsurance	[————none————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	10% coinsurance	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	10% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	10% coinsurance	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————none————]
	Delivery and all inpatient services	10% coinsurance	50% coinsurance	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	10% coinsurance	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	10% coinsurance	50% coinsurance	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	10% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	50% coinsurance	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	10% coinsurance	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	10% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan agreement for other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

Does this Coverage Provide Minimum Essential Coverage?

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,660
- **Patient pays** $880

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
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$730
Limits or exclusions	$150
Total	**$880**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,790
- **Patient pays** $610

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
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$530
Limits or exclusions	$80
Total	**$610**

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.
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What does a Coverage Example show?

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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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

Evergreen Health Cooperative: Individual Silver Plus Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$3,500** person/**$7,000** family **Non-Plan Provider** **$7,000** person/**$14,000** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$6,050** person/**$12,100** family **Non-Plan Provider** **$12,100** person/**$24,200** 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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	[————none————]
	Specialist visit	$60 copay/visit	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$60 copay/visit for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	**Preauthorization** is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	$10 copay retail/$30 copay mail order	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	$35 copay retail/$105 copay mail order	50% coinsurance	
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	
	Specialty drugs	30% coinsurance (maximum payment of $250 per prescription)	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	[————none————]
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Urgent care	$60 copay/visit	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay per admission	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	50% coinsurance	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$1,500 copay per admission	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$1,500 copay per admission	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————none————]
	Delivery and all inpatient services	$1,500 copay per admission	50% coinsurance	[————none————]
If you need help recovering or have other special health needs	Home health care	$60 copay/visit	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	$60 copay/visit	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	$60 copay/visit	50% coinsurance	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$1,500 copay per admission	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	30% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	50% coinsurance	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10 copay/visit	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	30% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan agreement for other excluded services.)**		
• Acupuncture • Cosmetic Surgery • Dental Care • Hearing Aids(Adult)	• Long-term Care • Most coverage provided outside the United States. • Non-emergency care when traveling outside the United States	• Private Duty Nursing • Routine eye care (Adult) • Routine foot care • Weight Loss Programs
Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery (Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $2,370
- **Patient pays** $5,170

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
Total	**$7,540**

Patient pays:

Deductibles	$3,500
Copays	$1,520
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,170**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,460
- **Patient pays** $3,940

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
Total	**$5,400**

Patient pays:

Deductibles	$3,500
Copays	$200
Coinsurance	$160
Limits or exclusions	$80
Total	**$3,940**

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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

Evergreen Health Cooperative: Individual Silver Plus (73) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$3,000** person/**$6,000** family **Non-Plan Provider** **$7,000** person/**$14,000** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$4,800** person/**$9,600** family **Non-Plan Provider** **$12,100** person/**$24,200** 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, health care this plan doesn't cover, deductibles, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-443-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	[————none————]
	Specialist visit	$60 copay/visit	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$60 copay/visit for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	**Preauthorization** is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	$10 copay retail/$30 copay mail order	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan Provider** contraceptives are not subject to a copay.
	Preferred brand drugs	$35 copay retail/$105 copay mail order	50% coinsurance	
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	
	Specialty drugs	30% coinsurance (maximum payment of $250 per prescription)	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	[————none————]
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	30% coinsurance	50% coinsurance	**Preauthorization** is required.
	Urgent care	$60 copay/visit	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay per admission	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	50% coinsurance	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$1,500 copay per admission	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$1,500 copay per admission	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————none————]
	Delivery and all inpatient services	$1,500 copay per admission	50% coinsurance	[————none————]
If you need help recovering or have other special health needs	Home health care	$60 copay/visit	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	$60 copay/visit	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	$60 copay/visit	50% coinsurance	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$1,500 copay per admission	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	30% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	50% coinsurance	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10 copay/visit	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	30% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan agreement for other excluded services.)**		
• Acupuncture • Cosmetic Surgery • Dental Care • Hearing Aids(Adult)	• Long-term Care • Most coverage provided outside the United States. • Non-emergency care when traveling outside the United States	• Private Duty Nursing • Routine eye care (Adult) • Routine foot care • Weight Loss Programs
Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery (Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $2,870
- **Patient pays** $4,670

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
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Copays	$1,520
Coinsurance	$0
Limits or exclusions	$150
Total	**$4,670**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,840
- **Patient pays** $3,560

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
Total	**$5,400**

Patient pays:

Deductibles	$3,000
Copays	$300
Coinsurance	$180
Limits or exclusions	$80
Total	**$3,560**

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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

Evergreen Health Cooperative: Individual Silver Plus (87) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$500** person/**$1,000** family **Non-Plan Provider** **$7,000** person/**$14,000** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$1,500** person/**$3,000** family **Non-Plan Provider** **$12,100** person/**$24,200** 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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	[————none————]
	Specialist visit	$60 copay/visit	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$60 copay/visit for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	**Preauthorization** is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	$5 copay retail/$15copay mail order	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	$35 copay retail/$105 copay mail order	50% coinsurance	
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	
	Specialty drugs	20% coinsurance (maximum payment of $250 per prescription)	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	[————none————]
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	20% coinsurance	50% coinsurance	**Preauthorization** is required.
	Urgent care	$60 copay/visit	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	50% coinsurance	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$500 copay per admission	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$500 copay per admission	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————————none————————]
	Delivery and all inpatient services	$500 copay per admission	50% coinsurance	[————————none————————]
If you need help recovering or have other special health needs	Home health care	$60 copay/visit	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	$60 copay/visit	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	$60 copay/visit	50% coinsurance	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$500 copay per admission	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	20% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	50% coinsurance	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10 copay/visit	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	20% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan agreement for other excluded services.)**		
• Acupuncture • Cosmetic Surgery • Dental Care • Hearing Aids(Adult)	• Long-term Care • Most coverage provided outside the United States. • Non-emergency care when traveling outside the United States	• Private Duty Nursing • Routine eye care (Adult) • Routine foot care • Weight Loss Programs
Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $6,300
- **Patient pays** $1,240

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
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$560
Coinsurance	$30
Limits or exclusions	$150
Total	**$1,240**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,030
- **Patient pays** $1,370

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
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$580
Coinsurance	$210
Limits or exclusions	$80
Total	**$1,370**

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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Evergreen Health Cooperative: Individual Silver Plus (94) Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$0** person/**$0** family **Non-Plan Provider** **$7,000** person/**$14,000** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$1,000** person/**$2,000** family **Non-Plan Provider** **$12,100** person/**$24,200** 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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

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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 a **non-plan 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 **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	[————none————]
	Specialist visit	$60 copay/visit	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$60 copay/visit for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	50% coinsurance	**Preauthorization** is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	$3 copay retail/$9 copay mail order	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan Provider** contraceptives are not subject to a copay.
	Preferred brand drugs	$35 copay retail/$105 copay mail order	50% coinsurance	
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	
	Specialty drugs	15% coinsurance (maximum payment of $250 per month)	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	15% coinsurance	50% coinsurance	[————none————]
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	15% coinsurance	50% coinsurance	**Preauthorization** is required.
	Urgent care	$60 copay/visit	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay per admission	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	50% coinsurance	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$250 copay per admission	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$250 copay per admission	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————none————]
	Delivery and all inpatient services	$250 copay per admission	50% coinsurance	[————none————]
If you need help recovering or have other special health needs	Home health care	$60 copay/visit	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	$60 copay/visit	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	$60 copay/visit	50% coinsurance	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$250 copay per admission	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	15% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	50% coinsurance	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10 copay/visit	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	15% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan agreement for other excluded services.)**		
• Acupuncture • Cosmetic Surgery • Dental Care • Hearing Aids(Adult)	• Long-term Care • Most coverage provided outside the United States. • Non-emergency care when traveling outside the United States	• Private Duty Nursing • Routine eye care (Adult) • Routine foot care • Weight Loss Programs
Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $6,770
- **Patient pays** $770

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
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$620
Coinsurance	$0
Limits or exclusions	$150
Total	**$770**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

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
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$510
Coinsurance	$190
Limits or exclusions	$80
Total	**$780**

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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

Evergreen Health Cooperative: Individual Gold Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** HMO

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$1,000** person/**$2,000** family **Non-Plan Provider** **Not Covered** Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$3,000** person/**$6,000** family **Non-Plan Provider** **Not Covered**	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 inthe out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/networkproviders.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

- **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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not Covered	[————————none————————]
	Specialist visit	20% coinsurance	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	20% coinsurance for chiropractic care	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan dagreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	20% coinsurance		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	20% coinsurance		
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)		
	Specialty drugs	20% coinsurance (maximum payment of $250 per prescription)		

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fees	20% coinsurance	Not Covered	[————————none————————]
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	20% coinsurance	Not Covered	**Preauthorization** is required.
	Urgent care	20% coinsurance	20% coinsurance	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	20% coinsurance	Not Covered	[————————none————————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	20% coinsurance	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	20% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	20% coinsurance	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————————none————————]
	Delivery and all inpatient services	20% coinsurance	Not Covered	[————————none————————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	**Preauthorization** is required.
	Rehabilitation services	20% coinsurance	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	20% coinsurance	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	20% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	20% coinsurance	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	20% coinsurance	Not Covered	Limited to 1 exam per benefit year.
	Glasses	20% coinsurance	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $5,120
- **Patient pays** $2,420

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
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$1,270
Limits or exclusions	$150
Total	**$2,420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,470
- **Patient pays** $1,930

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
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$850
Limits or exclusions	$80
Total	**$1,930**

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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Evergreen Health Cooperative: Individual Gold Plus Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** HMO

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$1,500** person/**$3,000** family **Non-Plan Provider** **Not Covered** Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$3,500** person/**$7,000** family **Non-Plan Provider** **Not Covered**	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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/networkproviders.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call **1-855-475-0990** or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

- **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**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not Covered	[————none————]
	Specialist visit	$40 copay/visit	Not Covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$40 copay/visit for chiropractic care	Not Covered	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	$100 copay	Not Covered	**Preauthorization** is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	$5 copay retail/$15 copay mail order		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	$20 copay retail/$60 copay mail order		
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)		
	Specialty drugs	20% coinsurance (maximum payment of $250 per prescription)		

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	**Preauthorization** is required.
	Physician/surgeon fees	20% coinsurance	Not Covered	[————none————]
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	20% coinsurance	Not Covered	**Preauthorization** is required.
	Urgent care	$40 copay/visit	Not Covered	**Non-plan providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay per admission	Not Covered	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	Not Covered	[————none————]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$1,000 copay per admission	Not Covered	**Preauthorization** is required.
	Substance use disorder outpatient services	$20 copay/visit	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$1,000 copay per admission	Not Covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	[————none————]
	Delivery and all inpatient services	$1,000 copay per admission	Not Covered	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	Not Covered	**Preauthorization** is required.
	Rehabilitation services	$40 copay/visit	Not Covered	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	$40 copay/visit	Not Covered	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$1,000 copay per admission	Not Covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	20% coinsurance	Not Covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	Not Covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10 copay/visit	Not Covered	Limited to 1 exam per benefit year.
	Glasses	20% coinsurance	Not Covered	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$1,010
Coinsurance	$0
Limits or exclusions	$150
Total	**$2,660**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,310
- **Patient pays** $2,090

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
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$310
Coinsurance	$200
Limits or exclusions	$80
Total	**$2,090**

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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

Evergreen Health Cooperative: Individual Gold Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$1,000** person/**$2,000** family **Non-Plan Provider** **$2,000** person/**$4,000** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$3,000** person/**$6,000** family **Non-Plan Provider** **$6,000** person/**$12,000** 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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not Covered	[————none————]
	Specialist visit	20% coinsurance	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	20% coinsurance for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	**Preauthorization** is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **http://www.evergreenmd.org/reg/formulary.pdf**	Generic drugs	20% coinsurance	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	20% coinsurance	50% coinsurance	
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	
	Specialty drugs	20% coinsurance (maximum payment of $250 per prescription)	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	[————none————]
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	20% coinsurance	50% coinsurance	**Preauthorization** is required.
	Urgent care	20% coinsurance	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————————none————————]
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	[————————none————————]
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	20% coinsurance	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	20% coinsurance	50% coinsurance	Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	20% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	20% coinsurance	50% coinsurance	**Preauthorization** is required.

If your child needs dental or eye care	Eye exam	20% coinsurance	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	20% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan agreement for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids(Adult)
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)

- Bariatric Surgery(Limitations Apply)
- Chiropractic Care
- Habilitative Services(Age 19 and over)
- Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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** $5,130
- **Patient pays** $2,410

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
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$1,260
Limits or exclusions	$150
Total	**$2,410**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,470
- **Patient pays** $1,930

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
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$850
Limits or exclusions	$80
Total	**$1,930**

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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
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Evergreen Health Cooperative: Individual Gold Plus Plan

Coverage Period: 1/1/2014-12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single + Family| **Plan Type:** POS

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 agreement at http://www.evergreenmd.org or by calling **1-855-475-0990.** Note: The Uniform Glossary can be accessed at: www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan Provider** **$1,500** person/**$3,000** family **Non-Plan Provider** **$3,000** person/**$6,000** family Copays and **coinsurance** go toward satisfying the **deductible**.	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 agreement 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 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.
Is there an out–of–pocket limit on my expenses?	**Plan Provider** **$3,500** person/**$7,000** family **Non-Plan Provider** **$7,000** person/**$14,000** 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, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of **plan providers**, see http://www.evergreenmd.org/reg/posdirectory.pdf or call **1-855-475-0990.**	If you use a **plan provider** or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use a **non-plan provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No written or oral approval is required to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan agreement for additional information about **excluded services**.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-877-267-2323 x61565 to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not Covered	[————none————]
	Specialist visit	$40 copay/visit	50% coinsurance	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$40 copay/visit for chiropractic care	50% coinsurance	Acupuncture is not covered. Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Refer to your plan agreement for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	$100 copay/visit	50% coinsurance	**Preauthorization** is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.evergreenmd.org/reg/formulary.pdf	Generic drugs	$5 copay retail/$15 mail order	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Plan provider** contraceptives are not subject to a copay.
	Preferred brand drugs	$20 copay retail/$60 mail order	50% coinsurance	
	Non-preferred brand drugs	80% coinsurance (minimum payment of $60 retail/$180 mail order per prescription)	Not Covered	
	Specialty drugs	20% coinsurance(maximum payment of $250 per prescription)	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	[————none————]
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Non-emergency use of the emergency room services are not a covered benefit.
	Emergency medical transportation	20% coinsurance	50% coinsurance	**Preauthorization** is required.
	Urgent care	$40 copay/visit	50% coinsurance	**Plan provider** benefits apply for **non-plan providers** out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay per admission	50% coinsurance	**Preauthorization** is required.
	Physician/surgeon fee	No Charge	50% coinsurance	[————none————]

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	$1,000 copay per admission	50% coinsurance	**Preauthorization** is required.
	Substance use disorder outpatient services	$20 copay/visit	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	$1,000 copay per admission	50% coinsurance	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	[————————none————————]
	Delivery and all inpatient services	$1,000 copay per admission	50% coinsurance	[————————none————————]
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	50% coinsurance	**Preauthorization** is required.
	Rehabilitation services	$40 copay/visit	50% coinsurance	Physical, speech, and occupational therapy are each limited to 30 visits per condition, per benefit year. Cardiac rehabilitation is limited to 90 visits per benefit year. **Preauthorization** is required.
	Habilitation services	$40 copay/visit	50% coinsurance	Limited to adults age 19 and over Physical, speech and occupational therapy are each limited to 30 visits per condition, per benefit year. **Preauthorization** is required.
	Skilled nursing care	$1,000 copay per admission	50% coinsurance	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	20% coinsurance	50% coinsurance	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% coinsurance	50% coinsurance	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10 copay/visit	50% coinsurance	Limited to 1 exam per benefit year.
	Glasses	20% coinsurance	50% coinsurance	Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	Not Covered	Not Covered	Dental check-ups are not covered under the **plan**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan agreement for other excluded services.)**		
• Acupuncture • Cosmetic Surgery • Dental Care • Hearing Aids(Adult)	• Long-term Care • Most coverage provided outside the United States. • Non-emergency care when traveling outside the United States	• Private Duty Nursing • Routine eye care (Adult) • Routine foot care • Weight Loss Programs
Other Covered Services **(This isn't a complete list. Check your policy or plan agreement for other covered services and your costs for these services.)**		
• Bariatric Surgery(Limitations Apply) • Chiropractic Care	• Habilitative Services(Age 19 and over)	• Infertility Treatment(Limitations Apply)

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 1-855-475-0990. You may also contact your state insurance department at 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.

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?

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.**

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

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
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$1,010
Coinsurance	$0
Limits or exclusions	$150
Total	**$2,660**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,310
- **Patient pays** $2,090

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
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$310
Coinsurance	$200
Limits or exclusions	$80
Total	**$2,090**

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.

Questions: Call 1-855-475-0990 or visit us at http://www.evergreenmd.org.
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