This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.evergreenmd.org/or by calling **410-844-0701**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250 person/$500 family** Does not apply to preventive care, prenatal and postnatal care, and certain pediatric dental services, which are provided at no cost. If you have been diagnosed with Diabetes Mellitus, you may be eligible for reduced or zero-dollar **copayments** or **coinsurance** for certain services and drugs under our Diabetes Support Program.	See the chart starting on page 3 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 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,000 person/$6,000 family** If you have family coverage and one family Member meets the individual coverage **out-of-pocket limit**, no further **coinsurance** or **copayments** will be required of that member in that benefit year.	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, and health care this plan does not cover.	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 3 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 **network providers**, see https://www.evergreenmd.org/tools-resources/find-a-doctor/ or call 410-844-0701.	If you use an in-network doctor 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 an out-of-network **provider** for some services. Plans use the term **in-network** or **network** for providers in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.

Questions: Call 410-844-0701 or visit us at **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 www.cciio.cms.gov or call 1-877-267-2323 x61565 to request a copy.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan. It is the Member's responsibility to select a Primary Care Provider from the plan's list of **Network Providers**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 Copayment per visit	Not covered	Members that receive services from an unassigned primary care provider are subject to the Specialist visit **copayment**. If your selected Primary Care Provider is part of a provider group and your selected Primary Care Provider is unavailable at the time services are required, you may obtain services from another Primary Care Provider within that group and still pay the Primary care **copayment**.
	Specialist visit	$40 Copayment per visit	Not covered	**Preauthorization** is required for podiatry services.
	Other practitioner office visit	$40 Copayment per visit	Not covered	Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required for chiropractic care.
	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% after Deductible	Not covered	**Preauthorization may be required.** Refer to your plan agreement.
	Imaging (CT/PET scans, MRIs)	10% after Deductible	Not covered	**Preauthorization** is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.evergreennmd.org/healthformulary.	Preferred Generic drugs	$5 Copayment per script (up to a 30-day supply); $15 Copayment per script (up to a 90-day supply)	Not covered	Preferred Generics for the following seven chronic conditions are covered at $0 per script: Diabetes, Hypertension, Congestive Heart Failure, Bipolar Disorder, Asthma, COPD, and Coronary Artery Disease. Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Network provider** contraceptives are not subject to a copay. **Preauthorization** may be required for certain drugs.
	Non-Preferred Generic drugs	$15 Copayment per script (up to a 90-day supply; $45 Copayment per script (up to a 90-day supply)	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Network provider** contraceptives are not subject to a copay. **Preauthorization** may be required for certain drugs.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Preferred brand drugs	20% Coinsurance after Deductible	Not covered	Preferred brand drugs for the following seven chronic conditions are covered with a 50% reduction in copayment for the following seven chronic conditions: Diabetes, Hypertension, Congestive Heart Failure, Bipolar Disorder, Asthma, COPD, Coronary Artery Disease. Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Network provider** contraceptives are not subject to a copay. **Preauthorization** may be required for certain drugs.
	Non-preferred brand drugs	60% Coinsurance after deductible	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). **Network provider** contraceptives are not subject to a copay. **Preauthorization** may be required for certain drugs.
	Generic & Preferred brand Specialty drugs	40% Coinsurance after deductible	Not covered	Up to a $150 max per 30-day supply per script. **Preauthorization** may be required for certain drugs.
	Non-Preferred Specialty drugs	50% Coinsurance after deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after deductible	Not covered	**Preauthorization** may be required. Refer to your plan agreement.
	Physician/surgeon fees	10% after deductible	Not covered	None.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	10% after Deductible if admitted, 20% after Deductible if not admitted	10% after Deductible if admitted, 20% after Deductible if not admitted	None.
	Emergency medical transportation	10% after Deductible	10% after Deductible	None.
	Urgent care	$50/visit	$50/visit	**Out-of-Network Providers** are covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after Deductible	Not covered	**Preauthorization** is required.
	Physician/surgeon fee	10% after Deductible	Not covered	None.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% after Deductible	Not covered	**Preauthorization** may be required. Refer to your plan agreement.
	Mental/Behavioral health inpatient services	10% after Deductible	Not covered	**Preauthorization** is required.
	Substance use disorder outpatient services	10% after Deductible	Not covered	**Preauthorization** may be required. Refer to your plan agreement.
	Substance use disorder inpatient services	10% after Deductible	Not covered	**Preauthorization** is required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not covered	**Preauthorization** is required for genetic testing during pregnancy.
	Delivery and all inpatient services	10% after Deductible	Not covered	None.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% after Deductible	Not covered	**Preauthorization** is required.
	Rehabilitation services	$20/visit	Not covered	For adults (19 and older) limited to 30 visits per member per benefit year for each of the following therapies: physical, speech, and occupational therapy. **Preauthorization** is required.
	Habilitation services	$20/visit	Not covered	For adults (19 and older), limited to 30 visits per member per benefit year for physical, speech, and occupational therapy. For members under 19, there are no visit limits.
	Skilled nursing care	10% after Deductible	Not covered	Limited to 100 days per benefit year. **Preauthorization** is required.
	Durable medical equipment	10% after Deductible	Not covered	**Preauthorization** may be required. Refer to your plan agreement.
	Hospice service	10% after Deductible	Not covered	**Preauthorization** is required.
If your child needs dental or eye care	Eye exam	$10/visit	Not covered	Limited to 1 exam per benefit year.
	Glasses	10% after Deductible	Not covered	Under age 19, limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year.
	Dental check-up	No Charge	Not covered	Limited to members under age 19. Diagnostic services, preventive services, and fillings included at no extra cost. Refer to your plan agreement for limitations.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-Duty Nursing	• Routine foot care • Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**		
• Bariatric Surgery • Chiropractic Care (with limits)	• Hearing aids (with limits) • Infertility Treatment (limits apply)	• Routine eye care (for adults, limited to one exam every benefit year)

Your Rights to Continue Coverage:

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

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

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

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** $
- **Patient pays** $

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	$250
Copays	$10
Coinsurance	$490
Limits or exclusions	$150
Total	$900

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

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

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	$250
Copays	$600
Coinsurance	$120
Limits or exclusions	$80
Total	$1,050

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.