YOUR MEMBER HANDBOOK

EVERGREEN HEALTH INSURANCE

evergreen™ HEALTH CO-OP

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evergreen™ HEALTH CO-OP

I. WELCOME TO EVERGREEN HEALTH!

WELCOME TO EVERGREEN HEALTH! In choosing Evergreen Health, you have decided to be part of Maryland's newest health insurance company. We are a not-for-profit health care cooperative—members are our first priority. Evergreen Health is committed to providing our members with quality health care choices, a voice in how their plan is operated, and the chance to experience being in a health plan designed with members at the core of all services. When you chose Evergreen Health, you chose a plan that puts members first.

This handbook is designed to inform you of the provisions of your plan, as well as give you guidance on what terms mean, and how you can go about getting care. This handbook is meant to be an overview of services and describes important features of your plan, but it does not represent your coverage contract. A detailed description of specific terms, conditions, and limitations of your coverage is included in your health Plan Agreement.

Should you have any questions not answered by this handbook, please contact the Member Services phone number listed on the front of your Member ID Card and we'll make sure you get the quickest answer possible. In addition, language interpretation services are also available through Member Services. TDD/TTY services for the hearing impaired can be accessed by calling (800) 735-2258.

KEEP THIS HANDBOOK IN A SAFE PLACE FOR FUTURE REFERENCE.

Also available online www.evergreenmd.org/memberportal

II. GLOSSARY

MEMBER HANDBOOK—This Handbook describes the services available to you based on your plan, your rights and responsibilities, included and excluded coverage, and conditions for coverage.

BENEFIT LIMIT—The day, visit, or dollar limit maximum that applies to certain benefits. Once you have reached the benefit limit, no more benefits will be paid for such services or supplies and you will be responsible for all further charges incurred.

COINSURANCE—A percentage of the allowable amount for certain covered benefits that must be paid by the member. Coinsurance amounts applicable to your plan are indicated in your Plan Agreement .

COPAYMENT—A fixed dollar amount you must pay for certain covered benefits. Usually due at the time of visit, or when you are billed by the provider. Copayment amounts applicable to your plan are stated in your Plan Agreement.

COSMETIC SERVICES—Services performed primarily to reshape or improve an individual's appearance.

COVERED BENEFITS—The products and services that a member is eligible to receive or obtain payment for under the plan.

CUSTODIAL CARE—Services provided to a person for the primary purpose of meeting non-medical personal needs (e.g., bathing, dressing, preparing meals, etc.)

DEDUCTIBLE—Specific dollar amount that is payable by the member for specific covered benefits received each calendar year before any benefits subject to the deductible are payable by the plan. If a family deductible applies, it is met when any combination of family members covered by the plan incur expenses for services to which the deductible applies. If a deductible applies to your plan, it will be stated in your Plan Agreement.

DEPENDENT—A member of the subscriber's family who meets the eligibility requirements for coverage and is enrolled in the plan. Eligibility requirements for dependents will be documented in your contract for coverage.

DOMICILIARY CARE—Services that are provided to aged or disabled individuals in a protective, institutional or home-type environment.

EVERGREEN HEALTH CO-OP—Evergreen Health is a nonprofit consumer oriented and operated health plan that offers an innovative, patient-centered alternative to traditional insurance plans in Maryland.

FAMILY COVERAGE—Coverage for a member and at least one dependent.

HABILITATIVE THERAPY—Services for the treatment of congenital and genetic birth defects, including cleft lip and palate, orthodontics, oral surgery, otologic therapy, audiological therapy, occupational therapy, physical therapy, and speech therapy designed to enhance a person's ability to function.

INDIVIDUAL COVERAGE—Coverage for subscriber only, no coverage for dependents provided.

MEDICAL EMERGENCY—A sudden and unexpected onset of a condition with symptoms so severe that a person possessing average knowledge of health would expect that without prompt medical attention, his or her health would be in serious jeopardy; or his or her body parts or functions would be seriously impaired. Examples include: actual or suspected heart attack or stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures, convulsions, and other major trauma.

MEDICALLY NECESSARY OR MEDICAL NECESSITY—Those medical services which are provided to a member for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease—or the symptoms thereof—in a manner consistent with generally accepted standards of medical practice; clinically appropriate in terms of type frequency, extent, location of service, and duration; demonstrated through scientific evidence to be effective in improving health outcomes; representative of best practices in the health profession; and not primarily for the convenience of the enrollee or physician (or other care provider).

MEMBER—Any subscriber or dependent covered by the plan.

MEMBER COST SHARING—The responsibility of members to assume a share of the costs of benefits provided under the plan. Member cost sharing may include coinsurance, copayments, and deductibles. Your Plan Agreement has more information about the cost sharing that applies to your plan.

NETWORK—Providers of health care services that are under contract with Evergreen Health to provide services to members.

NON-PLAN PROVIDER—Providers of health care services that are not under contract with Evergreen Health to provide services to members.

OUT OF POCKET MAXIMUM—A limit on the amount of member cost sharing that a member must pay for covered benefits in a calendar year. Once the out of pocket maximum is reached, additional non-excluded services will be paid for by the plan.

PEDIATRIC DENTAL CARE—Any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, or other condition of the human teeth, alveolar process, gums, jaw, or associated structure of the mouth. NOTE: Pediatric dental care coverage through Evergreen Health is limited to members under age 19 years who are enrolled in a health plan that is not issued by the Maryland Health Benefit Exchange.

PERSONAL CARE—Service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation.

PLAN—The package of benefits known as Evergreen Health Insurance described in this handbook.

PLAN PROVIDER—Providers of health care services that are under contract with Evergreen Health to provide services to members. Plan Providers are listed in the provider directory.

PLAN YEAR—The period for which benefits are purchased and administered. Benefits for which coverage is limited renew at the beginning of the plan year. Your Plan Agreement includes your plan year information.

PRIMARY CARE PROVIDER (PCP)—A Plan Provider designated to help you maintain your health and authorize your medical care under the plan. Primary care providers include physicians and nurse practitioners.

PROVIDER DIRECTORY—A directory that identifies Plan Providers.

REFERRAL—An instruction given by your PCP that gives you the ability to see another Plan Provider for services that may be outside your PCP's scope of practice. Your Plan Agreement includes additional information about those services requiring a referral.

REHABILITATIVE THERAPY—Treatments for disease or injury that restore or move an individual toward functional capabilities prior to disease or injury, or therapies which improve functional abilities toward normal functional capabilities for age appropriate skills.

SCHEDULE OF BENEFITS AND COVERAGE—A summary of benefits covered under your plan. It states the copayments, coinsurance, or deductible you must pay, and describes any limitations on your coverage.

SERVICE AREA— Geographic area (usually determined by zip code) in which the member can obtain health services from Plan Providers With the exception of Emergency and certain types of Urgent Care services, your providers must all be located within the service area.

SKILLED NURSING FACILITY—An inpatient extended care facility that is operating pursuant to law and provides skilled nursing services.

SUBSCRIBER—The person who subscribes to the plan by enrolling with the Maryland Health Benefit Exchange or directly with Evergreen Health.

SURGERY, OUTPATIENT—A surgery or procedure in a day surgery department, ambulatory surgery department, or outpatient surgery center that requires operating room, anesthesia, and recovery room services.

URGENT CARE—Medically necessary services for a condition that requires prompt medical attention but is not a medical emergency. Usually care needed for unforeseen illness, injury, or condition that occurs and does not give reasonable time to obtain care through your PCP or other Plan Provider.

USUAL, CUSTOMARY, AND REASONABLE CHARGE—An amount that is consistent, in the judgment of Evergreen Health, with the normal range of charges by health care providers for the same or similar products or services provided to a member.

III. FREQUENTLY ASKED QUESTIONS

Q: What is the Evergreen Health Member Portal?

A: The online Member Portal helps you stay informed and lets us stay in touch with you. The Member Portal is the place where you pay and manage your account, access important forms, and find information for your use as a member of Evergreen Health. Visit: www.evergreenmd.org/memberportal

Q: What is my Member Identification (ID) Card for?

A: Your Member Identification (ID) card is important in getting the most out of your health plan. You will present your Member ID Card when you receive care. Always carry your Member ID Card with you. You can get a copy of your Member ID card on the Member Portal: www.evergreenmd.org/memberportal

Q: How can I find out if a certain doctor participates in the Evergreen Health Provider Network?

A: You can access our Provider Directory on our website at:
http://www.evergreenmd.org/provider-directory
You can also call Member Services at the telephone number listed on your Member ID card to have a Member Services representative access the information for you.

Q: Do I need a referral for care?

A: You do not need a referral to seek care from a specialist. If the provider is a Plan Provider, in-network benefits will apply to covered services. When the provider is a Non-Plan Provider, out-of-network benefits will apply to covered services. If your physician is a Non-Plan Provider, you are responsible for obtaining prior authorization for certain services. Failure to do so may result in a denial of benefits. The only exceptions are for women seeking OB/GYN care or members seeking emergency care as defined in your Plan Agreement.

Q: How can I find out if I have a particular benefit?

A: Your benefits are detailed in your Plan Agreement. You may also contact Member Services to obtain specific information on applicable contract benefits such as medical care, prescription benefits, pediatric dental care, etc.

IV. COVERED BENEFITS: HOW TO GET CARE

THIS SECTION IS AN OVERVIEW OF WHAT BENEFITS ARE OFFERED, AND HOW YOU CAN RECEIVE CARE. FOR MORE DETAILED INFORMATION, SEE YOUR PLAN AGREEMENT.

Benefits apply when Covered Services are provided by Plan Providers and Non-Plan Providers. Benefit payments are based on the Allowed Benefit as determined by the Plan for various types of services and providers. Certain Covered Services require prior authorization. Plan Providers will obtain the prior authorization from Evergreen Health; members must obtain the prior authorization from Evergreen Health if the physician is a Non-Plan Provider.

▶ ACCESS TO PRIMARY CARE AND SPECIALTY CARE

- Members may freely select and visit a practitioner for primary care or specialty care—no referral is necessary. You are encouraged to make your selection from the many Plan Providers listed in the Provider Directory so that your in-network benefits apply to covered services.
- Whenever possible, make an appointment with your practitioner to be seen during regular office hours. If you need care after normal office hours, many practitioners have coverage for after hours care. Discuss this with your practitioner during your visit, or call the office number for instructions on reaching a practitioner after hours.
- If your condition is urgent and you cannot reach your primary care provider, see the information below regarding Emergency and Urgent Care.

▶ SELF REFERRED SERVICES

Members have open access to certain participating specialists known as self referred visits/services. *These include but are not limited to:*

Dentist for covered pediatric services – certain procedures require a prior authorization.

Dialysis – participating dialysis facilities only

Emergency Medicine – emergency care as defined in the Plan Agreement.

Optometry for covered pediatric services

Obstetric and Gynecological care – routine care and family planning

Psychiatrist, Psychologist, Licensed Clinical Social worker – outpatient behavioral health participating providers

▶ BEHAVIORAL HEALTH SERVICES

Benefits are available for behavioral health services from Plan and Non-Plan Providers.

▶ BEHAVIORAL HEALTH SERVICES (CONTINUED)

If you think you are in need of behavioral health care services, you may call the number on your Member ID Card during normal business hours. A trained representative will explain your benefits and assist you with locating a Plan Provider. **Service is available 24 hours, 7 days a week; for after hours service call 855-343-9027.** If you experience a behavioral health crisis and feel that you are in danger to yourself or others, you should seek immediate emergency room evaluation and treatment.

You may also choose to seek services from a Non-Plan Provider. When utilizing a Non-Plan Provider, you may call the number on your Member ID Card to obtain an explanation of your behavioral health benefits.

Authorization must be obtained at least five (5) business days prior to an elective or scheduled admission for inpatient behavioral health services. Plan Providers will be responsible for obtaining prior authorization. When utilizing a Non-Plan Provider, you or your representative must call to obtain prior authorization.

Your Plan Agreement has more information about the specific provisions and limitations of your coverage.

▶ PHARMACY SERVICES

Your plan includes certain prescription benefits. Your plan covers prescription drugs and devices, including insulin and birth control drugs, and refills for prescription eye drops in accordance with Evergreen Health's preferred drug list. At any time, you can access a copy of Evergreen Health's preferred drug list at: http://www.evergreenmd.org/healthformulary or by contacting Evergreen Health's Pharmacy Benefit Administrator at (855) 577-6516.

If you are given a prescription by a Non-Plan Provider, it will still be covered by your plan, subject to the same limitations as any drugs prescribed by your primary care provider.

Should your costs for a prescription not exceed the recognized retail price of the prescription you have been prescribed, you will be charged the lesser of the prescription cost or your copayment/coinsurance. Any and all refills are subject to the same provisions and limitations as the original prescription.

Your Plan Agreement has more information about the specific provisions and limitations regarding your prescription benefits.

▶ EMERGENCY AND URGENT CARE

If the situation is a medical emergency, call 911 or go directly to the nearest emergency facility.

In the event of an emergency within or outside of the Service Area, the Member may receive Emergency Services from a Plan Provider or a Non-Plan Provider.

Emergency Services provided in a hospital emergency department may be received:

1. Without the need for any prior authorization determination, even if the Emergency Services are provided by a Non-Plan Provider;

▶ EMERGENCY AND URGENT CARE (CONTINUED)

2. Without regard to whether the health care provider furnishing the Emergency Services is a Plan Provider; and

3. If the Emergency Services are provided by a Non-Plan Provider, no administrative requirement or limitation on coverage will be imposed on the Member that is more restrictive than the requirements or limitations that apply to Emergency Services received from Plan Providers.

If the situation is an urgent condition, contact your physician or go directly to an urgent care center.

Coverage for Urgent Care Services is covered in-network when:

1. Services are received in the service area by a Plan Provider

2. Services are obtained outside the service area by a Non-Plan Provider

If a medical condition requires emergency surgery:

A. Coverage shall be provided for services provided by the physician who performed the surgical procedure, for follow-up care that is:

1. Medically Necessary;

2. Directly related to the condition for which the surgical procedure was performed; and

3. Provided in consultation with the Member's Primary Care Physician, if applicable; and

B. The Member will be responsible for the same copayment or coinsurance for each follow up visit as would be required for a visit to a Plan Physician for corresponding type of care.

▶ HOSPITAL OBSERVATION

If your medical condition that brought you to an emergency room requires intensive treatment and close observation by a physician in order to determine if an acute inpatient admission is required, you could be placed in an "observation status" while in an acute facility. Members need to be aware that any outpatient cost shares will be applied; not your inpatient co-payment or deductible. Most observation stays are less than 24 hours but should not exceed 48 hours. If you have any questions about your bed status, Evergreen Health recommends that you speak with your treating physician regarding options available for you. Whenever possible, the hospital physician should consult with your primary care physician in regards to your treatment.

▶ OBTAINING PRIOR AUTHORIZATION

For certain services to be covered, the Plan Provider will have to receive prior authorization from Evergreen Health. Authorization must be obtained at least five (5) business days before the anticipated date upon which treatment will start or the admission date for an elective or planned hospitalization. Plan Providers will be responsible for obtaining prior authorization by calling 855-776-8839. When utilizing a Non-Plan Provider, you must call 855-776-8839 to obtain prior authorization. Evergreen Health will review such requests to determine the medical

▶ OBTAINING PRIOR AUTHORIZATION (CONTINUED)

necessity of the requested services, the appropriateness of the facility requested, and the necessary length of admission or course of treatment.

If a request for prior authorization is denied, a member may appeal the decision to Evergreen Health. Such appeals will be reviewed by a medical director or assistant medical director who was not involved with the initial decision. If necessary, the reviewing medical director will consult both with the member's treating physician, and a board certified specialist of the type requested. Any appeals of such decisions should follow Evergreen Health's standard appeals and complaint procedures.

Those services requiring prior authorization are listed on pages 11-15:

HOSPITAL INPATIENT SERVICES	All elective inpatient hospital admissions (except for maternity and emergency admissions) require prior authorization. The participating provider must contact Evergreen Health Co-op on the member's behalf at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because it is not feasible to delay the admission for five (5) business days due to the member's medical condition, Evergreen Health must receive notification of the admission as soon as possible but in any event within 48 hours following the beginning of the admission or by the end of the first business day following the beginning of the admission, whichever is later. This includes ER and maternity admissions. *Note the following:* Benefits for inpatient ancillary services (such as but not limited to radiology and laboratory) will not be denied solely based on the fact that the denial of the hospitalization day was appropriate. Instead, a denial of inpatient ancillary services shall be based on the Medical Necessity of the specific ancillary service. In determining the Medical Necessity of an ancillary service performed on a denied hospitalization day, consideration shall be given to the necessity of providing the ancillary service in the acute setting for each day in question. For emergency admissions, Evergreen Health may not render an adverse decision solely because Evergreen Health was not notified of the emergency admission within the prescribed period of time after that admission if the Member's condition prevented the hospital from determining the Member's insurance status or Evergreen Health's emergency admission requirements.

INPATIENT BEHAVIORAL HEALTH SERVICES	Evergreen Health Co-op must be contacted for prior authorization at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because care is required immediately due to the member's condition, Evergreen Health must receive notification of the admission as soon as possible but in any event within 48 hours of, or by the end of the first business day, following the beginning of the admission, whichever is later. For emergency admission, Evergreen Health may not render an adverse decision solely because Evergreen Health was not notified of the emergency admission within the prescribed period of time after that admission if the Member's condition prevented the hospital from determining the Member's insurance status or Evergreen Health's emergency admission requirements. In the case of an inpatient behavioral health admission of a member who is determined by the member's physician or psychologist, in conjunction with a member of the hospital staff who has admitting privileges, to be in imminent danger to self or others, Evergreen Health Co-op may not render an adverse authorization determination until the later of 24 hours after a voluntary admission and 72 hours after an involuntary admission. Behavioral Health Management Program means the Utilization Management benefits administration and provider network activities administered by or on behalf of Evergreen Health to ensure that behavioral health services are medically necessary and provided in a cost-effective manner. Prior authorization will be obtained by behavioral health Plan Providers. The Member is responsible for obtaining authorization for all other providers.

RELATED INSTITUTION	Related Institution means an organized institution, environment or home that maintains conditions or facilities and equipment to provide domiciliary, personal or nursing care for two or more unrelated individuals who are dependent on the administrator for overnight nursing care or the subsistence of daily living in a safe, sanitary and healthful environment. Related institution does not include a nursing facility or visiting nurse service that is conducted only by or for adherents of a bona fide church or religious organization, in accordance with tenets and practices that include reliance on treatment by spiritual means alone for healing. The treating provider must contact Evergreen Health Co-op's Behavioral Health Management Program for prior authorization at least five (5) business days prior to admission to a Related Institution.
TRANSPLANTS	Transplants and related services must be coordinated and prior authorized.
AMBULANCE SERVICES	Evergreen Health Co-op requires that all air transportation be reviewed for medical necessity.

OTHER SERVICES	If the Member requires any of the following services, Evergreen Health must be contacted by the provider for prior authorization at least five (5) business days prior to the anticipated date upon which the elective admission, treatment or service will be rendered. Acute rehabilitation and Long-Term Acute Hospitals. Long-Term Acute Hospitals provide specialized acute care for medically complex members who are critically ill with multi-system complications or failures and require long hospitalization (the average length of stay exceeds 25 days) • Home Health Services by HHA (PT/OT/ST/RN); • Diagnostic Imaging (PET scans, MRAs, MRIs); • Proton Beam Therapy; • Nuclear Cardiology; • Intensity Modulated Radiation Therapy (IMRT); Durable Medical Equipment (DME) is generally on a rent-to-own basis. Not all DME requires prior authorization. Providers need to call the Provider or Member Services number to check to see if Plan approval is required. The following is a list of DME that requires medical necessity review with limited replacement: • All rental equipment; • Apnea monitors - rental only; • Electric or custom wheelchairs and scooters; • CPAP; • BIPAP - rental only; • Bone Growth Stimulators - rental only; • High frequency chest compression devices and vests; • Air fluidized and specialty beds - rental only; • Wound vacs pumps - rental only; • Diabetic insulin pumps; • Augmentative communicator/speech generator device; • Pediatric feeding chairs or equipment; • Hearing Aids for pediatric members (limited to 1 per ear every 3 years); • Cochlear implants and supplies; • Any equipment that does not have a defined CPT code (i.e. E1399)

OTHER SERVICES (CONTINUED)

DME (continued)

Please note that replacement DME is considered medically necessary when: a) needed for normal wear; or b) the changes in the individual's condition warrant additional or different equipment, based on clinical documentation.

Other Services that require prior authorization:

- Inpatient hospice, sub-acute and skilled nursing facility
- Outpatient procedures (not all outpatient tests and services require prior authorization. Providers must call the Provider Services number located on the Member's ID card to check to see if plan approval is required)
- Out of service area provider requests (other than ER/Urgent)
- Non-participating providers (only for HMO Network Plans)
- Hospital outpatient observation greater than 24 hours
- Chiropractic services (after the first ten (10) visits)
- Podiatry (after the first ten (10) visits)
- Infertility services
- Genetic testing during pregnancy and for pediatric members and adults
- Rehabilitative services: physical, occupational, speech therapy and cardiac and pulmonary rehabilitation
- Prosthetics and orthotics
- Home infusion services
- Home services by Specialist
- Ancillary labs or tests performed as in home services
- Home hospice
- Partial hospitalization for behavioral health services
- Intensive Outpatient services
- Residential services for substance use disorders

Authorizations for below services are provided by ValueOptions, Evergreen Health's contracted provider of behavioral health services:

- Acute inpatient services for behavioral health
- Partial hospitalization for behavioral health services
- Intensive Outpatient (IOP) services;
- Residential services for substance use disorders

V. EXCLUSIONS

CERTAIN PRODUCTS AND SERVICES ARE NOT INCLUDED IN YOUR COVERAGE AS FOLLOWS:

- Services or supplies determined by the plan to not be medically necessary.
- Services performed or prescribed under the direction of a person who is not a health care practitioner.
- Services that are beyond the scope of practice of the health care practitioner providing the service.
- Services to the extent they are covered by a governmental unit, except for veterans in Veteran's Administration or armed forces facilities for services for which the recipient is liable.
- Services or supplies for which the Member is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
- The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury. This exclusion does not apply to the pediatric vision benefit for children up to age nineteen (19).
- Personal Care services and Domiciliary Care services, as defined: Personal Care means a service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation.

  Personal Care includes:

  - Help in walking;
  - Help in getting in and out of bed;
  - Help in bathing;
  - Help in dressing;
  - Help in feeding; and
  - General supervision and help in daily living.

- Domiciliary Care means services that are provided to aged or disabled individuals in a protective, institutional or home-type environment:

  - Shelter;
  - Housekeeping services;
  - Board;
  - Facilities and resources for daily living; and
  - Personal surveillance or direction in the activities of daily living.

- Services rendered by a Health Care Practitioner who is the Member's spouse, mother, father, daughter, son, brother or sister.

- Experimental Services, as defined: Experimental Services: Services that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. Experimental Services do not include Controlled Clinical Trials.

- Health Care Practitioner, hospital, or clinical services related to the radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

- Ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.

- Services to reverse a voluntary sterilization procedure.

- Services for sterilization or reverse sterilization for a Dependent minor. This exclusion does not apply to FDA approved sterilization procedures for women with reproductive capacity.

- Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified under "Covered Services."

  This exclusion does not apply to:

  - Surgical procedures for the treatment of Morbid Obesity;
  - Well child care visits for obesity evaluation and management;
  - Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
  - For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
  - Office visits for the treatment of childhood obesity; and
  - Professional Nutritional Counseling and Medical Nutrition Therapy as specified under "Covered Services."

- Services incurred before the effective date of the Member's coverage under this Agreement.

- Services incurred after the Member's termination of coverage, not including any services rendered during an extension of benefits period.

- Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital, or developmental anomalies.

- Services for injuries or diseases related to the Member's job to the extent the Member is required to be covered by a workers' compensation law.

- Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

- Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
- Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.
- Inpatient admissions primarily for diagnostic studies, unless authorized by the Plan.
- The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as provided in the Covered Services Section.
- Except for covered ambulance services and transplants, travel, whether or not recommended by a Health Care Practitioner.
- Except for Emergency Services, services received while outside the United States.
- Immunizations related to foreign travel.
- Unless otherwise specified under "Covered Services" dental work or treatment which includes hospital or professional care in connection with:

    A. The operation or treatment for the fitting or wearing of dentures;

    B. Orthodontic care or malocclusion;

    C. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within six months of the accident; and

    D. Dental implants.

- Accidents occurring while and as a result of chewing.
- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary.
- Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting unless these services or supplies are determined to be Medically Necessary.
- Inpatient admissions primarily for physical therapy, unless authorized by the Plan.
- Treatment leading to or in connection with transsexualism, or sex changes or modifications, including, but not limited to surgery.
- Treatment of sexual dysfunction not related to organic disease.
- Services or supplies that duplicate benefits provided under federal, State, or local laws, regulations or programs.

- Non-human organs and their implantation.
- Non-replacement fees for blood and blood products.
- Lifestyle improvements, nutrition counseling, or physical fitness programs unless included under “Covered Services.”
- Wigs or cranial prosthesis. This exclusion does not apply to hair prosthesis covered under Section 2.38 of this Agreement.
- Weekend admission charges, except for emergencies and maternity, unless authorized by the Plan.
- Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
- Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable evidence of joint abnormality due to disease or injury.
- Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payments provision of an automobile insurance policy.
- Services for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.
- Services for, or related to, the removal of an organ from a Member for purposes of transplantation into another person unless the transplant recipient is covered under this Agreement and is undergoing a covered transplant, and the services are not payable by another health plan.
- Physical examinations required for obtaining or continuing employment, insurance, or government licensing.
- Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
- Private hospital room, unless authorized by the Plan.
- Private duty nursing, unless authorized by the Plan.
- Services related to an abortion.
- Services that are determined by the appropriate regulatory licensing board to be furnished as a result of a prohibited referral as defined in Section 1-302 of the Health Occupations Article.

VI. NEW TECHNOLOGY ASSESSMENT

To ensure that our members have access to safe and effective care, Evergreen Health has a formal process to review and make decisions regarding new developments in medical technology. We evaluate new medical technologies and the use of existing technologies for inclusion as a covered benefit through a formal review process. We refer to medical personnel, governmental agencies, and published articles about scientific studies in this process.

VII. DEPENDENT COVERAGE

A DEPENDENT MUST MEET ONE OF THE REQUIREMENTS FOR COVERAGE LISTED BELOW TO BE ELIGIBLE FOR COVERAGE UNDER THE PLAN.

1. The legal spouse.

2. A child (including an adopted child) of the Subscriber, or a child of the spouse of the subscriber until the child's 26th birthday

3. A child (including an adopted child) of the Subscriber, or a child of the spouse of the Subscriber, who is no longer eligible under paragraph 2), above, and meets each of the following requirements: (1) currently disabled; (2) became disabled while enrolled as a dependent under paragraph 2), above, and (3) remains chiefly financially dependent on the Subscriber. An individual will be determined to be "disabled" if he or she: is mentally or physically incapable of earning his or her own living. In the event of a dispute concerning eligibility under this paragraph, the standard for determining disability under Title II of the Social Security Act will apply.

4. A child under the age of 26 years for whom the Subscriber, or the spouse of the Subscriber is the court appointed legal guardian. Proof of guardianship must be submitted to Evergreen Health prior to enrollment.

5. Exception for Newborns - Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his or her birth, if you elect Dependent Medical Insurance no later than 31 days after the birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

6. Exception for Newborn Grandchildren – Any child born to your Dependent child while you are insured for Medical Insurance will be covered for the first 31 days of his or her life. Coverage for such child will not continue beyond the 31st day and no benefits for expenses incurred beyond the 31st day will be payable. Reasonable evidence of eligibility may be required from time to time.

VIII. REIMBURSEMENTS AND CLAIMS PROCEDURES

In the event that you receive care from a Non-Plan Provider, your benefits may still apply, but you will be required to submit the claim to Evergreen Health, or have your health care provider submit the claim to Evergreen Health on your behalf. You will be liable for any deductible, copayment, or coinsurance that applies to the claim.

To file a claim, download and fill out the member claim form from the Evergreen Health website at www.evergreenmd.org/members and mail it to:

Evergreen Health Co-op Claims Processing Center
PO Box 2907
Clinton, IA 52733-2907

Claims must be filed within 180 days from the date of service. You will receive a claim determination within 30 days of receipt of your filing

Questions? Call the Member Services phone number on the front of your Member ID Card.

IX. APPEALS AND COMPLAINTS

Before you file an appeal, be aware that claims denials may often be the result of insufficient or incorrect information. Because these problems are easy to resolve, members should first contact the Member Services Department at the phone number on your Member ID Card. A Member Services representative will help you identify why the claim was denied and resolve the problem if possible. If you are still dissatisfied, you should then file an appeal.

When you file a benefit claim with the plan, it's possible that you will receive an adverse benefit determination. An adverse benefit determination is an indication that the benefit you filed a claim for has not been approved by Evergreen Health because it falls outside the scope of your coverage. For example, a claim for a service that requires prior authorization for which no authorization was given may be subject to an adverse benefit determination.

In the event that you receive an adverse benefit determination, you may appeal this decision through Evergreen Health's appeal process by filing a protest yourself, or having a representative or health care provider file a protest on your behalf.

To file an appeal, you, your representative, or your provider, may either contact the plan at the telephone number and Evergreen Health claims address located on your Member ID Card, or

submit a written request and any supporting record of medical documentation within 180 days of the adverse benefit determination to the following addresses:

Category	Vendor	Clinical Appeals	Administrative Appeals
Medical	CoreSource	PO Box 83301 Lancaster, PA 17608-3301	PO Box 2907 Clinton, IA 52733-2907
Behavioral Health	ValueOptions	Evergreen Health c/o ValueOptions Attn: Angel Haskins National Peer Advisor 12369-C Sunrise Valley Reston, VA 20190	PO Box 383 Latham, NY 12110
Vision	Block Vision	939 Elkridge Landing Rd Suite 200 Linthicum MD 21090	939 Elkridge Landing Rd Suite 200 Linthicum MD 21090
Dental	DentaQuest	12121 North Corporate Pkwy Mequon, WI 53092 Attn: Appeals Dept	12121 North Corporate Pkwy Mequon, WI 53092 Attn: Appeals Dept
Retail Pharmacy	Catamaran	PO Box 5252 Lisle, IL 60532	PO Box 5252 Lisle, IL 60532

The Maryland Health Education and Advocacy Unit is also able to help you file your appeal, or any other grievance. They can be contacted at:

Health Education and Advocacy Unit
Consumer Protection Division
MD/CFBC/DOL APPEAL (R. 9/11) [CP] [18] [control number]
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
410- 528-1840 or 1-877- 261-8807
Fax: 410- 576-6571
E-mail: heau@oag.state.md.us

Free of charge, you will have the opportunity to submit written comments, documents, records, and any other information relating to your claim and, upon request, be given reasonable access to all documents and records relevant to your claim. The plan will take into account all such material, whether or not it was considered in the original claim determination.

In reviewing your appeal, the plan will not give deference to the original decision, and the person reviewing your appeal will not be the same person who made the original determination, nor a subordinate thereof. In the event that your appeal is of a determination that a certain treatment or service was not medically necessary, the plan will consult with a health care provider of the same specialty as the treatment under review. Additionally, the plan will identify all persons who were consulted in arriving at the original benefit determination and evidence used in either the original or appeal determination.

An expedited appeal/grievance process may be available to you if your or a covered family member's condition is such that the time needed to complete a standard appeal/grievance could seriously jeopardize the patient's life, health or ability to regain maximum function. Expedited appeals/grievances involve care that has not yet occurred or is currently occurring (pre-service or concurrent care). If the plan confirms that an expedited appeal/grievance is needed, the plan will complete the review within 24 hours of receiving the request and any additional information. To request an expedited appeal/grievance, please call 855-776-8839.

If the determination remains as a denial of the original request, a detailed explanation that references the rule, policy or guideline used to make the determination will be included. Also provided will be an explanation of the appropriate next steps a member can take if he or she is not satisfied with the appeal process. Members have the right to an independent external review of any final appeal/grievance determination. If you wish, you may contact the Maryland Insurance Administration (MIA) to file a complaint. They can be contacted at:

Maryland Insurance Administration (MIA)
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone: 410-468-2000 or 1-800-492-6116
Fax: 410: 468-2270 or 410-468-2260
(Life and Health/Appeals and Grievance)

If you need assistance filing such a complaint, the Maryland Health Education and Advocacy Unit can assist you.

Evergreen Health is bound by law not to retaliate against you in any way, and will not under any circumstances. Further information about the appeals and complaint procedure can be found in your Plan Agreement.

Evergreen Health also investigates complaints from members related to the quality of care and services of providers in our networks and takes action when appropriate. In response to a member complaint, Evergreen Health will contact the provider in question for additional information. At the conclusion of our investigation, the plan will advise the provider and member about the findings and resolution.

You may submit a written complaint to:

Evergreen Health Co-op
Healthcare Management Department
PO Box 83301
Lancaster, PA 17608-3301

X. PROVIDER DIRECTORY

To access the provider directory which contains contracted medical, vision, dental, and behavioral health treatment providers visit: http://www.evergreenmd.org/provider-directory.

If you do not have access to a computer, please call Member Services at 855-475-0990.

XI. AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Evergreen Health is committed to delivering the most effective care possible to every member. This principle is the guiding force behind all decisions the plan makes when it comes to patient care, including those surrounding utilization management. Therefore, we are sharing this Affirmative Statement about incentives (specifically relating to Utilization Management).

Evergreen Heath affirms:

- Utilization management (UM) decisions are made using recognized criteria. UM decision making is based only on appropriateness of care and services, and the existence of coverage.
- Evergreen Health does not reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

XII. MEMBERS' RIGHTS AND RESPONSIBILITIES, PRIVACY NOTICE

MEMBERS HAVE THE RIGHT TO:

- Receive information about Evergreen Health, its services, practitioners, and providers
- Understand their coverage and benefits they are receiving from Evergreen Health
- Be treated with respect and dignity no matter their race, national origin, age, sexual orientation religion, gender, physical or mental disability, or type of illness or condition
- Have access to care no matter their race, national origin, age, sexual orientation, religion, gender, physical or mental disability, or type of illness or condition, including preexisting
- Not be charged more for having a preexisting condition or illness
- Receive free preventive care including preventive screenings, vaccines directly related to preventive care, and services for women
- Use out-of-network emergency services without a penalty
- Have coverage that cannot be cancelled based on frivolous reasons such as honest mistakes on their member application
- Know if they qualify for free or low-cost coverage through Medicaid or CHIP
- Have no yearly or lifetime limits on essential health benefits during enrollment in plan
- Expect security and privacy of all medical records and information about their health including their treatments and examinations
- Request and receive a copy of their medical records and request their medical record be amended or corrected
- Choose their own primary care provider (PCP)
- See an obstetrician or gynecologist without a referral from PCP
- Participate with practitioners in making decisions regarding Member's health care
- Discuss and understand appropriate or medically necessary treatment options including risks related to the illness and treatment
- Refuse any treatment by a provider and be made aware of the consequences should the Member refuse treatment
- Receive a second opinion from another doctor if the Member does not agree with the doctor's opinion about diagnosis or treatment
- Discuss treatment options regardless of the cost or Member's benefits coverage
- Have an Advance Directive, such as a living will, health care proxy, or durable power of attorney for health care, concerning treatment
- Designate someone who has the legal right to make health care decisions for the Member if the Member is unable to make their own wishes known
- File a complaint, appeal, or grievance with Evergreen Health for care provided and have it resolved in a reasonable amount of time
- File a complaint, appeal, or grievance against Evergreen Health
- Exercise their rights and know that such exercise will not result in retaliation such as adverse treatment from Evergreen Health or their providers
- Receive more information about Member's rights and responsibilities
- Make recommendations regarding member rights and responsibilities to Evergreen Health

MEMBERS HAVE THE RESPONSIBILITY TO:

- Tell the truth about their health including unexpected changes in health, medications they have used or are currently using, prior illnesses, and operations
- Provide, to the fullest extent possible, information that Evergreen Health and its practitioners or providers need to know in order to care for the Member
- Follow the plans and instructions for care that the Member and practitioner or provider have agreed upon
- Understand their health problem and the treatment and participate in developing treatment goals with the practitioner or provider including what could happen should the Member refuse treatment or does not follow the advice given to them
- Provide a copy of their Advance Directive if they have one
- Pay copayments or coinsurance at the time of service
- Be on time for appointments or to notify practitioners and providers when an appointment must be cancelled
- Read the enrollee handbook so they can understand the services provided, their rights as members, and how to contact Evergreen Health with questions
- Complete renewal application in a timely manner to prevent gaps in coverage
- Report any other health insurance coverage to their PCP and Evergreen Health
- Be courteous and respectful to Evergreen Health staff, healthcare providers, and office staff
- Report any known or suspected fraud and abuse as it relates to benefits, services, or payments

XIII. NOTICE OF MEMBER RIGHTS RELATED TO THE DESIGNATION OF A PRIMARY CARE PROVIDER

Evergreen Health Cooperative Inc. is required by law (ACA – 45 CFR 147.138) to provide its members of their rights related to the designation of a primary care provider.

MEMBER RIGHTS

- You can designate any participating primary care provider who is available to accept you or any member enrolled in a plan

- You can designate any participating physician who specializes in pediatrics as the primary care provider for a child enrolled in a plan

- You can designate any participating physician who specializes in obstetrical or gynecological care as the primary care provider for a female member

- Female members who have not designated a participating physician who specializes in obstetrical or gynecological care as her primary care provider can access obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology without prior authorization or referral. A health care professional who

specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care. Futhermore, the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services by a participating health care professional who specializes in obstetrics or gynecology, must be treated by Evergreen Health Co-op as the authorization of the primary care provider.

XIV. NOTICE OF PRIVACY PRACTICES

ATTENTION: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TOTHIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how Evergreen Health Co-op Health may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or behavioral health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

I. LEGAL DUTIES OF EVERGREEN HEALTH CO-OP

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Maryland's Confidentiality of Medical Records Act (MCMRA) impose certain legal responsibilities on health plans and healthcare providers concerning the use and disclosure of Protected Health Information (PHI). This notice of privacy practices is being provided to you so that you can be aware of and understand your rights regarding the ways in which Evergreen Health Co-op can use and disclose your PHI. PHI means any information or data that could connect you to information about your health; that is, not only does PHI encompass specific diagnoses and other clinical information, it also encompasses non-clinical information such as your name, date of birth, social security number, or anything else that could link you to information about your health.

Evergreen Health Co-op—and any entities that we contract with to provide you care—are required by law to maintain the privacy and security of your PHI, as well as keep you up-to-date on all of our security practices. The information regarding use and disclosure of your information applies both to Evergreen Health Co-op, and any entities we contract with to provide you care. It tells you how we'll use your information, and includes information on how you can exercise your rights regarding your PHI. While you should keep this copy for your records, you can receive a new copy from Evergreen Health Co-op anytime you ask.

II. USES AND DISCLOSURES PERMITTED FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

a. ***Treatment:*** Treatment includes any activities that are related to providing, coordinating, or managing your actual health care. For example, information about you may be shared with Doctors providing you care

b. ***Payment:*** Payment includes any activities by Evergreen Health Co-op, our Business Associates, or any care providers to obtain payment, make coverage decisions, determine eligibility, or provide reimbursement. For example, we may use your information to determine if certain treatments are covered under your selected plan, and how your claims will be paid.

c. ***Health Care Operations:*** Health Care Operations includes activities such as risk assessment, customer service, internal grievance procedures, and other activities as defined by HIPAA. For example, we may use your information to resolve a grievance you have against us.

III. OTHER ALLOWABLE DISCLOSURES OF PHI

a. Disclosures required by law: Any disclosures required by law will be made in compliance with any applicable law. If such disclosure is necessary, you will be informed of the law requiring disclosure of your information.

b. Disclosure for Public Health Activities: Evergreen Health Co-op may disclose PHI to a public health entity that is required by law to collect such information.

   i. For example, Maryland collects data related to the types of claims that arise in the state from year to year.
   ii. Some disclosures may be made to public health entities to prevent or control disease, or to report child abuse.
   iii. Disclosures may be made to the FDA for the purposes of reporting product defects or other adverse events.

c. Disclosure to Health Oversight Agencies: Evergreen Health Co-op may disclose protected health information to health oversight agencies, such as the Maryland Healthcare Commission, for oversight activities such as audits, licensing, or investigations.

d. Court Order: If Evergreen Health Co-op is order by a court to provide certain information, Evergreen Health Co-op will comply with the order only if Evergreen Health Co-op is provided with a subpoena.

e. Law Enforcement Purposes: Evergreen Health Co-op may be required to disclose PHI to law enforcement officials if it is such disclosure is required by law, or is necessary to identify a suspect, fugitive, witness, victim, or missing person. Disclosures may be made about a death resulting from criminal conduct, or if such information is necessary for immediate law enforcement activity, or may mitigate or prevent the imminent harm of another person.

f. Reporting Abuse, Neglect, or Domestic Violence: Evergreen Health Co-op may disclose protected health information to a public health authority authorized by law to receive reports of abuse, neglect, or domestic violence if Evergreen Health Co-op reasonably believes an individual is a victim, the victim agrees to the disclosure, or if the disclosure is expressly authorized by law.

g. Coroners, Medical Examiners, Funeral Directors, and Organ Donation: Evergreen Health Co-op may disclose protected health information to a coroner or medical examiner for the purposes of identifying a deceased individual, determining a cause of death; to funeral directors to aid them in completion of services for you; and to organizations that manage organ and tissue donation.

h. Worker's Compensation: Evergreen Health Co-op may disclose protected health information to comply with relevant Worker's Compensation laws and other similar benefits programs that provide benefits for work-related injuries or illnesses.

i. Research: Evergreen Health Co-op may disclose protected health information to researchers when their research has been approved by a duly and legally constituted institutional review board that has reviewed the research proposal and established protocols to ensure the protection of protected health information.

j. Special Government and Security Functions: Evergreen Health Co-op may disclose information about soldiers to the branch of the military they serve in, even if they serve in a foreign military. Evergreen Health Co-op may also disclose information to federal officials for the purpose of national security or intelligence activities. Evergreen Health Co-op may also make disclosures about inmates for custodial purposes.

IV. USES AND DISCLOSURES REQUIRING AUTHORIZATION

a. Authorizations: Any other disclosures of your PHI must be authorized by you, the Member. Authorizations may be freely revoked at any time, and for any reason, but disclosures previously made in accordance with an authorization cannot be taken back.

b. Retention policy: All signed authorizations will be documented and retained indefinitely.

V. STATEMENT OF INDIVIDUAL RIGHTS

a. You have a right to request restrictions on any uses or disclosures described in sections II, III, and IV, above

   i. Should such a request for restrictions be made, Evergreen Health Co-op is not obligated to agree to any such requests where individual authorization is not required, or where Evergreen Health Co-op has already acted upon previous authorization

   ii. You have the right to ask Evergreen Health Co-op to restrict the use and disclosure of your Protected Health Information to only what is necessary to carry out Treatment, Payment, or Health Care

Operations, except for uses or disclosures required by law. We are not required to agree to a requested restriction, but if we do, we will abide by the agreement (except in an emergency). Any agreement to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement. We will not be liable for uses and disclosures made outside of the requested restriction unless the agreement to restrict is in writing. We may end the agreement to the requested restriction by notifying you in writing. You may request such restrictions by writing to Evergreen Health Co-op at the address at the bottom of this Notice.

b. You have a right to receive confidential communications in alternative forms so long as such requests can be reasonably accommodated by Evergreen Health Co-op

    i. If you believe that a disclosure of all or part of your PHI may endanger you, you have the right to request that we communicate with you in confidence about your Protected Health Information. This means that you may request that we send you information by alternative means, or to an alternate location. Evergreen Health Co-op must accommodate your request if: it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premiums and claims) will be handled. You may request such confidential communications by writing to Evergreen Health Co-op at the address listed at the end of this notice.

c. You have the right to inspect and copy any of your own private health records; Evergreen Health Co-op may charge you for costs of copying, postage, and a preparation fee

    i. You have the right to inspect and obtain a copy of your Protected Health Information, including your medical records, except you do not have the right to copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. You must make a request in writing to obtain access to your Protected Health Information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the address at the end of this notice. If you request copies, we might charge you a reasonable fee for each page, and postage if you want the copies mailed to you. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. If you request an alternative format, we might charge a cost-based fee for providing your Protected Health Information in that format. If you prefer, we will prepare a summary or an explanation of your PHI, but we might charge a fee to do so. We might deny your request to inspect and copy your PHI in certain limited circumstances. Under certain conditions, our denial will not be reviewable. If this event occurs, we will in form you in our denial that the decision is not reviewable. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed. A licensed

health care professional chosen by us will review your request and the denial. The person performing this review will not be the same person who denied your initial request.

d. You have a right to receive an accounting of any and all disclosures of your protected health information

i. You have the right to a list of certain disclosures Evergreen Health Co-op has made of your Protected Health Information going back six years from the date of your request, but not for disclosures made prior to January 1, 2014. You do not have a right to receive an accounting of any disclosures made:

1. For Treatment, Payment, or Health Care Operations;
2. To you about your own health information;
3. Incidental to other permitted or required disclosures;
4. Where authorization was provided;
5. For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; and
6. As part of a "limited data set" (health information that excludes certain identifying information).

ii. You may request an accounting by submitting your request in writing to the address listed at the end of this notice. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made prior to January 1, 2014.

e. You have a right to receive paper copies of any requested materials, including this privacy notice, even if you have previously agreed to receive copies of your records and communications electronically.

i. If you are currently receiving your materials from Evergreen Health Co-op electronically, you may elect to receive them in hard copy at any time.

f. You have a right to request an amendment of any protected health information or other information in your health records kept by Evergreen Health Co-op.

i. Evergreen Health Co-op has no duty to comply with the request if the requested amendment is to a record created by an entity other than Evergreen Health Co-op; if the record is not part of the record set designated in the request; if the record is not available for inspection; or if Evergreen Health Co-op determines that the record is accurate and complete as-is.

g. You have a right to be notified if there is a security breach resulting in the disclosure of your protected health information to any party.

i. If there is ever a security breach of Evergreen Health Co-op security systems, or the security systems of an Evergreen Health Co-op Business Associate, you will be notified as soon as the extent and nature of the breach can be ascertained.

VI. DUTIES OF EVERGREEN HEALTH CO-OP

a. Evergreen Health Co-op has a legal duty under 45 CFR Parts 160, 162, and 164 to protect your protected health information, to provide covered individuals with notice of our privacy practices, to notify any covered individuals affected by a breach of security, and to abide by the contents of this notice.

b. Evergreen Health Co-op periodically reviews this privacy notice and reserves the right to amend it. All revisions will be performed in accordance with applicable local and federal and notification of any changes will be sent to you.

VII. GENERAL SAFEGUARDS FOR PHI

a. All employees of Evergreen Health Co-op and all contracted network providers of Evergreen Health Co-op strictly safeguard the confidentiality of all records concerning patients who have been provided care through a contract with Evergreen Health Co-op. These are some of the steps we take to protect your PHI:

i. Access to your personal information is limited to those persons who need the information to serve you, who have been trained how to protect and handle such information and who have signed statements indicating their awareness of the legal penalty for unauthorized disclosure. Evergreen Health Co-op security measures prohibit access to Member PHI for Evergreen Health Co-op employees whose responsibilities do not require access to Member PHI.

ii. The Evergreen Health Co-op makes efforts to limit the amount of hard copy of individually-identifiable health care information. When it is necessary to retain any hard copy files, such information is stored in locked file cabinets within the locked office space. All office doors are equipped with security locks requiring a key for entry.

iii. Electronic PHI is also secured. Depending on an employee's role with Evergreen Health Co-op, he or she will have different access to PHI; and only such access as is necessary to fulfill their employment responsibilities. Multiple levels of encryption are used and all computers, phones, and devices used to store PHI are protected by security software.

iv. Personnel policies strictly prohibit discussions among employees and with anyone else that involve Member PHI, except among authorized employees and clinicians working together for the Member. Violation of this policy carries serious penalties to the employee.

v. All Evergreen Health Co-op employees undergo HIPAA security and privacy training, and are periodically required to take refresher courses and pass appropriate compliance evaluation tests.

vi. Evergreen Health Co-op maintains a log of disclosures of individually identifiable health care information that do not fall within the parameters of allowable disclosure under HIPAA, and vigorously investigates unauthorized disclosures.

vii. Penalties for Evergreen Health Co-op staff violating our policies regarding PHI will result in corrective action up to and including termination as deemed appropriate by the Chief Privacy Officer and other Officers of Evergreen Health Co-op.

viii. All Business Associates and Plan Sponsors of Evergreen Health Co-op are required to adopt Evergreen Health Co-op's HIPAA and NCQA compliant policies regarding physical and technical security of PHI.

ix. Member's should refer to their individual owner's manual for information about the exchange of information between Evergreen Health Co-op and Plan Sponsors.

VIII. COMPLAINTS

a. In the event that you feel Evergreen Health Co-op is not in compliance with the law or the contents of this Privacy Notice, you have a right to file a complaint with Evergreen Health Co-op, or with the Secretary of Health and Human Services (HHS), or any other officer or employee of HHS to whom the authority involved has been delegated.

b. In the event you feel that you feel Evergreen Health Co-op is not in compliance with the law or this privacy notice, you may contact:

Chief Compliance Officer
(443)475-0990
3000 Falls Road, Suite 1
Baltimore, MD 21211

c. Should any individual make a complaint that this HIPAA privacy policy has been violated by Evergreen Health Co-op, Evergreen Health Co-op is bound by law not to retaliate against said individual, and shall not, under any circumstance, retaliate against any individuals filing complaints.

IX. CONTACT FOR FURTHER INFORMATION

a. If you have any questions about this privacy policy or your rights thereunder, you may contact:

Chief Compliance Officer
(443)475-0990
3000 Falls Road, Suite 1
Baltimore, MD 21211

X. EFFECTIVE DATE

a. This HIPAA compliant privacy policy was adopted by Evergreen Health Co-op on August 12, 2013 and is valid until any revisions are made, of which notice shall be given.