**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 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?** | **Network Provider**<br>**$850** person/**$1,700** family<br>**Non-Network Provider**<br>**$10,000** person/**$20,000** family<br>Does not apply to preventive care, prenatal and postnatal care, generic and preferred drugs, most office visits, urgent care, and certain pediatric dental services. | 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?** | Yes, for **Network Providers**<br>**$1,200** person/**$2,400** family<br>**Non-Network Provider**<br>**None** | 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/provider-directory<br>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. | |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document 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 www.cciio.cms.gov 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 an Evergreen Health Tier I Network Provider | Your Cost If You Use an Evergreen Health Tier II Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $10 copay/visit | $20 copay/visit | 50% coinsurance after deductible | [————none————] |
| | Specialist visit | No Tier 1 Providers Available | $40 copay/visit | 50% coinsurance after deductible | **Preauthorization** is required for podiatry services. |
| | Other practitioner office visit | No Tier 1 Providers Available | $40 copay/visit for chiropractor | 50% coinsurance after deductible | Chiropractic care is limited to 20 visits per condition per benefit year. **Preauthorization** is required. |
| | Preventive care/screening/ immunization | No Charge | No Charge | Not Covered | Refer to your plan agreement for limitations. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | 30% coinsurance after deductible | 50% coinsurance after deductible | **Preauthorization** may be required. Refer to your plan agreement. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 30% coinsurance after deductible | 50% coinsurance after deductible | **Preauthorization** is required. |

| Common Medical Event | Services You May Need | Your Cost If You Use an Evergreen Health Tier I Network Provider | Your Cost If You Use an Evergreen Health Tier II Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.evergreen.org/formulary | Generic drugs | No Tier 1 Providers Available | $5 copay retail/$15 copay mail order | 50% coinsurance after deductible | 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 Tier 1 Providers Available | $30 copay retail/$90 copay mail order | 50% coinsurance after deductible | |
| | Non-preferred brand drugs | No Tier 1 Providers Available | 50% coinsurance after deductible | 50% coinsurance after deductible | |
| | Specialty drugs | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | **Preauthorization** is required. The facility fee for a hospital based facility have a 30% **coinsurance** after **deductible**. |
| | Physician/surgeon fees | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | [————none————] |
| **If you need immediate medical attention** | Emergency room services | No Tier 1 Providers Available | 20% coinsurance after deductible | 20% coinsurance after deductible | Non-emergency use of the emergency room services are not a covered benefit. |
| | Emergency medical transportation | No Tier 1 Providers Available | 20% coinsurance after deductible | 20% coinsurance after deductible | **Preauthorization** is required for non-emergency services. |
| | Urgent care | No Tier 1 Providers Available | $60 copay/visit | Not Covered | **Non-plan providers** are covered out of the service area. |

| Common Medical Event | Services You May Need | Your Cost If You Use an Evergreen Health Tier I Network Provider | Your Cost If You Use an Evergreen Health Tier II Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | **Preauthorization** is required. |
| | Physician/surgeon fee | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | [————none————] |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No Tier 1 Providers Available | $20 copay/visit | 50% coinsurance after deductible | **Preauthorization** may be required. Refer to your plan agreement. |
| | Mental/Behavioral health inpatient services | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | **Preauthorization** is required. |
| | Substance use disorder outpatient services | No Tier 1 Providers Available | $20 copay/visit | 50% coinsurance after deductible | **Preauthorization** may be required. Refer to your plan agreement. |
| | Substance use disorder inpatient services | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | **Preauthorization** is required. |
| **If you are pregnant** | Prenatal and postnatal care | No Charge | No Charge | 50% coinsurance after deductible | [————none————] |
| | Delivery and all inpatient services | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | [————none————] |

| Common Medical Event | Services You May Need | Your Cost If You Use an Evergreen Health Tier I Network Provider | Your Cost If You Use an Evergreen Health Tier II Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | **Preauthorization** is required. |
| | Rehabilitation services | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | 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. **Plan providers** at a hospital based facility have 30% **coinsurance**. |
| | Habilitation services | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | Limited to adults age 19 and over. Physical, speech and occupational therapy are each limited to 30 visits per therapy type, per benefit year. **Preauthorization** is required. **Plan providers** at a hospital based facility have 30% **coinsurance**. |
| | Skilled nursing care | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | Limited to 100 days per benefit year. **Preauthorization** is required. |
| | Durable medical equipment | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | **Preauthorization** may be required. Refer to your plan agreement. |
| | Hospice service | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | **Preauthorization** is required. |

| Common Medical Event | Services You May Need | Your Cost If You Use an Evergreen Health Tier I Network Provider | Your Cost If You Use an Evergreen Health Tier II Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If your child needs dental or eye care** | Eye exam | No Tier 1 Providers Available | $10 copay/visit | 50% coinsurance after deductible | Limited to 1 exam per benefit year. |
| | Glasses | No Tier 1 Providers Available | 20% coinsurance after deductible | 50% coinsurance after deductible | Limited to 1 frame and 1 pair of lenses or 1 pair of contact lenses per benefit year under age 19. |
| | Dental check-up | No Tier 1 Providers Available | No Charge | 50% coinsurance after deductible | Limited to under age 19. Refer to your plan agreement for limitations. Diagnostic services, preventive services and fillings included at no extra cost. |

## 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.)**

- Cosmetic Surgery
- Dental Care (Adult)
- 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
- 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.)**

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Habilitative Services (Age 19 and over)
- Infertility Treatment (Limitations Apply)
- Routine eye care - adult (limited to one exam every benefit year)
- Routine foot care (only for patients with systemic circulatory disease)

## 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** $6,190
- **Patient pays** $1,350

**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 | $850 |
| Copays | $0 |
| Coinsurance | $350 |
| Limits or exclusions | $150 |
| **Total** | **$1,350** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,120
- **Patient pays** $1,280

**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 | $850 |
| Copays | $200 |
| Coinsurance | $150 |
| Limits or exclusions | $80 |
| **Total** | **$1,280** |

# 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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