Evergreen Health Cooperative Inc.
3000 Falls Road, Suite 1
Baltimore, Maryland 21211
443-475-0990

EVERGREEN HEALTH HMO
INDIVIDUAL PLAN AGREEMENT

This Individual Agreement (the "Agreement"), including any amendments and riders, is part of the Agreement issued to the Subscriber, and contains the principal provisions affecting the enrolled Members and other provisions that explain the duties of Evergreen Health Cooperative Inc. ("Evergreen Health" or "the Plan") and those of the Subscriber. The Agreement, in its entirety, is the complete contract between Evergreen Health and the Subscriber.

The Subscriber accepts and agrees to the Agreement by making payment to Evergreen Health as required under the Agreement. Evergreen Health agrees to the Agreement when it is issued to the Subscriber. The Subscriber's payment and Evergreen Health's issuance make the Agreement's terms and provisions binding on Evergreen Health and the Subscriber.

Any application or enrollment form completed by the Subscriber shall constitute agreement on the part of the Subscriber to adhere to all provisions contained in this Agreement. Each individual covered under this Agreement will be a Member of Evergreen Health. Evergreen Health will not cancel or refuse to renew this Agreement unless any of the following circumstances occur: a) nonpayment of the required premiums; b) where the Member has performed an act or practice that constitutes fraud; c) where the Member has made an intentional misrepresentation of a material fact that is relevant to the terms of the coverage; or d) if the Member no longer resides in the State of Maryland.

[Subscriber Name: _____]

[Subscriber ID Number: _____]

[Effective Date: _____]

[Product: _____]

Evergreen Health Cooperative Inc.

_____
[Name and Title]

THE SUBSCRIBER MAY CANCEL THIS AGREEMENT WITHIN TEN (10) DAYS
The Subscriber may, if the Agreement is not satisfactory for any reason, return it within ten (10) days of its receipt and receive a full refund of the charges paid. This right may not be exercised if a Member utilizes Covered Services under this Agreement during this ten (10) day period.

Introduction to Your Individual Plan Agreement

We, Evergreen Health Cooperative Inc., are pleased to provide you this Plan Agreement. This Plan Agreement and other documents describe your benefits, as well as your rights and responsibilities.

How to Use this Document
We encourage you to read the Individual Plan Agreement and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Description of Covered Services, including Exclusions and Limitations, along with the Schedule of Benefits. You should also read the General Provisions section of the Individual Plan Agreement to better understand how your benefits work. You should call the Member Services number listed on your ID card if you have questions about the limits of the coverage available to you.

Many of the sections of this Individual Plan Agreement are related to other sections of the document. You may not have all of the information you need by reading just one section. Your Plan Agreement and Schedule of Benefits and any attachments will be made available on the Member Portal for your future reference.

Please be aware that your Health Care Practitioner is not responsible for knowing or communicating your coverage available to you under this Individual Plan Agreement.

Information about Defined Terms
Because this Individual Plan Agreement is part of a legal document, we want to give you information that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the Definitions section of the Individual Plan Agreement and Description of Covered Services, which you can refer to as you read this document to have a clearer understanding.

When we use the words “we,” “us,” and “our” in this document, we are referring to Evergreen Health Cooperative Inc. When we use the words “you” and “your,” we are referring to Members, as that term is defined in the Definitions section.

Don’t Hesitate to Contact Us
Whenever you have a question or concern regarding your benefits, please contact the Member Services phone number listed on your ID card.

Your Responsibilities

Be Enrolled and Pay Required Contributions
Covered Services are available to you only if you are enrolled for coverage under the Individual Plan Agreement.

Be Aware this Benefit Plan Does Not Pay for All Health Services
Your right to benefits is limited to Covered Services. The extent of this benefit plan's payments for Covered Services and any obligation that you may have to pay for a portion of the cost of those Covered Services is set forth in the Schedule of Benefits. You must pay the cost of all excluded services and items. Review the Exclusions and Limitations section to become familiar with this benefit plan's exclusions.

Decide What Services You Should Receive
Care decisions are between you and your Health Care Practitioners. We do not make decisions about the kind of care you should or should not receive.

Choose Your Provider
It is your responsibility to select your Primary Care Provider when enrolling, and notify the Plan to change Primary Care Provider. We arrange for physicians and other Health Care Practitioners to participate in our network as Network Providers. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization
Some Covered Services require prior authorization. Network Providers are responsible for obtaining prior authorization.

Pay Your Share
You must pay a Deductible, Copayment and/or Coinsurance for most Covered Services These payments are due at the time of service or when billed by the Network Provider. Copayment and Coinsurance amounts are listed in the Schedule of Benefits. These terms are defined in the Definitions section of this Plan Agreement.

Show Your ID Card
You should show your identification (ID) card every time you request health services. If you do not show your ID card, the Health Care Practitioner may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any benefits otherwise owed to you. While failing to provide an ID may delay processing benefits, benefits will not be denied based solely on this.

Our Responsibilities

Determine Benefits
We make administrative decisions regarding whether this benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:
- Interpret benefits and the other terms, limitations and exclusions set out in this Individual Plan Agreement, the Schedule of Benefits and any Riders and/or Amendments.
- Make factual determinations relating to benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Services
We pay benefits for Covered Services as described in Description of Covered Services and in the Schedule of Benefits, unless the service is excluded in Exclusions and Limitations. This means we only pay our portion of the cost of Covered Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this benefit plan.

Pay Network Providers
It is the responsibility of our Network Providers to file for payment from us.

Offer Health Education Services to You
From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Primary Care Provider.

SECTION 1
DEFINITIONS

The following terms, when capitalized and used in this Agreement, have the meanings shown.

1.1 **Allowed Benefit** means the maximum amount payable by the plan for Covered Services received by a Member. Members are responsible for payment of their portion of the Allowed Benefit as set forth in the Schedule of Benefits, including any applicable Copayment amount or Coinsurance percentage.

A. **Tier 1** Benefits

1. The Plan encourages you to receive care from a Tier 1 Network Provider, and you may have a lesser cost share for certain services than you would have if you receive services from Tier 2 Network Providers. When Covered Services are provided by a Tier 1 Network Provider, the Allowed Benefit for a Covered Service is the lesser of:
   a. The physician's or provider's actual charge which, in some cases, will be a rate set by a regulatory agency; or
   b. The amount agreed to between the Plan and the Tier 1 Network Provider for the Covered Service that applies on the date that the service is rendered.

B. **Tier 2** Benefits

1. Members may choose to obtain services from Tier 2 Network Providers. Members' share of the cost for certain services provided by Tier 2 providers may be greater than the Members' share of the cost of services for Tier 1 providers. For a Tier 2 Provider, the Allowed Benefit for a Covered Service is the lesser of:
   a. 1. The physician's or provider's actual charge which, in some cases, will be a rate set by a regulatory agency; or
   b. 2. The amount agreed to between the Plan and the Tier 2 Network Provider for the Covered Service that applies on the date that the service is rendered.

C. For a Tier 1 or Tier 2 hospital in the State of Maryland, the Allowed Benefit for a Covered Service is a rate set by the Health Services Cost Review Commission.

D. **Out-of-Network Benefits**

1. For an Out-of-Network Ambulance Service Provider, the Allowed Benefit will be the greater of the amount required by the Annotated Code of Maryland, Health - General Article, §19-710.1 or the Allowed Benefit for Network Ambulance Service Providers.

2. Except for Covered Services rendered by an Out-of-Network hospital in the State of Maryland or an Out-of-Network Ambulance Service Provider, the Allowed Benefit for a Covered Service rendered by an Out-of-Network Provider, including a Non-Contracting Trauma Physician for trauma care rendered to a Trauma Patient in a Trauma Center, will be no less than the amount specified in the Annotated Code of Maryland, Health - General Article, §19-710.1.

3. For an Out-of-Network hospital in the State of Maryland, the Allowed Benefit for a Covered Service is a rate set by the Health Services Cost Review Commission

4. For Emergency Services provided by an Out-of Network Provider, the Allowed Benefit for a Covered Service will be no less than the amount specified section 2719A of the Public Health Service Act and the regulations promulgated pursuant thereto.

5. See Section 6.2, Payment of Claims, for information concerning payment of claims to the Health Care Practitioner or the Member.

1.2 **Ambulance** means any conveyance designed and constructed or modified and equipped to be used, maintained, or operated to transport individuals who are sick, injured, wounded, or otherwise incapacitated.

1.3 **Ambulance Service Provider** means a provider of Ambulance services that:

A. is owned, operated, or under the jurisdiction of a political subdivision of the State of Maryland or a volunteer fire company or volunteer rescue squad; or

B. has contracted to provide Ambulance services for a political subdivision of the State of Maryland.

1.4 **Benefit Year** means a calendar year for which the Plan provides coverage for health benefits.

1.5 **Congenital or Genetic Birth Defect** means a defect existing at or from birth, including a hereditary defect, which includes, but is not limited to, autism or an autism spectrum disorder and cerebral palsy.

1.6 **Coinsurance.** Your share of the costs of a Covered Service, calculated as a percent (for example, 20%) of the Allowed Benefit for the service. You pay coinsurance amounts after reaching any deductibles you owe. Evergreen Health pays for the rest of the Allowed Benefit. This percentage is in the Schedule of Benefits for your health plan.

1.7 **Copayment**. A fixed amount (for example, $10) you pay for a Covered Service, owed when you get the service. The amount can vary by the type of Covered Service or Network Provider. These amounts are in the Schedule of Benefits for your health plan.

1.8 **Covered Service** means a health care service included in the Agreement and rendered to a Plan Member by:

A. A Network Provider under contract with the Plan, when the service is obtained in accordance with the terms of this Agreement; or

B. An Out-of-Network Provider, when the service is

1. obtained in accordance with the terms of the Agreement; or

2. obtained pursuant to a verbal or written referral, or preauthorized or otherwise approved either verbally or in writing by:

a. the Plan; or

b. a provider under written contract with the Plan.

C. A health care provider or representative of a health care provider may collect or attempt to collect from the Member: (i) any copayment or coinsurance owed by the Member; or (ii) any payment or charges for services that are not Covered Services. For Trauma Care rendered to a Trauma Patient in a Trauma Center by a Trauma Physician, the plan will not require a referral or preauthorization for a service to be covered.

1.9 **Deductible.** The amount you owe for Covered Services before Evergreen Health begins to pay. For example, if your Deductible is $1,000, Evergreen Health will not pay anything until you have met your $1,000 Deductible for Covered Services which are subject to your Deductible. The Deductible may not apply to all services. Depending on your health plan, you may owe Copayments for Covered Services which you pay even if you have not reached the Deductible and Evergreen Health will pay for the rest of the Allowed Benefit. The Copayment amounts for certain Covered Services is in the Schedule of Benefits for your health plan.

1.10 **Dependent** means a Member who is covered under this Individual Plan Agreement as the eligible spouse, domestic partner, or eligible child, including an eligible grandchild of the Subscriber, who meets eligibility requirements in Section 2 of this Agreement.

1.11 **Effective Date** means the date on which the Member's coverage becomes effective. Covered Services rendered on or after the Member's Effective Date are eligible for coverage.

1.12 **Dependent Child** means a child, including an eligible grandchild of the Subscriber, who meets the eligibility requirements in Section 2.4 of this Agreement.

1.13 **Emergency Services** means, with respect to an Emergency Medical Condition:

A. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and

B. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as

are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

C. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

1.14 **Health Care Practitioner** means any individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care in the ordinary course of business or practice of a profession or in an approved education or training program.

1.15 **HMO** means a health maintenance organization as defined in Health General Article § 19- 701, Annotated Code of Maryland.

1.16 **Institute** means the Maryland Institute for Emergency Medical Services Systems.

1.17 **Medical Child Support Order** means an "order" issued in the format prescribed by Federal law and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An "order" means a judgment, decree or a ruling (including approval of a settlement agreement) that:

A. is issued by a court of Maryland, the District of Columbia, or another State or an administrative child support enforcement agency of another State or the District of Columbia; and

B. creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage, or establishes a parent's obligation to pay child support and provide health insurance for a child.

1.18 **Medically Necessary or Medical Necessity** means health care services or supplies that a health care provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services are:

A. In accordance with generally accepted standards of medical practice;

B. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;

C. Not primarily for the convenience of a patient or health care provider; and

D. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury or disease.

E. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of health care providers practicing in relevant clinical areas, and any other relevant factors.

1.19 **Member** means an individual who meets all applicable eligibility requirements of Section 2, is enrolled for coverage, either as a Subscriber or as a Dependent, and for whom the premiums required by Section 3 have been received by the Plan. References to "you" and "your" throughout this Individual Plan Agreement are references to a Member.

1.20 **MHBE** means the Maryland Health Benefit Exchange**.**

1.21 **Network Provider** is a physician or other Health Care Practitioner, hospital and other health care entity, or a health care vendor that has entered into a written agreement with the Plan from whom the Member is entitled to receive Covered Services.

1.22 **Non-physician Specialist** means a health care provider who: is not a physician; is licensed or certified under the Health Occupations Article of the Annotated Code of Maryland or the applicable licensing laws of any State or the District of Columbia; and is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider.

1.23 **Out-of-Network Provider** means any physician, Health Care Practitioner or health care facility that is not a Network Provider.

1.24 **Out-of-Pocket Limit.** The most you pay during the Benefit Year before Evergreen Health starts to pay 100% for Covered Services. This limit includes Deductibles, Coinsurance, or Copayments. This limit does not count premiums. The amount is in the Schedule of Benefits for your health plan.

1.25 **Plan** means Evergreen Health Cooperative Inc.

1.26 **Primary Care** means services rendered by a Health Care Practitioner who is a Family Practice Physician, General Practice Physician, Geriatric Physician, Allopathic or Osteopathic Pediatrician, OB-GYN, Internal Medicine Physician, or Nurse Practitioner.

1.27 **Primary Care Provider** means a Health Care Practitioner, who is a Network Provider, selected by a Member to provide Primary Care to the Member and to coordinate and arrange for other required services. This Primary Care Provider is a health care practitioner who provides Primary Care.

1.28 **Qualified Medical Support Order ("QMSO")** means a Medical Child Support Order issued under State law, or the laws of the District of Columbia, and, when issued to an employer sponsored health plan, one that complies with Section 609(A) of the Employee Retirement Income Security Act of 1974, as amended.

1.29 **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 (2) 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's Mental Health Management Program for prior authorization at least five (5) business days prior to admission to a Related Institution. 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 condition, Evergreen Health must receive notification of the admission as soon as possible but in any event within forty-eight (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.

1.30 **Residential Crisis Services** means intensive mental health and support services that are:

A. provided to a Dependent Child or an adult Member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the individual's ability to function in the community; and

B. designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency department; and

C. provided by entities that are licensed by the State of Maryland Department of Health and Mental Hygiene or the applicable licensing laws of any State or the District of Columbia to provide Residential Crisis Services; or located in subacute beds in an inpatient psychiatric facility for an adult Member.

1.31 **Service Area** is the State of Maryland.

1.32 **Specialist** means any Health Care Practitioner not listed as a Primary Care Provider and whose practice is limited to a specific area of medicine. A Health Care Practitioner who provides Primary Care may be considered a Specialist for

copayment purposes in the event that a Member sees the Specialist in a Specialist capacity.

1.33 **Subscriber** means the individual identified as the Subscriber on page 1 of this Agreement. A Subscriber may be under 19 years of age in the case of a child-only plan. A parent or guardian enrolling only a minor under this Agreement, assumes all of the Subscriber responsibilities on behalf of the minor.

1.34 **Tier 1 Network Provider** means a physician, Health Care Practitioner, or health care facility that has contracted with the Plan to render Covered Services to Members. Tier 1 Network Provider relates only to method of payment, and does not imply that any physician, Health Care Practitioner, or health care facility is more or less qualified than another.

A listing of Tier 1 Network Providers will be provided to the Member at the time of enrollment and is also available from the Plan upon request. The listing of Tier 1 Network Providers is subject to change. Members may confirm the status of any physician, Health Care Practitioner or health care facility prior to making arrangements to receive care by contacting the Plan for up-to-date information.

1.35 **Tier 2 Network Provider** means a physician, Health Care Practitioner or health care facility that has contracted with the Plan to render Covered Services to Members. Tier 2 Network Provider relates only to method of payment, and does not imply that any physician, Health Care Practitioner or health care facility is more or less qualified than another.

A listing of Tier 2 Network Providers will be provided to the Member at the time of enrollment and is also available from the Plan upon request. The listing of Tier 2 Network Providers is subject to change. Members may confirm the status of any physician, Health Care Practitioner or health care facility prior to making arrangements to receive care by contacting the Plan for up-to-date information.

1.36 **Trauma Center** means a primary adult resource center, Level I Trauma Center, Level II Trauma Center, Level III Trauma Center, or pediatric Trauma Center that has been designated by the Institute to provide care to the Trauma Patients. Trauma Center includes an out-of-state pediatric facility that has entered into an agreement with the Institute to provide care to Trauma Patients.

1.37 **Trauma Patient** means a Member that is evaluated or treated in a Trauma Center and is entered into the State trauma registry as a Trauma Patient.

1.38 **Trauma Physician** means a licensed physician who has been credentialed or designated by a Trauma Center to provide care to a Trauma Patient at a Trauma Center.

1.39 **Type of Coverage** means Individual, which covers the Subscriber or Member only, or family, under which an Individual may also enroll his or her Dependents.

1.40 **Utilization Management** means the process of evaluating and determining the appropriateness of the utilization of covered medical services, including prior

authorization, concurrent review, retrospective review, discharge planning, and case management.

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 **Requirements for Coverage** To be covered under this Agreement, all of the following conditions must be met:

A. The individual must be eligible for coverage as a Subscriber or Dependent as defined under the terms of this Agreement.

B. The Plan must receive from the MHBE notice that the individual is a qualified individual and information required for enrollment.

C. Premium payments must be made by or on behalf of the Member as required by Section 3.

If you are eligible to enroll both as a Subscriber and as a Dependent of another Subscriber, you cannot enroll as both.

2.2 **Eligibility.** To enroll in the Plan, an individual must be determined to be eligible by the MHBE in accordance with 45 CFR 155.305 and any other applicable eligibility requirements of the MHBE and must satisfy the basic eligibility requirement under this Agreement applicable to the type of enrollee. The individual must also work or reside in the Service Area at the time of enrollment. To enroll in a Catastrophic Plan, please consult the eligibility requirements listed under section 2.8.

2.3 **Eligibility of Subscriber's Spouse.** An eligible spouse is a person married to the Subscriber by a ceremony recognized by the law of the State or jurisdiction in which the Subscriber resides. The spouse may not be covered if divorced or if the marriage has been annulled.

2.4 **Eligibility of Subscriber's Domestic Partner or Dependent of a Domestic Partner.** An eligible domestic partner is a person who is of the same or opposite sex of the Subscriber and: a) meets the criteria as a domestic partner that is established by the state; and b) signs the requisite Affidavit attesting to the domestic partnership. The Affidavit states that the Domestic Partners are: a) both at least 18 years old; b) are not related to the other by blood or marriage within four degrees of consanguinity under civil law rule; c) are not married or in a civil union or domestic partnership with another individual; d) have been financially interdependent for at least 6 consecutive months prior to application in which each individual contributes some to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and e) share a common primary residence.

A. Any one of the following documents is acceptable as proof of common primary residence between the domestic partners: i) common ownership of the primary residence via joint deed or mortgage agreement; ii) common leasehold interest in the primary residence; iii) driver's license or State-issued identification listing a common address; or iv) utility or other

household bill with both the name of the insured and the name of the domestic partner appearing.

1. Any one of the following documents is acceptable as proof of financial interdependence between domestic partners: i) joint bank account or credit account; ii) designation as the primary beneficiary for life insurance or retirement benefits of the domestic partner; iii) designation as primary beneficiary under the domestic partners' will; iv) mutual assignment of valid durable powers of attorney under Estates and Trusts Article §13-601, Annotated Code of Maryland; v) mutual valid written advance directives under Health General Article §5-601 et seq Annotated Code of Maryland, approving the other domestic partner as health care agent; vi) joint ownership or holding of investments; or vii) joint ownership or lease of a motor vehicle.

B. A dependent of the domestic partner is any individual who is related to the domestic partner in the same manner that a dependent is related to the Subscriber. A dependent of the domestic partner is also eligible to be covered under the Subscriber's Agreement.

2.5 **Eligibility as a Dependent Child.**

A. To be covered as a Dependent Child, the child must be under the age of twenty-six (26) years old on the contract effective date and must be related to the Subscriber in one of the following ways:

1. A biological child or stepchild of the Subscriber;

2. A grandchild who:
   a. is unmarried;
   b. is in the court-ordered custody of the insured, Subscriber;
   c. resides with the Subscriber;
   d. is the dependent of the Subscriber; and
   e. has not attained the limiting age under the terms of the contract;

3. A lawfully adopted child of the Subscriber, or, from the date of placement, a child in the process of being adopted by the Subscriber;

4. A child for whom the Subscriber has been granted legal custody, including custody as a result of a guardianship, other than a temporary guardianship of less than 12 months duration, by a court or testamentary appointment; or

5. A child for whom the Subscriber has the legal obligation to provide coverage pursuant to court order, court-approved agreement, or testamentary appointment.

B. A currently enrolled Dependent Child who otherwise meets the Dependent

Child eligibility requirements, except for the age limit, may be eligible as a disabled Dependent Child if the child meets all of the following requirements: (i) the child is incapable of self-sustaining employment because of a mental or physical incapacity that occurred prior to reaching the age limit for Dependents; (ii) the child receives 50 percent or more of his or her support and maintenance from the Subscriber or the Subscriber's lawful spouse; and (iii) the Subscriber provides the Plan proof of the child's incapacity and dependency within 60 days after requested by the Plan.

C. For a QMSO, upon receipt of a QMSO the Plan will accept enrollment regardless of enrollment period restrictions. If the Subscriber does not enroll the child then the Plan will accept enrollment from the non-insuring custodial parent; or, the appropriate child support enforcement agency of any State or the District of Columbia. If the Subscriber has not completed an applicable waiting period for coverage the child will not be enrolled until the end of the waiting period.

The Subscriber must be enrolled in order for the child to be enrolled. If the Subscriber is not enrolled when the Plan receives the QMSO, the Plan will enroll both the Subscriber and the child, without regard to enrollment period restrictions.

1. Enrollment for such child will not be denied because the child:

    a. was born out of wedlock;

    b. is not claimed as a Dependent on the Subscriber's Federal tax return;

    c. does not reside with the Subscriber; or

    d. is receiving benefits or is eligible to receive benefits under any Medical Assistant or Medicaid program.

2. When the child subject to a QMSO does not reside with the Subscriber, the Plan will:

    a. send the non-insuring custodial parent ID cards, claim forms, the applicable Agreement or Member contract and any information needed to obtain benefits;

    b. allow the non-insuring custodial parent or a provider of a Covered Service to submit a claim without the approval of the Subscriber;

    c. provide benefits directly to:

        i the non-insuring parent;

        ii the provider of the Covered Services; or

iii the appropriate child support enforcement agency of any State or the District of Columbia.

D. Children whose relationship to the Subscriber is not listed above are not covered under the Agreement, even though the child may live with the Subscriber and be dependent upon the Subscriber for support.

2.6 **Special Enrollment Periods.** In addition to any open enrollment periods or any other special enrollment periods during which an individual may enroll through the MHBE as permitted or required by law, members may access a special enrollment period of sixty (60) days will be provided through the MHBE for triggering events including marriage, birth, foster care, adoption or placement for adoption. A special enrollment period of sixty (60) days prior to and after the end of coverage for loss of minimum essential coverage, end of policy year for an individual under a non-calendar year plan, end of coverage for loss of pregnancy related coverage, end of coverage for loss of medically needy coverage, and loss of eligibility for qualifying coverage in an eligible employer-sponsored plan. Other triggering events include:

A. loss of minimum essential coverage by the qualified individual or dependent (loss of coverage does not include termination or loss due to failure to pay premiums on a timely basis);

B. an individual or dependent who was not previously a citizen, national or lawfully present individual gains such status;

C. a qualified individual or dependent's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the MHBE.

D. an individual or dependent adequately demonstrates to the MHBE that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

E. an individual or dependent becomes newly eligible or ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether the individual is already enrolled in a qualified health plan.

F. The MHBE must permit individuals whose existing coverage through an employer- sponsored plan is no longer affordable or no longer provides minimum value to gain access to a qualified health plan through the MHBE prior to the end of coverage through the employer-sponsored plan;

G. a qualified individual or dependent gains access to new qualified health plans as a result of a permanent move;

H. an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one PHQ to another one time per month;

I. an individual or dependent who becomes eligible due to the end of policy year for an individual or dependent covered under a non-calendar year individual health insurance plan;

J. an individual or dependent loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)).;

K. an individual or dependent loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year;

L. It has been determined by the Exchange that a qualified individual or enrollee, or his or her dependents, was not enrolled in QHP coverage; was not enrolled in the QHP selected by the qualified individual or enrollee; or is eligible for but is not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. For purposes of this provision, misconduct includes, but is not limited to, the failure of the non-Exchange entity to comply with applicable standards under this part, part 156 of this subchapter, or other applicable Federal or State laws, as determined by the Exchange;

M. a qualified individual or dependent demonstrates to the MHBE, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the MHBE may provide.

2.7 **Effective Date of Coverage.**

A. For any member who enrolls between the first and eighteenth day of any month, the MHBE must ensure a coverage effective date of the first day of the following month. If enrollment occurs between the nineteenth and last day of the month, the MHBE must ensure a coverage effective date of the first day of the second following month.

B. The effective date of coverage for an individual enrolled during a special enrollment period due to birth, adoption, placement for adoption, placement in foster care or a minor under guardianship that is granted by a court or testamentary appointment shall be the date of birth, adoption, or placement for adoption or the date of the testamentary or court appointment of the guardianship. Coverage is automatic for the first 31 days from the date of the birth, adoption, placement in foster care or placement for adoption or for a guardianship that is granted by a court or testamentary appointment. A Subscriber has 60 days from the date of the birth, adoption, or placement for adoption to determine whether to keep his or her current health insurance coverage or to choose a different coverage.

C. In the case of birth, adoption, placement for adoption or placement in foster care, if advance payments of the premium tax credit and cost-sharing reductions are applicable, the effective date of the advance payments of the premium tax credits and cost-sharing reductions will be the first day of the following month unless the birth, adoption of placement for adoption occurs on the first day of the month.

D. In the case of marriage, the MHBE must ensure that coverage is effective for a qualified individual on the first day of the month following plan selection.

E. In the case where a qualified individual loses coverage, the MHBE must ensure coverage is effective on the first day of the month following loss of coverage, if the plan selection occurs on or before the day of the loss of coverage. If the plan selection occurs after the loss of coverage, the MHBE, at its option, must ensure a coverage effective date on the first day of the month following plan selection or a coverage effective date in accordance with paragraph A of this section.

2.8 **Catastrophic Plan Eligibility.** To enroll in a Catastrophic Plan, only individuals who have not attained the age of 30 prior to the first day of the plan or policy year, or who have received a certificate of exemption for the reasons identified in section 1302(e)(2)(B)(i) or (ii) of the Affordable Care Act. For other than self-only coverage, each individual must meet the requirements described in the preceding sentence. An individual covered under a catastrophic plan is no longer eligible for coverage if at the beginning of the new policy year the individual fails to meet the eligibility requirements described above.

SECTION 3
PREMIUMS AND PAYMENTS

3.1 **Premiums.**

A. Initial premiums are due on or before the effective date of this Agreement. Subsequent premiums are due each month on the Premium Due Date. The Premium Due Date is the first of the month for which the premium applies.

B. Except for the initial premium(s), there is a grace period following the Premium Due Date within which overdue premiums can be paid without loss of coverage. The grace period begins on the day after the Premium Due Date. The grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period this Agreement shall continue in force.

C. **Subscribers Receiving Advanced Payment of Premium Tax Credit.** If a Subscriber is receiving advance payments of the premium tax credit under the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended, and the Subscriber has previously paid at least one full month's premium during the Benefit Year, the grace period is extended to three (3) consecutive months for such Subscriber. During the first (1st) month of the grace period, all appropriate claims for services rendered during the (1st) month to the Member will be paid. During the second (2nd) and third (3rd) months of the grace period, all appropriate claims for services rendered to the Member during the (2nd) and (3rd) month will be pended and providers will be notified of the possibility of denied claims when the Member is in the second (2nd) and third (3rd) months of the grace period.

D. **Unpaid Premiums.** Upon the payment of a claim under this Agreement, any premium then due and unpaid or covered by any note or written order may be deducted from the claim payment.

3.2 If premiums are not received by the Premium Due Date, the Plan will notify the Subscriber in writing of the overdue premiums. The Plan's notice will include a bill for the full amount owed. This includes premiums which are past due and any additional premiums which will become due during the 31-day period following the notice. If the Plan receives payment of all amounts listed on the bill within 31 days following the date of notice, coverage will continue without interruption. If full payment is not received within the 31-day notice period, this Agreement will automatically terminate as outlined below in section 4.1.C.1.

3.3 **Copayments.** Members are responsible for payment of Copayments at the time services are received.

3.4 **Premium Adjustments.** All premium adjustments for Members enrolling or terminating during a coverage month will be calculated on a pro-rated basis. Calculated Premium Adjustments will be applied to the next month's premium charges as follows:

1. New enrollment will result in additional premium charges depending upon the Subscriber's current coverage; and

2. Terminations will result in a credit toward the premium charges due.

3.5 **Notice of Renewal.** The Plan shall issue a notice of renewal to the Subscriber before the date of the first day of the next annual open enrollment period. The notice of renewal shall include the dates of the renewal period, the amount of premiums for that year, and the terms of coverage under this Agreement.

3.6 **Premium Increases.** Premium rates will be set for the entire Benefit Year and will not be subject to change during that year. The Plan reserves the right to increase a premium at the end of any Benefit Year by giving 45 days advance notice.

SECTION 4
TERMINATION

4.1 **Termination of Agreement.** The Agreement may be terminated as follows:

A. The MHBE must permit a Subscriber to terminate his or her coverage with appropriate notice to the MHBE or the Health Plan. If the Subscriber provides the notice at least fourteen (14) days prior to the proposed effective date of termination, the last day of coverage is the termination date specified by the Subscriber in the notice of termination. If the Subscriber provides notice less than fourteen (14) days prior to the proposed effective date of termination, and if the Plan is able to effectuate termination in fewer than fourteen (14) days, the termination will occur on the date determined by the Plan if the enrollee requested an earlier termination effective date. If the notice requested termination in less than 14 days and the Plan cannot terminate in less than 14 days, termination will be 14 days from the date of the notice. If the Subscriber is newly eligible for Medicaid, the Basic Health Program or a Children's Health Insurance Program, the last day of coverage is the day before such coverage begins.

B. If a member has a claim in progress when the coverage terminates, benefits related to that claim shall continue until the earlier of: a) the date the Member is released from the care of the physician for the condition that is the basis of the claim; or b) twelve (12) months after the date coverage terminates. Additionally if a Member has ordered glasses or contact lenses before the date coverage terminates, the coverage will continue provided the Member obtains the glasses or contact lenses within thirty (30) days after the date of the order.

C. The Plan may terminate the Agreement for any of the following reasons:

1. Failure of the Subscriber to pay premiums as described in Section 3. The Plan, without undue delay, will provide the Subscriber with a notice of termination of coverage that includes the termination effective date and reason for termination. For Subscribers receiving advance payments of premium tax credit, the Plan will terminate coverage on the last day of the first month of the 3-month grace period. For Subscribers not receiving advance payments of premium tax credit, the Plan will terminate coverage consistent with existing State laws regarding grace periods;

2. The Plan determines that the Subscriber performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. They may include, but are not limited to, fraudulent use of an identification card and attempts to enroll non-eligible persons. In the case of fraud or intentional misrepresentation of material fact, the Plan may rescind the

Member's coverage back to the date of the fraud or intentional misrepresentation of material fact. The Member shall be given 30 days advance notice, which includes the effective date of termination and reason for termination, for any rescission that is related to fraud or intentional misrepresentation of material fact.

3. The Subscriber no longer lives, resides or works in the Service Area the Plan will terminate coverage after giving the Member 30 days advance notice;

4. If the Plan terminates or is decertified by the MHBE coverage will be terminated after the Plan provides 30 days advance notice to the Member;

5. If the Plan elects not to renew all of a particular type of product in the individual market in Maryland, the Plan will notify the Subscriber and the Maryland Insurance Commissioner at least 90 days prior to the effective date of non-renewal. The Subscriber will have the option to purchase any other product offered by the Plan to individuals in Maryland. We will send written notice to each person, and act uniformly without regard to the claims experience of the affected Subscriber or any health status-related factor of any person. Health status-related factor means a factor related to: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability; or

6. If the Plan elects not to renew all individual health benefit plans in Maryland, the Plan will notify the Subscriber and the Maryland Insurance Commissioner at least 180 days prior to the effective date of non-renewal; and shall give notice to the Maryland Insurance Commissioner at least 30 working days before giving this notice.

7. If the Subscriber obtains other minimum essential coverage, with appropriate notice to the MHBE.

D. The MBHE must allow qualified individuals and enrollees to enroll in or change from one plan to another as a result of the triggering events outlined in Section 2.6. Notwithstanding any Plan changes that the member may wish to initiate as the result of a triggering event, a member may always terminate coverage by providing 14-days' notice to the Health Plan. For a Member changing to another plan during an annual open enrollment period or a special enrollment period, the Plan will terminate coverage to the Member the day before the effective date of coverage in the Member's new plan.

E. If the termination occurs because the Member is no longer eligible for

coverage through a Qualified Health Plan through the MHBE, the Plan, without undue delay, will provide the Member with a notice of termination of coverage that includes the termination effective date and reason for termination. The last day of coverage is the last day of the month following the month in which the MHBE notifies the Member unless the Member requests an earlier termination date as provided above.

F. Entitlement to Medicare. If a Subscriber, spouse or Dependent becomes eligible for Medicare mid-year, a Subscriber, spouse or Dependent ***may* (but is not required)** terminate coverage.

G. It is the Subscriber's responsibility to notify the Plan of any changes in the status of his or her Dependents which affect their eligibility for coverage under this Agreement. If the Subscriber does not notify the Plan of any changes and it is later determined that a Dependent was not eligible for coverage, the Plan will provide 30 days advance written notice to the Member that the Dependent's coverage will be terminated.

H. If the Member [or a person seeking coverage on the Member's behalf] performs an act, practice, or omission that constitutes fraud, or if the Member [or individual seeking coverage on the Member's behalf] makes an intentional misrepresentation of material fact, as is prohibited under the terms of this Agreement, coverage will be rescinded as of the date of the act, practice or omission that constitutes fraud or the intentional misrepresentation of material fact. The Plan, without undue delay, will provide the Member with a notice of termination of coverage that includes the termination effective date and reason for termination.

I. In the event of the Subscriber's death, the Subscriber's enrolled Spouse will become the successor Subscriber. If there is no enrolled spouse, coverage of any Dependents will continue under the Subscriber's enrollment until the last day of the month in which the Subscriber's death occurs.

4.2 **Qualified Medical Child Support Order** Unless coverage is terminated for non-payment of the premium, a child subject to a QMSO may not be terminated unless written evidence is provided to the Plan that:

A. The QMSO is no longer in effect; or

B. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage.

4.3 **Reinstatement**

A. If any premium is not paid in full within the time granted the Subscriber for payment, a later acceptance of premium in full by the Plan or by any agent authorized by the Plan to accept the Premium, without requiring a reinstatement application in connection with the acceptance of the

premium in full, shall reinstate the Agreement.

B. If the Plan or the agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Agreement will be reinstated upon approval of the application by the Plan or, lacking approval, upon the forty- fifth (45th) day following the date of the conditional receipt unless the Plan has previously notified the Subscriber in writing of its disapproval of the reinstatement application.

C. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

4.4 **Effect of Termination.** Except as specifically provided in Sections 4.1.B and 4.5, no benefits will be provided for any services a Member receives on or after the date on which the Agreement terminates or the Member's coverage under this Agreement terminates. This includes services received for an injury or illness that occurred before the effective date of termination.

4.5 **Extension of Benefits.**

A. If a Member is Totally Disabled at the time coverage terminates, the Plan will continue to provide the benefits described in this Agreement for the services and supplies received which are directly related to the condition which caused the Total Disability. Benefits will be provided for such services and supplies until the earlier of:

1. The end of the month the Member is no longer Totally Disabled; or

2. Twelve (12) months after the date of the Member's termination of coverage.

B. **Totally Disabled** is a condition of physical or mental incapacity of such severity that an individual considering age, education, and work experience, cannot engage in any kind of substantial gainful work or engage in the normal activities as a person of the same age group. A physical or mental incapacity is an incapacity that results from anatomical, physiological, or psychological abnormality or condition, which is demonstrated by medically acceptable clinical and laboratory diagnostic techniques.

C. If a Member's coverage terminates, the Plan will provide covered orthodontia benefits described in this Agreement for orthodontia services:
1. for 60 days after the date coverage terminates if the orthodontist has agreed to or is receiving monthly payments; or
2. until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

D. If a Member's coverage terminates, the Plan will provide covered dental benefits described in this Agreement for a course of treatment for at least 90 days after the date the Member's coverage terminates if the treatment:
   1. begins before the date coverage terminates; and
   2. requires two or more visits on separate days to a dentist's office.

E. The extension of benefits described in this Section will not apply if:

   1. coverage is terminated for fraud or intentional misrepresentation by the Subscriber; or
   2. coverage is terminated because the Subscriber failed to pay the required premiums;
   3. any coverage provided by a succeeding health benefit plan:

      a. is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefits under this Agreement; and

      b. does not result in an interruption of benefits

F. During an extension period under this Agreement premiums may not be charged.

4.6 **Death of Subscriber** In the event of the Subscriber's death, the Subscriber's enrolled Spouse will become the successor Subscriber. If there is no enrolled Spouse, coverage of any Dependents will continue under the Subscriber's enrollment until the last day of the month in which the Subscriber's death occurs.

4.7 **Residing Outside the Service Area.** The Plan may terminate the coverage of a Subscriber and his or her Dependents upon 31 days written notice if the Subscriber no longer resides or works in the Service Area.

SECTION 5
COORDINATION OF BENEFITS; SUBROGATION

5.1 Coordination of Benefits ("COB")

A. Applicability

1. This COB provision applies to this Evergreen Health Plan (Plan is defined for purposes of this Section 5 below) when a Member has health care coverage under more than one Plan.

2. If this COB provision applies, the Order of Determination Rules should be looked at first. Those rules determine whether the benefits of this Evergreen Health Plan are determined before or after those of another Plan. The benefits of this Evergreen Health Plan:

    a. Shall not be reduced when, under the Order of Determination Rules, this Evergreen Health Plan determines its benefits before another Plan; but

    b. May be reduced when, under the Order of Determination Rules, another Plan determines its benefits first. The above reduction is described in the Effect on the Benefits section of this Evergreen Health Plan Agreement.

B. Definitions

For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions sections of this Agreement.

1. **Allowable Expenses** means any health care expense, including deductibles, coinsurance or copayments that are covered in whole or in part by any of the Plans covering the Member. This means that any expense or portion of an expense that is not covered by any Plan is not an Allowable Expense. If Evergreen Health is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible as set forth in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

2. **Evergreen Health Plan** means this Agreement.

3. **Intensive Care Policy** means a health insurance policy that provides benefits only when treatment is received in that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

4. **Plan** *as used in this section* means any health insurance policy, including a) group and non-group insurance contracts and subscriber contracts; b) uninsured arrangements of group or group-type coverage; c) group and non-group coverage through close panel plans; d) group-type contracts; e) the medical care components of long-term care contracts, such as skilled nursing care; f) Medicare or other governmental benefits, as permitted by law. This does not include a State Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time) or a Medicare supplement plan.

5. The term Plan does not include:

    a. Hospital indemnity coverage benefits or other fixed indemnity coverage;

    b. Accident only coverage;

    c. An individually underwritten and issued, guaranteed renewable, specified disease policy, or intensive care policy, which does not provide benefits on an expense incurred basis;

    d. Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

    e. Benefits payable under an automobile policy; and

    f. Specified accident coverage;

    g. School-accident type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a ‘to and from school’ basis;

    h. Medicare supplement policies; and

    i. Coverage under a governmental Plan, which, by law, provides benefits that are in excess of those of any private insurance Plan or other non- governmental Plan, or coverage required or provided by law.

6. **Primary Plan or Secondary Plan** means the order of benefit determination rules state whether this Evergreen Health Plan is a Primary Plan or Secondary Plan as to another Plan covering the

Member.

a. When this Evergreen Health Plan is a Primary Plan, its benefits are determined as if the secondary plan or plans did not exist.
b. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid by the primary plan.
c. When this Evergreen Health Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

d. When there are more than two Plans covering the Member, this Evergreen Health Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

7. **Specified Disease Policy** means a health insurance policy that provides (1) benefits only for a disease or diseases specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

C. **Order of Determination Rules**

1. **General**

a. When there is a basis for a claim under this Evergreen Health Plan and another Plan, this Evergreen Health Plan is a Secondary Plan which has its benefits determined after those of the other Plan; unless:

i The other Plan has rules coordinating benefits with those of this Evergreen Health Plan; and

ii Both those rules and this Evergreen Health Plan's rules require that this Evergreen Health Plan's benefits be determined before those of the other Plan.

2. **Rules**
This Evergreen Health Plan determines its order of benefits using the first of the following rules which applies:

a. Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent;

except that if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

i Secondary to the Plan covering the person as a dependent, and

ii Primary to the Plan covering the person as other than a dependent (e.g. retired employee).

Then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

b. Dependent child covered by more than one Plan. Unless there is a court decree stating otherwise, when this Evergreen Health Plan and another Plan cover the same child as a dependent, the order of benefits shall be determined as follows:

i For a dependent child whose parents are married or are living together:

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

(b) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

ii For a dependent child whose parents are separated, divorced, or not living together:

(a) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan.

(b) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of C.2.b.i. of this Section determine the order of benefits.

(c) If a court decree states that the parents have joint custody without specifying that one parent

has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of C.2.b.i. of this Section determine the order of benefits.

(d) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

(e) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(i) The Plan of the parent with custody of the child;

I. The Plan of the spouse of the parent with the custody of the child;

II. The Plan of the parent not having custody of the child; and then

III. The Plan of the spouse of the parent who does not have custody of the child.

iii For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules set forth in 1) and 2) of this paragraph as if those individuals were parents of the child.

iv For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule under C.2.g. of this Section applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule under C.2.b.i. of this Section to the dependent child's parents and the dependent's spouse.

c. Active Employee or Retired or Laid-Off Employee. The Plan which covers a person as an active employee who is neither laid off nor retired is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

d. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is

ignored.

e. Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to Federal or State law also is covered under another Plan, the following shall be the order of benefits determination:
   i First, the benefits of a Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent);
   ii Second, the benefits under the continuation coverage.

f. If the other Plan does not have the rule described above, and if, as a result, the Plan does not agree on the order of benefits, this rule is ignored.

g. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered a person longer are determined before those of the Plan that covered that person for the shorter term.
   i To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended.
   ii The start of a new plan does not include:
      (a) A change in the amount or scope of a plan's benefits;
      (b) A change in the entity that pays, provides or administers the plan's benefits; or
      (c) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
   iii The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

h. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

D. **Effect on the Benefits of this Evergreen Health Plan**

1. **When this Section Applies** This section applies when, in accordance with the prior section, Order of Determination Rules, this Evergreen Health Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this Evergreen Health Plan may be reduced under this section. Such other Plans are referred to as "the other Plans" immediately below.

2. **Reduction in this Evergreen Health Plan's Benefits** When this Evergreen Health Plan is the Secondary Plan, the benefits under this Evergreen Health Plan *may* be reduced so that the total benefits that would be payable or provided by all the other Plans do not exceed 100% of the total Allowable Expenses. If the benefits of this Evergreen Health Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Evergreen Health Plan.

3. **Right to Receive and Release Needed Information** Certain facts are needed to apply these COB rules. Evergreen Health has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. Evergreen Health need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Evergreen Health Plan must give Evergreen Health any facts it needs to pay the claim.

4. **Facility of Payment** A payment made under another Plan may include an amount that should have been paid under this Evergreen Health Plan. If it does, this Evergreen Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Evergreen Health Plan. This Evergreen Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

5. **Right of Recovery** If the amount of the payments made by this Evergreen Health Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

   a. The persons it has paid or for whom it has paid.

   b. Insurance companies; or

   c. Other organizations.

   The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

5.2 Medicare Eligibility

A. This provision applies to Members covered under Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of 65 or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in the Evidence of Coverage. Benefits that are

covered by Medicare are subject to the provisions in this section.

B. Coverage Secondary to Medicare

1. Except where prohibited by law, the benefits under this Evergreen Health Plan are secondary to Medicare.

C. Medicare as Primary

1. When benefits for Covered Services are paid by Medicare as primary, this Plan will calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under this Plan that is unpaid by Medicare. This Plan may reduce its payment by the amount so that, when combined with the amount paid by Medicare, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, Evergreen Health shall credit to its plan deductible any amounts that it would have credited to its deductible in the absence of other health care coverage.

D. Benefits under this Evergreen Health Plan will be coordinated as described above to the extent a benefit would have been provided or payable under Medicare if the Member had diligently sought to establish his or her right to such benefits. Members shall agree to complete and submit to Medicare, Evergreen Health Cooperative and/or providers all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

5.3 **Employer or Governmental Benefits.** Coverage under this Agreement does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit [as defined below] is provided or is required to be provided either:

A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or

B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

5.4 **Subrogation** Evergreen has subrogation and reimbursement rights. Subrogation requires the Member to turn over to Evergreen any rights the Member may have against a third party. A third party is any person, corporation, insurer or other

entity that may be liable to a Member for an injury or illness. This right applies to the amount of benefits paid by Evergreen for injuries or illnesses where a third party could be liable. Evergreen Health benefits are not secondary to benefits payable under an automobile policy.

Recovery means to be successful in a lawsuit; to collect or obtain an amount; to obtain a favorable or final judgment; to obtain an amount in any legal manner; an amount fully collected or the amount of judgment as a result of an action brought against a third-party or involving uninsured or underinsured motorist claims. A Recovery does not include payments made for medical expenses of a Subscriber or Member unless the Subscriber or Member recovers for medical expenses in a cause of action.

A. The Member shall notify Evergreen as soon as reasonably possible that a third-party may be liable for the injuries or illnesses for which benefits are being provided or paid.

B. To the extent that actual payments made by Evergreen result from the occurrence that gave rise to the cause of action, Evergreen shall be subrogated and succeed to any right of recovery of the Member against any person or organization.

C. The Member shall pay Evergreen the amount recovered by suit, settlement, or otherwise from any third-party's insurer, any uninsured or underinsured motorist coverage, or as permitted by law, to the extent that any actual payments made by Evergreen result from the occurrence that gave rise to the cause of action.

D. The Member shall furnish information and assistance, and execute papers that Evergreen may require to facilitate enforcement of these rights. The Member shall not commit any action prejudicing the rights of interests of Evergreen.

E. In a subrogation claim arising out of a claim for personal injury, the amount recovered by Evergreen may be reduced by:

    1. Dividing the total amount of the personal injury recovery into the total amount of the attorney's fees incurred by the injured person for services rendered in connection with the injured person's claim; and

    2. Multiplying the result by the amount of Evergreen's subrogation claim. This percentage may not exceed one-third (1/3) of Evergreen's subrogation claim.

    3. Evergreen may not recover any payment made to a Member under the personal injury protection coverage of a motor vehicle liability insurance policy.

F. On written request by Evergreen, a Member or Member's attorney who

demands a reduction of the subrogation claim shall provide Evergreen with a certification by the Member that states the amount of the attorney's fees incurred.

SECTION 6
GENERAL PROVISIONS

6.1 **No Assignment.** A Member cannot assign any benefits or payments due under this Agreement to any person, corporation or other organization, except as specifically provided by this Agreement or as required by law.

6.2 **Payment of Claims.** Payments for Covered Services will be made by the Plan directly to Network Providers and Emergency Services and Ambulance Out-of-Network Service Providers and are accepted as payment in full, except for any Member payment amounts stated in the Schedule of Benefits. The Member is responsible for any applicable Deductible, Copayment and Coinsurance stated in the Schedule of Benefits, and the Network Provider or Out-of-Network Ambulance Service Provider may bill the Member directly for such amounts.

When a Dependent child is the subject of a Medical Child Support Order or a QMSO and the parent who is not the Subscriber incurs covered expenses on the child's behalf, the Plan reserves the right to make payment for these covered expenses to the non-Subscriber parent, the provider, or the Maryland Department of Health and Mental Hygiene. The payment will, in either case, constitute full and complete satisfaction under the Agreement.

6.3 **Provider and Services Information.** Current listings of Network Providers will be made available to potential Subscribers at the time of enrollment. Updated listings are available to Subscribers or Members at any time upon request. Members regularly receive information regarding how services and benefits may be obtained in Member Handbooks and Member newsletters. This and other Member information is available at any time upon request.

6.4 **Events Outside the Plan's Control.** If the Plan, for any reason beyond its control is unable to provide the health care services promised in the Agreement, the Plan is liable for reimbursement of the expenses necessarily incurred by any Member in procuring the services through other providers, to the extent prescribed by the Insurance Commissioner of Maryland.

6.5 **Selection of Primary Care Provider.**

A. It is the Member's responsibility to select a Primary Care Provider from the Plan's current list of Network Providers when electing coverage with Evergreen Health. If the Primary Care Provider is not available, the Plan will assist the Member in making another selection. If the Member does not make a selection within 10 days of the effective date, the Plan will select a Primary Care Provider for the member. Once the Primary Care Provider has been designated, Primary Care services must be obtained from that Primary Care Provider in order to be covered. If you fail to use the selected Primary Care Provider for Primary Care services, claims will not be paid other than for Preventive Care, and medically necessary~~,~~ obstetric and gynecological care.

B. Members may change Primary Care Provider by notifying the Plan. If the Plan receives the request by the 20th day of the month, the change will be made effective on the first day of the following month. If the request is received after the 20th day of the month, the change will be made effective on the first day of the second month following notice.

C. The Plan may require a Member to change to a different Primary Care Provider if the Member's Primary Care Provider is no longer available as a Primary Care Provider under the coverage provided by the Agreement.

D. The Plan may require a Member to change to a different Primary Care Provider if the Plan determines that the furnishing of adequate medical care is jeopardized by a seriously impaired physician-patient relationship between the Member and his or her Primary Care Provider due to any of the following:

1. The Member refused to follow a treatment procedure recommended by his or her Primary Care Provider and the Primary Care Provider believes that no professionally acceptable alternative exists;
2. The Member engages in threatening or abusive behavior toward the physician, the physician's staff or other patients in the office; or
3. The Member attempts to take unauthorized controlled substances from the physician's office or to obtain these substances through fraud, misrepresentation, forgery or by altering the physician's prescription order.

E. If a change in Primary Care Providers is required under Section 6.5.C., the action is effective upon written notice to the Member. However, if the Primary Care Provider was terminated by the Plan for any reasons unrelated to fraud, patient abuse, incompetency, or loss of license, the Member may, upon request to the Plan, continue to use the Primary Care Provider that was terminated for up to 90 days beyond the date of the Plan's notice to the Member. However, the Member may request a review of the action under the Plan's appeals and grievance process.

6.6 **Member Medical Records.** It may be necessary to obtain Member medical records and information from hospitals, skilled nursing facilities, physicians or other providers who treat the Member. When a Member becomes covered under the Agreement, the Member (or, if the Member is legally incapable of giving such consent, the representative of such Member) automatically gives the Plan permission to obtain and use such records and information, including without limitation medical records and information requested to assist the Plan in determining benefits and eligibility of Members.

6.7 **Member Privacy.** The Plan shall comply with State, Federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable medical or health related data. In that regard, the Plan will not provide to the Subscriber or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.

6.8 **Relationship of the Plan to Network Providers.** Network Providers are independent individuals or organizations and are related to the Plan by contract only. Network Providers are not employees or agents of the Plan and are not authorized to act on behalf of or obligate the Plan with regard to interpretation of the terms of the Agreement, including eligibility of Members for coverage or entitlement to benefits, except that services rendered by a Network Provider, preauthorized by a Network Provider or obtained pursuant to a referral by Network Provider are considered Covered Services under the plan. Network Providers maintain a physician-patient relationship with the Member and are solely responsible for the professional services they provide. The Plan is not responsible for any acts or omissions, including those involving malpractice or wrongful death, by Network Providers or any other individual, facility or institution that provides services to Members or any employee, agent or representative of such providers.

6.9 **Legal Actions.** Any lawsuit by a Member against the Plan may not be brought to recover on the Agreement before the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Agreement; or after the expiration of three years after the written proof of loss is required to be furnished.

6.10 **Acceptance of Agreement.** The Agreement is deemed to have been accepted by the Subscriber upon the Subscriber's making payment to the Plan pursuant to Section 3 hereof and by the Plan upon issuance to the Subscriber of the Agreement. Such payment and issuance renders all terms and provisions hereof binding on the Plan and the Subscriber.

6.11 **Administration of Agreement.** The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Agreement. The Plan may delegate functions it is obligated to perform under this Agreement or applicable law to an entity designated by the Plan to perform such functions, including any administrative services or utilization review services; provided, however, that the Plan shall remain responsible to the Subscriber for compliance with the terms of this Agreement.

6.12 **Amendment Procedure.** The Plan may amend the Agreement with respect to any changes required or permitted by law or to change premiums on or after the first anniversary of the effective date of the Agreement or after twelve (12) months of continuous Subscriber coverage. Notwithstanding, premiums shall be fixed for the entire benefit year. For renewals or uniform modifications of coverage, even if the modifications are required to conform the Agreement to changes in applicable state or federal law, the Plan will provide notice of renewal to the Member before the date of the first day of the next annual open enrollment period. For material modifications in any terms of the Plan Agreement or coverage that would affect the content of the summary of benefits and coverage, that is not reflected in the most recently provided summary of benefits and coverage, and that occurs not in connection with renewal or reissuance of coverage, the Plan will provide notice of the modification to Members not later than 60 days prior to the date on which the modification will become effective.

No agent or other person, except an officer of the Plan, has authority to waive any conditions or restrictions of the Agreement, or to extend the time for making payments hereunder, or to bind the Plan by making any promise or representation or by giving or receiving any information. No change in the Agreement will be binding on the Plan, unless evidenced by an amendment signed by an authorized representative of the Plan.

6.13 **Rights to Vest in Guarantor.** In the event of insolvency, the Plan's rights under the Agreement (including, but not limited to, all rights to premiums to the extent permitted by applicable bankruptcy law) shall become vested in any person or entity which guarantees payment and actually pays for the services and benefits which the Plan is obligated to make available under the Agreement.

6.14 **Rules for Determining Dates and Times.** The following rules will be used when determining dates and times under this Agreement:

A. All dates and times of day will be based on the dates and times applicable to Eastern Standard Time or Eastern Daylight Savings Time, as applicable.

B. When reference is made to coverage being effective on a particular date, this means 12:00 A.M. on that date.

C. When reference is made to termination being effective on a particular date, this means 11:59:59 P.M on that date.

D. "Days" means calendar days, including weekends, holidays, etc.

E. "Year" refers to calendar year

6.15 **Notices**

A. **To the Member.** Notice to Members will be sent by first class mail to the most recent address for the Member in the Plan's files or, if consent has been given, by e-mail to the Member's last known e-mail address. It is the Member's responsibility to notify Evergreen Health of an address or e-mail address change. The notice will be effective on the date mailed or sent by e-mail, whether or not the Member in fact receives the notice or there is a delay in receiving the notice.

B. **To the Plan.** When notice or payment is sent to the Plan, it must be sent by first class mail to:

Evergreen Health Cooperative Inc.
3000 Falls Road, Suite 1
Baltimore, Maryland 21211
Attn: President

Notice will be effective on the date of receipt by the Plan, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service. The Plan may change the address at which notice is to be given by giving written notice thereof to the Subscriber.

6.16 **Right to Examine.** The Plan has the right to examine a Member when and as often as it may reasonably require during the pendency of a claim under the Agreement. Any physical examination required by the Plan will be performed at the expense of the Plan.

6.17 **Misstatement of Age.** If the age of the oldest Member is misstated, an equitable adjustment to the premium or benefits, or both, will be made. Coverage will continue in effect until the end of the period for which the Health Plan has accepted the premium if this Agreement establishes, as an age limit or otherwise, a date after which the coverage will not be effective and: a) the date falls within a period for which the Health Plan accepts premium; or b) the Health Plan accepts premium for the contract after the date after which coverage provided by this Agreement shall not be effective

6.18 **Incontestability.** This Agreement may not be contested, except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue. A statement made by a Member relating to insurability may not be used in contesting the validity of the coverage with respect to which the statement was made after coverage has been in force for two (2) years. Absent fraud, each statement made by an applicant, Subscriber, or a Member is considered to be a representation and not a warranty. A statement made to effectuate coverage may not be used to avoid the coverage or reduce benefits under the contract unless the statement is contained in a written instrument signed by the Subscriber or Member, and a copy of the statement is given to the Subscriber or Member.

6.19 **Notice of Claim.**

A. **Requesting a Claims Form.** A Member may request a claim form by writing or calling the Plan. The Plan upon receipt of a notice of claim and request for claims forms will send the Member claim forms. When a Dependent child subject to a Medical Child Support Order or a Qualified Medical Support Order does not reside with the Subscriber, the Plan will:

1. Send the non-insuring, custodial parent ID cards, claims forms, the applicable certificate of coverage or member contract and any information needed to obtain benefits;

2. Allow the non-insuring, custodial parent or a provider of a Covered Service to submit a claim without the approval of the Subscriber;

3. Provide benefits directly to:

   a. The non-insuring, custodial parent;

   b. The provider of the Covered Services; or

   c. The appropriate child support enforcement agency of any state or the District of Columbia.

B. **Claims Forms.** The Plan does not require a written notice of a claim. The Plan, upon receipt of a notice of a claim, will send the Member claims forms. If claim forms are not sent within fifteen (15) days after the Member gives the Plan notice of a claim, the Member shall be considered to have complied with the requirements of this Agreement as to proof of loss, if the Member submits, within the time stated in the Agreement for filing proof of loss, written proof of the occurrence, character, and the extent of the loss for which claim is made. Benefits under this Agreement will be paid within 30 days after receipt of a written proof of loss.

C. **Claim Payments Made in Error.** If the Plan makes a claim payment to or on behalf of a Member in error, the Member is required to repay the Plan the amount that was paid in error. If the Member has not repaid the full amount owed the Plan and the Plan makes a subsequent benefit payment, the Plan may subtract the amount owed the Plan from the subsequent payment.

6.20 **Proof of Loss.** Written proof of loss shall be furnished to the Plan at its office within ninety (90) days following the date of service. Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

6.21 **Identification Card.** Any cards issued under this Agreement are for identification only. Possession of an identification card confers no right to benefits under this Agreement. To be entitled to such benefits the holder of the card must, in fact, be a Member on whose behalf all applicable premiums under this Agreement have actually been paid. Any person receiving benefits to which he or she is not then titled under the provisions of this Agreement will be liable for the actual cost of such benefits.

6.22 **Entire Contract.** The entire contract between the Subscriber and the Plan consists of this Agreement, any application for coverage, and all attachments to this Agreement; and any riders, endorsements, and amendments attached to this Agreement. No amendment or modification of any term or provision is valid until approved by an officer of the Plan and unless the approval is endorsed and attached to this Agreement. No other person has authority to change this Agreement or waive any of its provisions.

Oral statements cannot be relied upon to modify this Agreement or otherwise affect the benefits, limitations, and/or exclusions of this Agreement, or increase or void any coverage or reduce any benefits under this Agreement. Such oral statements cannot be used in the prosecution or defense of a claim under this Agreement.

6.23 **Complaints about Evergreen Health.** Members may complain to the Maryland Insurance Administration about the operation of Evergreen Health Cooperative

Inc. Such complaints would include matters other than coverage decisions or adverse decisions as described in Appeal and Grievance Procedures. To complain about the operation of Evergreen Health, Members should contact:

[Maryland Insurance Administration
Life and Health Complaints
200 St. Paul Place, Suite 2700
Baltimore MD 21202
Toll Free: 1-800-492-6116
Fax: 410-468-2260
Website: http://www.mdinsurance.state.md.us]

Evergreen Health Cooperative Inc.

3000 Falls Road, Suite 1
Baltimore, MD 21211
443-475-0990

EVERGREEN HEALTH HMO – INDIVIDUAL PLAN AGREEMENT
DESCRIPTION OF COVERED SERVICES

The Description of Covered Services section of your Individual Plan Agreement describes the services eligible for benefits and any specific limits on the number of services that will be covered. It is important to refer to the Schedule of Benefits to determine the payments the Plan will make and the charges for which the Member will be responsible.

Evergreen Health Cooperative Inc.

_____
[Name]
[Title]

SECTION 1
GENERAL PROVISIONS

1.1 **Benefits Overview.** The services described here are eligible for coverage under your health plan. Evergreen Health will provide benefits described here for your Medically Necessary Covered Services. The Schedule of Benefits lists your Deductibles, Out-of-Pocket Maximum and Copayments and Coinsurance amounts for certain Covered Services. It is important to refer to the Schedule of Benefits to determine your cost-share and to this Description of Covered Services for any limitations.

Benefits apply when Covered Services are provided by the Member's Primary Care Provider or obtained from other Network or non-Network Providers with a referral from the Primary Care Provider, and prior authorization when necessary. Except for Emergency Services or Out-of-Area Urgent Care, obstetric and gynecological care visits or for a referral to a Specialist or Non-physician Specialist who is not a Network Provider, services must be provided or arranged by your Primary Care Provider and obtained from a Network Provider. Benefit payments are based on the Allowed Benefit as determined by the Plan for various types of services and providers.

1.2 **Care Which is Provided by Network Providers.** Members receive benefits for Covered Services when care is provided or arranged by the Member's Primary Care Provider except in the case of OB/GYN visits, as specified in this Description of Covered Services.

A pregnant Member shall receive a standing referral to an obstetrician. After the Member who is pregnant receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with the Plan's policies and procedures, through the postpartum period. A written treatment plan is not required.

When benefits apply, Members receive full coverage for Covered Services, except for Member Copayment and Coinsurance (see Schedule of Benefits). Member cost share will differ for certain Network Providers, such as Primary Care Providers, Laboratory and Radiology providers, depending upon whether the Member chooses to receive care from a Tier 1 or Tier 2 Network Provider.

1.3 **Care Which is Provided by Out-of-Network Providers.** Except for Emergency Services or 'out-of-area' Urgent Care, benefits for services provided by Out-of-Network Providers will not be covered by Evergreen Health, unless prior written or verbal authorization is specifically given to the Member by Evergreen Health's Health Care Management Department or other approval by the Plan or by a Network Provider to obtain specified services from such physician or provider. This provision does not apply to referral to a Specialist or Non-physician Specialist as specified immediately below.

1.4 **Direct Access of Obstetric and Gynecological Care.** A female Member may receive Medically Necessary, routine and non-routine obstetric and gynecological care from a certified nurse midwife or any other Network Provider authorized under the Health Occupations Article to provide obstetric and gynecological services without a visit to the Primary Care Provider first. This care includes the ordering of related obstetric and gynecological items and services. The Network Provider shall consult with an obstetrician/ gynecologist with whom the Network Provider has a collaborative agreement, in accordance with the collaborative agreement, regarding any care rendered. When benefits apply, Members receive full coverage for Covered Services, except for the Deductible, Copayments and Coinsurance (see Schedule of Benefits).

1.5 **Standing Referral to a Specialist.**

A. A Member may receive a standing referral to a Specialist who is a Network Provider if all the following are met:

1. The Primary Care Provider of the Member determines, in consultation with the Specialist, that the Member needs continuing care from the Specialist;

2. The Member has a condition or disease that:

a. Is life threatening, degenerative, chronic, or disabling; and

b. Requires specialized medical care.

3. The Specialist:

a. Has expertise in treating the life-threatening, degenerative, chronic, or disabling disease or condition; and

b. Is a Network Provider.

4. A standing referral shall be made in accordance with a written treatment plan for a Covered Service developed by:

a. The Primary Care Provider;

b. The Specialist; and

c. The Member.

B. A treatment plan may:

1. Limit the number of visits to the Specialist;

2. Limit the period of time in which visits to the Specialist are authorized; and

3. Require the Specialist to communicate regularly with the Primary

Care Provider regarding the treatment and health status of the Member.

C. The Member is not required to see a physician other than the Primary Care Provider in order to obtain a standing referral.

1.6 **Referral to a Specialist or Non-physician Specialist Who is Not a Network Provider Under Certain Conditions.**

A. A Member may request a referral to a Specialist or Non-physician Specialist who is not a Network Provider if:

1. The Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and

a. Evergreen Health does not contract with a Specialist or Non-physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or

b. Evergreen Health cannot provide reasonable access to a Specialist or Non-physician with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

B. For the purposes of calculating the Copayment or Coinsurance amount payable by the Member, Evergreen Health will treat the services received by the Out-of-Network Provider Specialist or Non-physician Specialist as if the services were rendered by a Network Provider.

C. A decision by Evergreen Health not to provide access to or coverage of treatment by a Specialist or Non-physician Specialist in accordance with this Section constitutes an adverse decision as defined in the Plan's appeals and grievance process if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

1.7 **Direct Access to Network Providers for Services Related to Cancer.** Benefits under the Plan will be provided for Covered Services that are directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an oncologist, chemotherapy, and radiation therapy by Network Providers. A referral by a Member's Primary Care Physician shall be required only for an initial visit to an oncologist. Benefits are subject to review and approval under Utilization Management requirements established by the Plan.

1.8 **Utilization Management.** The utilization management ("UM") process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include prior authorization, second opinion, notification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Evergreen Health requires prior authorization for certain Covered Services. Network Providers are responsible for obtaining prior authorization before they provide these services to you.

Before receiving these services from a Network Provider, you may want to contact us to verify that the Hospital, Health Care Practitioner and other Health Care Practitioners are Network Providers and that they have obtained the required prior authorization. Network Providers cannot bill you for services they fail to prior authorize as required.

Prior Authorization for Certain Services

If the Member requires any of the following services, Evergreen Health must be contacted by the provider for prior authorization at least (5) business days prior to the anticipated date upon which the elective admission, treatment or service will be rendered:

A. Acute rehabilitation and Long-Term Acute Hospitals. Long-Term Acute Hospitals provider 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);

B. Home Health Services by HHA (PT/OT/ST/RN);

C. Diagnostic Imaging (PET scans, MRAs, MRIs);

D. Interventional Radiology;

E. Nuclear Cardiology;

F. Intensity Modulated Radiation Therapy (IMRT);

G. Inpatient hospice, sub-acute and skilled nursing facility;

H. 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.

I. Hospital outpatient observation greater than twenty-four (24) hours;

J. Chiropractic services;

K. Infertility services;

L. Genetic testing during pregnancy and for pediatric members and adults;

M. Rehabilitative services: physical, occupational, speech therapy and cardiac and pulmonary rehabilitation;

N. Podiatry;

O. Prosthetics;

P. Home Infusion Services;

Q. Home Hospice;

R. Partial hospitalization for mental health services;

S. Intensive Outpatient (IOP) services;

T. Residential services for substance abuse;

U. Durable Medical Equipment;

1. Durable Medical Equipment is generally on a rent to own basis. Not all DME requires prior authorization. Providers need to call the Provider Services 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:

a. All rental equipment;

b. Apnea monitors – rent only;

c. Electric or custom wheelchairs and scooters;

d. CPAP;

e. BIPAP – rental only;

f. Bone Growth Stimulators – rental only;

g. High frequency chest compression devices and vests;

h. Air fluidized and specialty beds – rental only;

i. Would vac pumps – rental only;

j. Diabetic insulin pumps;

k. Augmentative communicator/speech generator device;

l. Pediatric feeding chairs or equipment;

m. Hearing aids for pediatric members (limited to 1 per ear every 3 years);

n. Cochlear implants and supplies;

o. Any equipment that does not have a defined CPT code (i.e. E1399)

2. 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.

V. Transplants (see Section 2.28, Organ Transplants, under Covered Services for more details);

W. Hospital Inpatient Services (see Section 2.19, Hospital Inpatient Stay, under Covered Services for more details);

X. Inpatient Mental Health and Substance Abuse Services (see Section 2.24, Mental Health and Substance Abuse Services, under Covered Services for more details);

Y. Admission to a Related Institution.

Evergreen Health reserves the right to make changes to the categories of services

that are subject to Utilization Management requirements or to the procedures the Member and/or the providers must follow. Evergreen Health will notify the Member of these changes at least forty-five (45) days in advance.

Appealing a Utilization Management Decision. If you, your representative or your provider disagrees with a Utilization Management decision, Evergreen Health will review the decision upon the request. A Utilization Management appeal will be reviewed and decided upon by the Evergreen Health Medical Director or Associate Medical Director not involved in the initial denial decision. If necessary, the Medical Director or Associate Medical Director will discuss the case with your physician and/or request the opinion of a board certified specialist in the same specialty as the treatment under review. Any non-certification or penalty may be appealed pursuant to Evergreen Health's appeals and grievance procedures.

Evergreen Health, and its delegates, apply criteria that are nationally recognized and approved by internal and provider committees. These criteria are applied in an objective, transparent and consistent fashion in order to evaluate that services are:

A. in accordance with generally accepted standards of medical practice;

B. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;

C. not primarily for the convenience of a patient or health care provider; and

D. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury or disease.

Evergreen Health also affirms the following:

E. UM decision making is based only on appropriateness of care and service and existence of coverage.

F. The organization does not specifically reward Health Care Practitioners or other individuals for issuing denials of coverage.

G. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

1.9 **Case Management.** When your Network Provider seeks prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as:

A. Assessment of individual/family needs related to the understanding of health status and physician treatment plans, self-care, compliance capability, and continuum of care;

B. Education of individual/family regarding disease, treatment compliance,

and self-care techniques;

C. Help with organization of care, including arranging for needed services and supplies;

D. Assistance in arranging for a principal or Primary Care Provider to deliver and coordinate the Member's care, and/or consultation with physician specialists; and

E. Referral of Member to community resources.

1.10 **Members Transitioning to Evergreen Health from the Maryland Medical Assistance Program or Other Relinquishing Carrier**

A. With respect to any benefit or service provided through the Maryland Medical Assistance fee-for-service Program, this subsection shall apply:

1. only to enrollees transitioning from the Maryland Medical Assistance Program to Evergreen Health; and

2. only to behavioral health and dental benefits, to the extent they are authorized by a third-party administrator.

B. At the request of a Member or the Member's parent, guardian, designee or health provider, Evergreen Health will accept a preauthorization from a relinquishing carrier, managed care organization, or third-party administrator for:

1. the procedures, treatments, medications, or services covered by the benefits offered by the receiving carrier or managed care organization; and ,

2. the following time periods:

a. the lesser of the course of treatment or 90 days; and

b. the duration of the three trimesters of a pregnancy and the initial postpartum visit.

C. After the time periods under paragraph B, above, have lapsed, Evergreen Health may elect to perform its own utilization review in order to:

1. reassess and make its own determination regarding the need for continued treatment; and

2. authorize any continued procedure, treatment, medication, or service determined to be medically necessary.

1.11 **Members Transitioning to Evergreen Health from Other Health Plans (including Maryland Medical Assistance Program)**

A. Subject to paragraphs B.1 through B.4 of this subsection, at the request of a Member or a Member's parent, guardian, designee, or health care provider, Evergreen Health shall allow a new Member to continue to receive health care services being rendered by a nonparticipating provider at the time of the Member's transition to Evergreen Health.

B. The services a Member shall be allowed to continue to receive are services for:

1. the following conditions:

a. acute conditions;

b. serious chronic conditions;

c. pregnancy; and

d. mental health conditions and substance abuse disorders; and

2. any other condition on which the nonparticipating provider and Evergreen Health reach agreement.

3. Examples of conditions set forth in subparagraphs 1a and 1b above may include:

a. bone fractures;

b. joint replacements;

c. heart attacks;

d. cancer;

e. HIV/AIDS; and

f. organ transplants.

4. An enrollee shall be allowed to continue to receive services for the conditions under this paragraph for the time periods under subsection B.2. of Section 1.10.

SECTION 2
COVERED SERVICES

Benefits will be provided for the services and supplies described in this Section. Coverage is subject to all terms of this Plan Agreement, including Section 3, Exclusions and, where applicable, the Utilization Management and other requirements described in Section 1.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Service, you will be responsible for paying all charges and no benefits will be paid.

2.1 **Emergency Ambulance Services.** Medically Necessary hospital to hospital transfers and emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to or from the nearest hospital where Emergency Services can be provided.

2.2 **Non-Emergency Ambulance Services.** Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance), as determined to be medically appropriate, between facilities when the transport is any of the following:

A. From an Out-of-Network Provider hospital to a Network Provider hospital.

B. To a hospital that provides a higher level of care that was not available at the original hospital.

C. To a more cost-effective acute care facility.

D. From an acute facility to a sub-acute setting.

2.3 **Blood and Blood Products.**

A. Cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums, including: autologous services; whole blood; red blood cells; platelets; plasma; immunoglobulin; and albumin.

2.4 **Case Management Program**

A. Any other service approved by the Plan under case management program.

2.5 **Chiropractic Manipulation Services**

A. Benefits shall be provided for Medically Necessary chiropractic manipulation when provided by a licensed chiropractor, doctor of osteopathy (D.O.) or other eligible Health Care Practitioner.

B. Chiropractic manipulation services are limited to 20 visits per condition per Benefit Year.

2.6 **Clinical Trials**

A. Benefits will be provided for Routine Patient Costs incurred during participation in Approved Clinical Trials by Qualified Individuals provided or arranged by a Health Care Practitioner for prevention, early detection and treatment studies on cancer or treatment of other Life-Threatening Conditions.

B. **Approved Clinical Trial** is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition; and the clinical trial is approved or funded by:

1. The National Institutes of Health (NIH).

2. The Centers for Disease Control and Prevention.

3. The Agency for Health Care Research and Quality.

4. The Centers for Medicare & Medicaid Services.

5. A cooperative group or center of any of the entities listed immediately above or the Department of Defense or the Department of Veterans Affairs.

6. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.

7. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy but only if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (i) to be comparable to the system of peer review of studies and investigations used by the NIH, and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

8. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).

9. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

C. **Life-Threatening Condition** means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

D. **Qualified Individual** means a Member who meets the following conditions:

1. The Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or

other Life-Threatening Condition; and

2. Either: (i) the referring Health Care Practitioner is a participating health care provider and has concluded that the Member's participation in such trial would be appropriate based upon the Member the conditions for participation; or (ii) the Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate based upon the individual meeting the conditions for participation in the trial.

E. **Routine Patient Costs** means all items and services consistent with the coverage provided under the Plan Agreement that is typically covered for a Member who is not enrolled in a clinical trial. Routine Patient Costs, however, does not include:

1. The investigational item, device, or service, itself;

2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

F. Covered Services may not be limited to those provided by a Network Provider for. Routine patient costs for clinical trials occurring outside the Service Area or from a non-Network Provider must still meet all the aforementioned requirements of 2.6, in order for the benefit to be a Covered Service.

2.7 **Dental Anesthesia (Pediatric) - Hospital and Outpatient Health Services Related to Dental Care**

A. General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to a Member:

1. Seven (7) years of age or younger or is developmentally disabled: a) for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member, and b) for whom a superior result can be expected from dental care provided under general anesthesia; or

2. Seventeen (17) years of age or younger: a) who is extremely uncooperative, fearful, or uncommunicative; b) who has dental needs of such magnitude that treatment should not be delayed or deferred; and c) for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

B. Coverage for general anesthesia and associated hospital or ambulatory facility care is restricted to dental care that is provided by a: (a) fully accredited specialist in pediatric dentistry; (b) fully accredited specialist in oral and maxillofacial surgery; and (c) dentist to whom hospital privileges have been granted.

C. Benefits will not be provided for dental care for which general anesthesia is required.

2.8 **Pediatric Dental**

A. Pediatric dental benefits for children up to age nineteen (19) years old as follows:

1. Class I Services – Diagnostic & Preventive

a. Oral Exams and periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry

b. Prophylaxis

c. Fluoride

d. X-Rays

e. Restorations, including fillings

f. Lab and other tests

g. Sealants for children

h. Limitations are as follows for Class I Services:

i Oral exams, prophylaxis and topical application of fluoride are limited to two times per Plan Year for each service per Member.

ii Topical fluoride varnish is limited to eight times per twelve months for Members age 0 to 2 years and four times per twelve months for Members age 3 years and older.

iii Sealants are limited to one per lifetime, per Member per tooth.

2. Class II Services – Basic Restorative

a. Emergency (Palliative)

b. Space maintainers

c. Simple extractions

d. Surgical extractions

e. Oral surgery

f. Anesthesia

g. Periodontics

h. Endodontics

3. Class III Services – Major Restorative

a. Inlays/Onlays/Crowns

b. Dentures

c. Bridges

d. Simple repair

e. Other prosthetics

4. Class IV Services – Orthodontia Services

a. Orthodontia. Orthodontia is covered only for children with severe dysfunctional, handicapping malocclusion.

B. Class II, III, and IV services are subject to Medical Necessity review. The cost-share amounts are listed in the Schedule of Benefits.

2.9 **Diabetes Services**

In addition to Medically Necessary Covered Services for treatment of diabetes additional benefits are provided as follows:

A. **Diabetes self-management and training, treatment, equipment and supplies.**

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Health Care Practitioner and provided by appropriately licensed or registered healthcare professionals.

Diabetes self-management training includes training provided to a Member after the initial diagnosis of diabetes and or pregnancy induced elevated blood glucose levels in the care and management of those conditions, including nutritional counseling and proper use of the diabetic self-management items. Benefits are also provided for additional training upon

diagnosis of a significant change in medical condition that requires a change in the self-management regime, and periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Members with diabetes.

B. **Diabetes Equipment and Supplies**

1. Diabetes equipment includes glucose monitoring equipment under the durable medical equipment coverage for Insulin-Using Beneficiaries. Insulin pumps are included if Medically Necessary. Diabetes supplies include coverage for insulin syringes and needles and testing strips for glucose monitoring equipment under the prescription drug coverage for Insulin-Using Beneficiaries.

2. **Insulin Using Beneficiary** means a Member who uses insulin as part of a treatment plan prescribed by his/her medical care provider.

2.10 **Durable Medical Equipment**

A. Durable Medical Equipment , including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses, that meets each of the following criteria:

1. Ordered or provided by a Health Care Practitioner for outpatient use primarily in a home setting.

2. Used for medical purposes.

3. Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.

4. Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Health Care Practitioner.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs.

2.11 **Emergency Services.**

In the event of an emergency, the Member may receive Emergency Services from a Network Provider or an Out-of-Network Provider. Emergency Services are provided at the Network Provider level regardless of where Covered Services are provided.

A. **Emergency Services**

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 an Out-of-Network Provider;

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

3. If the Emergency Services are provided by an Out-of-Network 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 a Network Provider.

B. **Notice and Transfer** The physician or facility will notify the Plan directly prior to or as soon as possible after first receiving Emergency Services, but in any event within 48 hours after the Member is admitted.

C. **Benefits Not Provided** Benefits will not be provided for:

1. Any service that is excluded from coverage under this Agreement.

2. Except as stated in 2.12, routine follow-up treatment is covered if required in connection with a covered out-of-Network Emergency Care episode and the Plan determines that the Member could not reasonably be expected to receive such care from a Network Provider.

2.12 **Follow-up Care after Emergency Surgery.** If the Plan authorizes, directs, refers, or otherwise allows a Member to access a hospital emergency facility for a medical condition that requires emergency surgery:

1. Coverage shall be provided for services provided by the physician, oral surgeon, periodontist, or podiatrist, who performed the surgical procedure, for follow-up care that is:

a. Medically Necessary;

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

c. Provided in consultation with the Member's Primary Care Provider; and

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 Network Provider

for corresponding type of care.

2.13 **Family Planning Services**

Cost-sharing will not be accessed for Family Planning Services which fall under Preventive Care as mentioned in Section 2.35, Preventive Care Services.

Services are covered including prescription contraceptive drugs or devices and coverage for the insertion or removal of contraceptive devices, Medically Necessary examination associated with the use of contraceptive drugs or devices, and voluntary sterilization.

Services are covered for health services and associated expenses for surgical, non-surgical or drug-induced pregnancy termination.

2.14 **Habilitative Services**

A. **Habilitative Services** means services, including occupational therapy, physical therapy, speech therapy, orthodontics, oral surgery, and otologic and audiological therapy for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of habilitative services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect.

B. For Members under age 19, there are no visit limits and includes services for the treatment of congenital and genetic birth defects, including cleft lip and cleft palate.

C. Benefits are not available for Habilitative Services provided in early intervention and school services.

D. Habilitative Services for adults (age 19 and older) are provided for a maximum of:

1. 30 physical therapy visits per condition per year;

2. 30 speech therapy visits per condition per year;

3. 30 occupational therapy visits per condition per year.

2.15 **Hair Prosthesis**

A single hair prosthesis for loss of natural hair resulting from chemotherapy or radiation treatment for cancer when prescribed by the resident oncologist.

2.16 **Hearing Aids for children up to age nineteen (19) years old as follows:**

A. Benefits are provided for hearing aids for children up to age nineteen (19).

B. For purposes of this provision, a "hearing aid" is a device that is of a design and circuitry to optimize audibility and listening skills in the environment

commonly experienced by children and that is nondisposable.

2.17 **Home Health Care**

A. Home Health Care services as follows:

1. as an alternative to otherwise Covered Services in a hospital or related institution; and

2. for Members who receive less than forty-eight [48] hours of inpatient hospitalization following a mastectomy or removal of a testicle or who undergo a mastectomy or removal of a testicle on an outpatient basis:

a. one home visit scheduled to occur within twenty-four [24] hours after discharge from the hospital or outpatient facility; and

b. an additional home visit if prescribed by the Member's attending physician.

B. **Home Health Care** means the continued care and treatment of a Member in the home if:

1. The inpatient admission of the Member in a hospital, related institution, or Skilled Nursing Facility would otherwise have been required if Home Health Care were not provided; and

2. The treating physician develops a plan covering the Home Health Care service which is approved by Evergreen Health.

C. Except for the services required by state law, services received from a Home Health Agency that meets the following requirements:

1. Services received from a Home Health Agency that are both of the following:

a. Ordered by a Health Care Practitioner.

b. Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

2.18 **Hospice Care**

A. Hospice Care as defined in 42 U.S.C. §1395x[dd].

2.19 **Hospital Inpatient Stay**

A. The following Utilization Management requirements must be met to qualify for benefits:

1. **Hospital Inpatient Services.** All elective inpatient hospital admissions (except for maternity and emergency admissions) require prior authorization. The Network Provider must contact Evergreen Health 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 forty-eight (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. Note the following:

    a. 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.

    b. For emergency admissions, Evergreen Health may not render an adverse decision solely because Evergreen 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.

B. Services and supplies provided during a Hospital Inpatient Stay. Benefits are available for:

1. Supplies and non-Health Care Practitioner services received during the Hospital Inpatient Stay.

2. Room and board in a semi-private room (a room with two or more beds).

3. Health Care Practitioner services for radiologists, anesthesiologists, pathologists and emergency room Health Care Practitioners. (Benefits for other Health Care Practitioner services are described under Health Care Practitioner Fees for Surgical and Medical Services.)

4. Hospital admission charges.

C. Benefits include at least 48 hours of inpatient hospitalization following a Member's mastectomy.

1. For the purpose of this benefit, "mastectomy" means the surgical removal of all or part of the breast as a result of breast cancer.

2.20 **Infertility services**, including in vitro fertilization subject to the limitations in this Section.

A. In vitro fertilization is covered only under the following circumstances and if all of the following conditions are satisfied:

1. The patient is a covered Member;

2. The patient's oocytes are fertilized with human viable sperm;

3. The patient and the patient's spouse have a history of infertility of at least 2 years duration, or the infertility is associated with any of the following medical conditions: (i) endometriosis; (ii) exposure in utero to diethylstilbestrol, commonly known as DES; (iii) blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or (iv) abnormal male factors, including oligospermia, contributing to the infertility;

4. The patient has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this Agreement; and

5. The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

B. Limitations on in vitro fertilization benefit:

1. Coverage for in vitro fertilization is limited to three (3) in vitro fertilization attempts per live birth.

2.21 **Laboratory, Radiology/Lab, X-Ray and Diagnostics Services – Outpatient**

A. In order for laboratory and radiology services to be covered, Members are required to have the services performed only by Network Provider laboratory and radiology providers. Services rendered by Network Provider laboratory and radiology providers will be covered even if ordered by Health Care Practitioners who are not Network Providers. The Member's cost share for Laboratory and Radiology Services may vary depending upon whether the Member selects Tier 1 or Tier 2 Network Providers to provide such services.

B. Services for sickness and injury-related diagnostic purposes, received on

an outpatient basis at a hospital or outpatient facility or in a Health Care Practitioner's office include:

1. Lab and radiology/X-ray.

2. Mammography.

3. Bone mass measurement testing for diagnostic and treatment purposes. Bone Mass Measurement means a radiological or radioisotopic procedure or other scientifically proven technology performed on a Qualified Individual of the purpose of identifying bone mass or detecting bone loss.

    a. Qualified Individual means

        i an estrogen deficient individual at clinical risk for osteoporosis;

        ii an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenograhic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;

        iii an individual receiving long-term glucocorticoid (steroid) therapy;

        iv an individual with primary hyperparathyroidism; or

        v an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

C. Health Care Practitioner services for radiologists, anesthesiologists and pathologists. (Benefits for other Health Care Practitioner services are described under Health Care Practitioner Fees for Surgical and Medical Services.)

Laboratory, Radiology and Diagnostic Services for preventive care are described under *Preventive Care Services*. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Imaging Services - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

2.22 **Imaging Services - CT, PET Scans, MRI, MRA and Nuclear Medicine – Outpatient**

A. In order for imaging services (CT/PET scans, MRIs) to be covered, Members are required to have the services performed only by Network Provider imaging providers. Services (CT/PET scans, MRIs) rendered by Network

Provider imaging providers will be covered even if ordered by Health Care Practitioners who are not Network Providers.

B. Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a hospital or outpatient facility or in a Health Care Practitioner's office.

C. Benefits under this section include:

1. The facility charge and the charge for supplies and equipment.

2. Health Care Practitioner services for radiologists, anesthesiologists and pathologists. [Benefits for other Health Care Practitioner services are described under Professional Fees for Surgical and Medical Services.]

2.23 Illness and Injury

A. Care in medical offices for treatment of illness or injury.

2.24 Mental Health and Substance Abuse Services

A. **Inpatient Mental Health and Substance Abuse Services.** The following Utilization Management requirements must be met to qualify for benefits:

1. Evergreen Health must be contacted by the facility or the Network Provider 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 it is not feasible to delay the admission for five [5] business days due to the Member's condition, Evergreen Health must receive notification of the admission as soon as possible but in any event within forty-eight [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 mental health and/or substance abuse 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 may not render an adverse authorization determination until the later of twenty-four [24] hours after a voluntary admission and seventy-two [72] hours after an involuntary admission.

Mental Health Management Program means the Utilization Management benefits administration and Network Provider activities administered by or on behalf of Evergreen Health to ensure that mental health and substance abuse services are Medically Necessary and provided in a cost-effective manner. Prior authorization will be obtained by Network mental health Providers. The Member is responsible to obtain prior authorization for all other Out-of-Network Providers.

B. Coverage is provided for mental health and substance abuse services set forth below, subject to the limitations and exclusions set forth in this section.

1. Professional services by licensed professional mental health and substance use practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists:

a. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders, including:

i diagnostic evaluation;

ii crisis intervention and stabilization for acute episodes;

iii medication evaluation and management (pharmacotherapy);

iv treatment and counseling (including individual or group therapy visits);

v diagnosis and treatment of alcoholism and drug abuse, including detoxification in a hospital or Related Institution, treatment and counseling;

vi professional charges for intensive outpatient treatment in a provider's office or other professional setting;

b. Electroconvulsive therapy;

c. Inpatient professional fees;

d. Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner;

e. Outpatient diagnostic tests provided and billed by a

laboratory, hospital or other covered facility;

f. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.

2. Inpatient hospital and inpatient residential treatment centers services, which includes;

   a. Room and board, such as:

      i Ward, semi-private, or intensive care accommodations. Private room is covered only if Medically Necessary. If private room is not Medically Necessary, the contract covers only the hospital's average charge for semiprivate accommodations;

      ii General nursing care;

      iii Meals and special diets.

   b. Other facility services and supplies – Services provided by a hospital or residential treatment center.

3. Outpatient hospital – Services such as partial hospitalization or intensive day treatment programs.

   a. **Partial Hospitalization** means the provision of medically directed intensive or intermediate short-term treatment for mental illness, emotional disorders, Drug Abuse or Alcohol Abuse for a period of less than 24 hours but more than 4 hours in a day for a Member or Subscriber in a licensed or certified facility or program.

4. Emergency room – Outpatient services and supplies billed by a hospital for emergency room treatment.

5. Residential Crisis Services.

   a. Residential Crisis Services mean intensive mental health and support services that are:

      i Provided to a Dependent child or an adult Member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the ability of the Member to function in the community; and

      ii Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient

admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency departments; and

iii Provided by entities that are licensed by the State of Maryland Department of Health and Mental Hygiene or the applicable licensing laws of any State or the District of Columbia to provide Residential Crisis Services; or

b. Benefits will be provided for Medically Necessary Residential Crisis Services.

6. The following are ***not covered*** mental health and substance use benefits:

a. Services by pastoral or marital counselors;

b. Therapy for sexual problems;

c. Treatment for learning disabilities and intellectual disabilities;

d. Telephone therapy;

e. Travel time to the Member's home to conduct therapy;

f. Services rendered or billed by schools, or halfway houses or members of their staffs;

g. Marriage counseling;

h. Service that are not Medically Necessary.

2.25 **Medical Food**

Medical food for persons with metabolic disorders when ordered by a Health Care Practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders.

2.26 **Morbid Obesity – Surgical Treatment**

A. **Morbid Obesity** means a Body Mass Index that is greater than forty [40] kilograms per meter squared; or equal to or greater than thirty five [35] kilograms per meter squared with a co- morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

B. **Body Mass Index (BMI)** means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

C. Utilization Management review is required for the surgical treatment of

Morbid Obesity.

1. Surgical treatment for Morbid Obesity shall occur in a facility that is:

   a. Designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence; and

   b. Designated by Evergreen Health.

D. If Evergreen does not designate a facility for the surgical treatment of Morbid Obesity, benefits will be provided at any facility that is designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence.

E. Surgical treatment for Morbid Obesity shall use a procedure that is:
   1. recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and
   2. consistent with guidelines approved by the National Institutes of Health.

2.27 **Nutritional Counseling and Medical Nutrition Therapy**
Unlimited Medically Necessary professional nutritional counseling and medical nutritional therapy.

A. **Professional Nutritional Counseling** means individualized advice and guidance given to a Member at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness or condition, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a licensed dietitian-nutritionist, physician, physician assistant or nurse practitioner.

B. **Medical Nutrition Therapy**, provided by a licensed dietitian-nutritionist, involves the assessment of the Member's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. The licensed dietitian-nutritionist, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a Member's condition, food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

C. Benefits are available for Medically Necessary Professional Nutritional Counseling and Medical Nutrition Therapy as determined by Evergreen Health.

D. Benefits for Professional Nutritional Counseling and Medical Nutrition Therapy are available to the same extent as benefits provided for Primary Care Provider office visits for medical treatment.

2.28 **Organ Transplants**

Organ transplants as follows:

A. Autologous and non-autologous bone marrow transplants, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants, and all Medically Necessary non-experimental/investigational solid organ transplant, and other non- solid organ transplant procedures, as determined by Evergreen Health.

B. Covered Services include the cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of eighteen (18) years, to and from the site of the transplant if approved by Evergreen.

Transplants and related services must be coordinated and prior authorization must be obtained from Evergreen Health.

2.29 **Outpatient Facility Fee**

Outpatient facility fees for surgical procedures and other medical care received on an outpatient basis in a hospital, Skilled Nursing Facility, Outpatient Rehabilitation Facility, or for Health Care Practitioner house calls.

2.30 **Patient Centered Medical Homes**

A. Delivery of benefits through patient centered medical homes for individuals with chronic conditions, serious illnesses or complex health care needs who agree to participate in a patient centered medical home program. This includes associated costs for coordination of care, such as:

1. Liaison services between the individual and the health care provider, nurse coordinator, and the care coordination team;

2. Creation and supervision of a care plan;

3. Education of the individual and family regarding the individual's disease, treatment compliance and self-care techniques; and

4. Assistance with coordination of care, including arranging consultations with specialists and obtaining Medically Necessary supplies and services, including community resources.

2.31 **Professional Fees for Surgical and Medical Services**

Professional fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or outpatient facility, or for Health Care Practitioner house calls.

2.32 **Pregnancy - Maternity Services**

A. Benefits for pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. Benefits include those of a certified nurse-midwife or pediatric nurse practitioner.

B. Benefits include services in a hospital and/or a birthing center accredited by the Commission for Accreditation of Birth Centers.

C. Both before and during a pregnancy, benefits include the services of a genetic counselor when provided or referred by a Health Care Practitioner. These benefits are available to all Members in the immediate family. Covered Services include related tests and treatment.

1. Inpatient hospitalization services are provided to a mother and newborn for at least forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated cesarean section.

2. Benefits will be provided for home health care visits related to maternity services, without any Copayment or coinsurance requirement.

3. If prescribed by the attending provider, a home visit will be covered for a mother and newborn who remain in the hospital for at least forty-eight (48) hours following an uncomplicated vaginal delivery or ninety-six (96) hours following an uncomplicated cesarean section.

4. Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, coverage includes additional hospitalization for the newborn for up to four days as required by state law. Inpatient hospitalization for maternity confinement will be limited to one cost share unless the baby is detained after the mother's discharge, in which case a second cost share for baby is applied.

5. If the Member is enrolled in a high deductible plan that meets the federal requirements established by § 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and if the Member receives home visits as outlined in this Section 2.32, the services provided may be subject to the plan Deductible but will not be subject to any Copayment or Coinsurance. For plans other than high deductible plans described in this paragraph, no Copayment, Coinsurance or Deductible will be assessed.

D. A hearing loss screening for a newborn child prior to discharge from the Hospital.

E. One home visit scheduled to occur within 24-hours of hospital discharge

and an additional home visit when prescribed by a Health Care Practitioner for a mother and newborn child following discharge from a hospital prior to a 48 hour Inpatient Stay for an uncomplicated delivery or 96 hours for a cesarean delivery. Such newborn home visits are not subject to any, Deductible, Copayment or Coinsurance payments shown in the Schedule of Benefits.

F. One home visit when prescribed by a Health Care Practitioner for a mother and newborn child following discharge from a hospital after a 48 hour Inpatient Stay for an uncomplicated delivery or 96 hours for a cesarean delivery. Such a home visit is not subject to any Deductible, Copayment or Coinsurance payments shown in the Schedule of Benefits.

G. Visits to an International Board Certified Lactation Consultant lactation specialist for a mother and newborn child following discharge from a hospital.

H. Such home visits shall be provided with the following conditions:

1. They will comply with generally accepted standards of nursing practice for home care of a mother and newborn child;

2. They will be provided by registered nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and

3. They will include any services required by the attending health care provider.

2.33 **Prescription Drugs**

A. Prescription drugs are subject to the provisions of this section. The specific Copayments and Coinsurances are listed in the Schedule of Benefits.

B. Definitions.

1. **Preventive Medications.** Certain prescription drug products on the Prescription Drug List that are intended to help reduce the likelihood of sickness. In accordance with the Affordable Care Act (ACA), these prescription drug products are provided at a zero-dollar Copayment. You may obtain the Preventive Medications List through the Internet at [www.evergreenmd.org/healthformulary] or by calling the Pharmacy Benefits Manager at the telephone number on your ID card.

2. **Generic Drug.** A prescription drug that has the same active-ingredient formula as a Brand Name Drug and has been approved by the Food and Drug Administration (FDA). The FDA rates these drugs to be as safe and effective as Brand Name Drugs.

3. **Brand Name Drug.** A drug sold by a drug company under a specific

name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.

4. **Closed Formulary**. A Closed Formulary plan provides coverage for generic drugs, formulary brand-name drugs, and specialty drugs. Evergreen Health offers a Closed Formulary. Without a special exception, submitted by calling the Pharmacy Benefits Manager at the telephone number on your ID card, a non-formulary drug will not be covered.

5. **Maintenance Drug.** A prescription drug anticipated to be required for 6 months or more to treat a chronic condition.

6. **Prior Authorization.** Evergreen Health requires your Provider to get prior authorization for certain drugs. This means that your Provider will need to get approval from the Plan before you can fill your prescription. If you do not get approval, Evergreen Health may not cover the drug. Please note if the prescription is written by an Out-of-Network Provider, it is the Member's responsibility to get prior authorization from the Plan.

7. **Step Therapy.** In some cases, Evergreen Health requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Evergreen Health may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Evergreen Health will then cover Drug B. Evergreen Health will not impose a step therapy protocol on a Member if the step therapy drug has not been approved by the U.S. Food and Drug Administration for the medical condition being treated, or a prescriber provides supporting medical information to Evergreen Health that a prescription drug covered by Evergreen Health was ordered by a prescriber for the Member within the past 180 days and based on the professional judgment of the prescriber, was effective in treating the Member's medical condition or disease. Your Provider should work with the Plan to provide appropriate documentation for the Step Therapy process.

8. **Quantity Limits**: For certain drugs, Evergreen Health limits the amount of the drug that we will cover. Evergreen Health might limit how much of a drug you can get each time you fill your prescription and/or how long we may cover the drug. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Some drugs like antibiotics may be limited to less than a 30-day supply. Specialty drugs are limited to a 30-day supply regardless of tier placement.

9. **Prescription Drug List is** a list of FDA-approved medications, products, or devices that are categorized into tiers. This list is also referred to as the formulary and is subject to our periodic review and

modification [generally quarterly, but no more than six times per calendar year]. You may determine to which tier a particular prescription drug product has been assigned through the Internet at [www.evergreenmd.org/healthformulary] or by calling the Pharmacy Benefits Manager at the telephone number on your ID card.

10. **Preferred Brand Name Drug.** A Brand Name Drug that is included on the Plan's Prescription Drug List.

11. **Non-Preferred Brand Name Drug.** A Brand Name Drug that the Plan has not designated as a preferred drug and is included on the Plan's Prescription Drug List.

12. **Specialty Prescription Drug Product** are Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.evergreenmd.org/healthformulary] or by calling the Pharmacy Benefits Manager at the telephone number on your ID card.

C. **Procedure for receipt of noncovered prescriptions.** The plan will provide coverage for a prescription drug or device that is not in the formulary, if in the judgment of the authorized prescriber:

1. there is no equivalent prescription drug or device in the entity's formulary; or

2. an equivalent prescription drug or device in the entity's formulary:

   a. has been ineffective in treating the disease or condition of the Member; or

   b. has caused or is likely to cause an adverse reaction or other harm to the Member.

D. 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 Prescription Drug List. At any time, you can access a copy of Evergreen Health's Prescription Drug List through the Internet at [www.evergreenmd.org/healthformulary] or by calling the Pharmacy Benefits Manager at the telephone number on your ID card.

If you are given a prescription by an Out-of-Network Provider, it will still be covered by the Plan, subject to the same limitations as any drugs prescribed by a Network Provider.

Should your costs for a prescription 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.

E. **Preventive Medications**. The Affordable Care Act (ACA) requires private insurers to cover certain preventive services without any patient cost-sharing, such as Deductible, Coinsurance or Copayments, when they are delivered by a Network Provider. The Department of Health and Human Services (HHS) has recognized several recommending bodies (e.g., United States Preventive Services Task Force [USPSTF], Advisory Committee on Immunization Practices [ACIP], Health Resources and Services Administration [HRSA]) who have identified several medication categories that fall within the preventive health mandate.

The current list of Preventive Medications includes: Aspirin, fluoride supplementation, folic acid, iron supplementation, Vitamin D, smoking cessation products, immunizations, contraceptives, and bowel prep agents for colorectal screening. Please access [www.evergreenmd.org/healthformulary] through the Internet or call the Pharmacy Benefits Manager at the telephone number on your ID card to access the most up to date Preventive Medications list.

F. **Maintenance Drugs**: Prescription drugs covered by the Plan that meet the above definition of Maintenance Drugs are available to be dispensed for up to 90-day supply at a retail pharmacy or mail order.

G. **Mail Order Medications.** The Plan has a "Voluntary Mail Order Program." Under the Voluntary Mail Order Program, you and your covered Dependents may fill your prescriptions through our designated mail order vendor. You and your covered Dependents may obtain a 90-day supply of prescription drugs or covered supplies through our designated mail order vendor, subject to the cost-share amounts outlined in the Schedule of Benefits.

To obtain these benefits, your Health Care Practitioner must prescribe the 90-day supply of the prescription drugs or covered supplies. Detailed information about how to use the mail order program is provided to you at [www.evergreenmd.org/providers]. If you have a prescription that for any reason cannot be filled by our designated mail order vendor and you need to use a retail pharmacy to fill it instead, the retail pharmacy cost-share amount found in the Schedule of Benefits applies.

We have the right to change or limit the drugs eligible for dispensing through this program at our discretion. Please call the Pharmacy Benefits Manager to determine if you medication is eligible to be filled through the Voluntary Mail Order Program.

Please access [www.mycatamaranrx.com] through the Internet or call the Pharmacy Benefits Manager at the telephone number on your ID card to determine if benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order pharmacy.

H. **Specialty Drugs.** Most Specialty Prescription Drugs require Prior Authorization. You can determine if your medication is a Specialty Prescription Drugs or requires Prior Authorization through the Internet at [www.mycatamaranrx.com] or call the Pharmacy Benefits Manager at the telephone number on your ID card. If you are prescribed a Specialty Prescription Drug, your Provider may need to provide the necessary clinical information to the Plan to review and approve the Prior Authorization request. Specialty Prescription Drugs are available through [BriovaRx]. Certain Specialty Prescription Drug will be covered under your plan if your Prior Authorization is approved and your prescription is filled by our specialty pharmacy, subject to terms and conditions of this Agreement. Specialty Prescription Drug, when Prior-Authorized, will be dispensed for a maximum of 30 days except Specialty Drugs that meet the definition of Maintenance Drugs, above, are available for 90 days.

Evergreen Health contracts with a robust network of pharmacies and most of these can dispense Specialty Prescription Drugs. You may obtain the contact information for the specialty pharmacy by calling the Pharmacy Benefits Manager at the telephone number on your ID card. The Specialty Prescription Drugs may be shipped to your provider's office, your home, or other location based on the type of drug or treatment. Specialized counseling and education is available to you from the specialty pharmacy regarding proper administration, storage, dosage, drug interactions, and side effects of these Specialty Prescription Drugs.

If you are out of a Specialty Prescription Drug or if the Specialty Prescription Drug ordered by your Health Care Practitioner does not arrive in time, we may authorize the specialty drug for up to a 30-day supply, so you can obtain the needed medication at a participating pharmacy.
The list of Specialty Prescription Drugs covered under the Plan may change at any time. Please visit [www.evergreenmd.org/healthformulary] through the Internet or call the Pharmacy Benefits Manager at the telephone number on your ID card.

I. **Limits**. Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include: Prior Authorization, Quantity Limits, and Step Therapy. You can find out if your drug has any additional requirements or limits by looking in the formulary [www.evergreenmd.org/healthformulary] through the Internet or calling the Pharmacy Benefits Manager at the telephone number on your ID card.

J. The refill of prescription eye drops must be issued in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors by the CMS; and if (i) the prescribing Health Care Practitioner indicates on the original prescription that additional quantities of the prescription eye drops are needed; ii) the refill requested by the insured does not exceed the number of additional quantities indicated on the original prescription by the prescribing health care practitioner; and iii) the prescription eye drops prescribed by the Health Care Practitioner are a covered benefit under the Agreement.

2.34 **Prevention and Treatment of Obesity.**

A. Treatment of obesity benefits are provided for as follows:

Surgical treatment of morbid obesity that is:

1. Recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and

2 Consistent with guidelines approved by the National Institutes of Health.

2.35 **Preventive Care Services**

A. In addition to any other preventive benefits provided in this Agreement, Evergreen Health shall cover the following preventive services and shall not impose any cost-sharing requirements, such as Deductibles or Copayment or Coinsurance amounts to any Member receiving any of the following benefits for services received from participating providers:

1. Evidenced-based items or services that have in effect a rating of “A” or “B’ in the current recommendations of the United States Preventive Services Task Force. The recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention of breast cancer issued on or around November 2009 shall not be considered the most current;

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member involved;

3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided in comprehensive guidelines supported by the Health Resources and Services Administration. Evergreen shall update new recommendations to the preventive services listed above pursuant to the schedule established by the Secretary of the United States Department of Health and Human Services.

B. If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, Evergreen Health can use reasonable medical management techniques to determine any coverage limitations.

2.36 **Reconstructive Breast Surgery and Breast Prosthesis.**

A. **Mastectomy** means the surgical removal of all or part of a breast.

B. Breast prosthesis and breast reconstruction on the non-diseased breast to achieve symmetry is covered regardless of the patient's insurance status at the time of the mastectomy or the time lag between the mastectomy and reconstruction.

C. Reconstructive breast surgery means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts including, coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast. Reconstructive breast surgery also includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

D. Coverage will also be provided for physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Member.

2.37 **Renal Dialysis**

Coverage will be provided for Medically Necessary hemodialysis and peritoneal dialysis for chronic kidney conditions.

2.38 **Rehabilitation Services – Outpatient Therapy**

A. Short-term outpatient rehabilitation services, including:

1. Physical therapy, subject to a limit of 30 physical therapy visits per condition per year.

2. Occupational therapy, subject to a limit of 30 occupational therapy visits per condition per year.

3. Speech therapy, subject to a limit of 30 speech therapy visits per condition per year.

4. Pulmonary rehabilitation services are covered as follows:

a. Pulmonary rehabilitation services are provided to Members who have been diagnosed with significant pulmonary disease, or who have undergone certain surgical procedures of the lung.

b. Coverage is provided for all Medically Necessary pulmonary rehabilitation services.

c. The Member pays for services, supplies or care that is not covered.

d. Benefits are available to the same extent as benefits

provided for office visits for medical treatment. The Member pays any applicable Deductible, Copayment or Coinsurance.

e. The following limitations apply to pulmonary rehabilitation services:

i Services must be provided by a Health Care Practitioner at an Evergreen Health approved place of service equipped and approved to provide pulmonary rehabilitation services.

ii Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the Member's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

iii Pulmonary rehabilitation services are limited to one [1] program per lifetime and must be authorized in advance under Utilization Management program.

5. Cardiac rehabilitation services are covered as follows:

a. Cardiac rehabilitation benefits are provided to Members who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation.

b. Coverage is provided for all Medically Necessary services.

c. Cardiac rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling.

d. A cardiac rehabilitation program includes continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription, and follow up examination for physician to adjust medication or change regimen.

e. Outpatient Rehabilitative Services [physical therapy, speech therapy and occupational therapy] for cardiac rehabilitation increases the thirty [30] visits, per therapy to ninety [90] visits, per therapy, per Benefit Year.

f. The following limitations apply to cardiac rehabilitation benefits:

i Services must be provided at an Evergreen approved place of service equipped and approved to provide cardiac rehabilitation.

ii Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the Member's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

iii The additional sixty (60) visits per therapy are limited to cardiac rehabilitation services.

5. Rehabilitation services must be performed by a Health Care Practitioner or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Health Care Practitioner's office or on an outpatient basis at a hospital or outpatient facility.

6. Benefits can be denied or shortened for Members who are not progressing in rehabilitation services or if rehabilitation goals have previously been met. Benefits will not be denied or shortened for rehabilitation services for which prior authorization has been obtained. Medical Necessity is required for all rehabilitation services.

2.39 **Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

A. Skilled Nursing Facility services as an alternative to Medically Necessary inpatient hospital services, limited to one hundred (100) days per Benefit Year.

B. **Skilled Nursing Facility** means an institution, or a distinct part of an institution which is:

1. Primarily engaged in providing:

a. Skilled nursing care, and related services, for residents who require medical or nursing care; or

b. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

2. Certified by the Medicare Program as a Skilled Nursing Facility and, if located in the State of Maryland, licensed by the Department of Health and Mental Hygiene.

C. Benefits are available for:

1. Supplies and non-Health Care Practitioner services received during

the inpatient stay.

2. Room and board in a semi-private Room (a room with two or more beds).

D. Health Care Practitioner services for radiologists, anesthesiologists and pathologists

E. All Skilled Nursing Facility/Inpatient Rehabilitation Facility Services admissions require prior authorization. The Network Provider must contact Evergreen Health 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 forty-eight (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.

F. Evergreen Health will determine if benefits are available by reviewing both the skilled nature of the service and the need for Health Care Practitioner-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

G. Benefits can be denied or shortened for Members who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

2.40 **Urgent Care Services**

A. **Urgent Care Services** are services rendered for an unforeseen illness or injury which requires medical care to prevent health deterioration or to alleviate acute pain, but which could not reasonably be expected to result in serious physical impairment or loss of life if not treated immediately.

B. **Urgent Care Facility** means a freestanding outpatient care facility, other than a physician's office or hospital facility that has the primary purpose of rendering Urgent Care Services.

C. Coverage for Urgent Care Services are covered in-network when:

1. Services are received in the Service Area by a Network Provider

2. Services are obtained outside the Service Area by an Out-of-Network Provider.

2.41 **Vision Benefit**

A. Benefits for children up to age nineteen (19) as follows:

1. One routine eye examination, including dilation if professionally indicated, each Benefit Year;

2. One pair of prescription eyeglass lenses each Benefit Year;

3. One frame each year;

4. In lieu of eyeglasses, contact lenses covered once every Benefit Year; and

5. Low vision services, including one comprehensive low vision evaluation every five (5) years, four (4) follow-up visits in any five (5) year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes.

B. Benefits for Members nineteen (19) years of age and older as follows:

1. One routine eye examination, including dilation if professionally indicated, each Benefit Year.

2.42 **Wellness Benefit**

A. **Wellness Benefit** means a benefit that provides coverage for a program or activity that is designed to:

1. Promote health or prevent or detect disease or illness;

2. Reduce or avoid poor clinical outcomes;

3. Prevent complications from medical conditions;

4. Promote healthy behaviors; or

5. Prevent and control injury.

B. The Wellness Benefit includes:

1. A Health Risk Assessment that is available at no cost to all covered Members; and completed by each Member on a voluntary basis; and

2. Written feedback to each Member who completes a Health Risk Assessment, with recommendations for lowering risks identified in the completed Health Risk Assessment.

C. **Health Risk Assessment** means a self-reported health questionnaire that:

1. Asks a variety of personal questions about lifestyle and behavioral habits, such as physical activity level, eating habits, and stress; and

2. Includes, but is not limited to, biometric measures and other health status information.

SECTION 3
EXCLUSIONS

The following exclusions apply:

3.1 Services or supplies that are determined by the Plan to be not Medically Necessary, as defined in the Individual Plan Agreement Section 1: Definitions.

Payment for inpatient ancillary services may not be denied solely based on the fact that the denial of the hospitalization day was appropriate. A denial of inpatient ancillary services must 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 must be given to the necessity of providing the ancillary service in the acute setting for each day in question.

3.2 Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.

3.3 Services that are beyond the scope of practice of the Health Care Practitioner performing the service.

3.4 Services to the extent they are covered by any governmental unit, except for veterans in Veteran's Administration or armed forces facilities for services received for which the recipient is liable.

3.5 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.

3.6 The purchase 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 vision benefit for children up to age nineteen (19) set forth in Section 2.41.A.

3.7 Personal Care services and Domiciliary Care services, as defined:

A. **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:

1. Help in walking;

2. Help in getting in and out of bed;

3. Help in bathing;

4. Help in dressing;

5. Help in feeding; and

6. General supervision and help in daily living.

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

1. Shelter;

2. Housekeeping services;

3. Board;

4. Facilities and resources for daily living; and

5. Personal surveillance or direction in the activities of daily living.

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

3.9 Experimental Services, as defined:

A. **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 clinical trials as provided in Covered Services Section 2.6.

3.10 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.

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

3.12 Services to reverse a voluntary sterilization procedure.

3.13 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.

3.14 Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified under "Covered Services." This exclusion does not apply to:

A. Surgical procedures for the treatment of Morbid Obesity;

B. Well child care visits for obesity evaluation and management;

C. 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];

D. 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;

E. Office visits for the treatment of childhood obesity; and

F. Professional Nutritional Counseling and Medical Nutrition Therapy as specified under “Covered Services.”

3.15 Services incurred before the effective date of the Member’s coverage under this Agreement.

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

3.17 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.

3.18 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.

3.19 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.

3.20 Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.

3.21 Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.

3.22 Inpatient admissions primarily for diagnostic studies, unless authorized by the Plan.

3.23 The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as provided in the Covered Services Section 2.16.

3.24 Except for covered ambulance services and transplants, travel, whether or not recommended by a Health Care Practitioner.

3.25 Except for emergency services, services received while outside the United States.

3.26 Immunizations related to foreign travel.

3.27 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.

3.28 Except for the pediatric dental benefit, accidents occurring while and as a result of chewing.

3.29 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.

3.30 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.

3.31 Inpatient admissions primarily for physical therapy, unless authorized by the Plan.

3.32 Treatment leading to or in connection with transsexualism, or sex changes or modifications, including, but not limited to surgery.

3.33 Treatment of sexual dysfunction not related to organic disease.

3.34 Services or supplies that duplicate benefits provided under federal, State, or local laws, regulations or programs.

3.35 Non-human organs and their implantation.

3.36 Non-replacement fees for blood and blood products.

3.37 Lifestyle improvements, nutrition counseling, or physical fitness programs unless included under “Covered Services.”

3.38 Wigs or cranial prosthesis. This exclusion does not apply to hair prosthesis covered under Section 2.15 of this Agreement.

3.39 Weekend admission charges, except for emergencies and maternity, unless authorized by the Plan.

3.40 Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.

3.41 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.

3.42 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.

3.43 Services for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.

3.44 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.

3.45 Physical examinations required for obtaining or continuing employment, insurance, or government licensing.

3.46 Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

3.47 Private hospital room, unless authorized by the Plan.

3.48 Private duty nursing, unless authorized by the Plan.

3.49 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.

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443-475-0990

SCHEDULE OF BENEFITS

EVERGREEN HEALTH HMO SILVER 0 (CSR 94)

ANNUAL DEDUCTIBLE	
For individual coverage the In-Network Deductible per Benefit Year is:	$0
For individual coverage the Out-of-Network Deductible per Benefit Year is:	N/A
For family coverage the In-Network Deductible per Benefit Year is:	$0
For family coverage the Out-of-Network Deductible per Benefit Year is:	N/A

The annual Deductible applies to all Covered Services except for preventive care services that has no charge to member, or any service, drug or supply that has a fixed dollar copayment. Copayments do not apply toward the annual Deductible and will continue to be assessed until the individual or family meets their Out-of-Pocket Limit. For family coverage, the annual Deductible may be met entirely by one Member or by combining eligible expenses of two or more family Members. Only incurred Allowed Amounts may be used to satisfy the Deductible.

OUT-OF-POCKET LIMIT	
For individual coverage the In-Network Out-of-Pocket Limit per Benefit Year is:	$425
For individual coverage the Out-of-Network Out-of-Pocket Limit per Benefit Year is:	N/A
For family coverage the In-Network Out-of-Pocket Limit per Benefit Year is:	$850
For family coverage the Out-of-Network Out-of-Pocket Limit per Benefit Year is:	N/A

Deductible, Copayments and Coinsurance amounts may be used to meet the Out-of-Pocket Limit. The following amounts may not be used to meet the Out-of-Pocket Limit:

- Amounts incurred for failure to comply with the Utilization Management Program requirements;
- Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days permitted by the Evidence of Coverage are listed in table below.

Your Out-of-Pocket Limit applies on a Benefit Year basis even though you may have been enrolled for less than a Benefit Year. If you have individual coverage and meet the Out-of-Pocket Limit, no further Coinsurance amounts or Copayments will be required in that Benefit Year. If you have family coverage, the Out-of-Pocket Limit can be met entirely by one family Member or by combining eligible expenses of two or more covered family Members. After the family Out-of-Pocket Limit is met no further Coinsurance amounts or Copayments will be required in that Benefit Year.

REDUCED COST-SHARING FOR AMERICAN INDIANS

If the MHBE has determined that you are an Indian as defined in 25 U.S.C. § 450b and eligible for the special cost-sharing rule under 42 U.S. C. § 18071 (§ 1402(d)(2) of the Patient Protection and Affordable Care Act), you will not be subject to any cost-sharing requirement for any covered item or service that is furnished directly to you by the Indian Health Service, an Indian Tribe, a Tribal Organization, or an Urban Indian Organization (each as defined in 25 U.S.C. § 1603), or through referral under Contract Health Services (also as defined in 25 U.S.C. § 1603). All other services are subject to the cost-sharing requirements set forth below.

This Schedule of Benefits does not describe benefits and does not provide an exhaustive summary of limitations. Please refer to your Description of Covered Services for a description of Covered Services, including exclusions and limitations.

SERVICES SUBJECT TO MEMBER COST-SHARING

If you receive care from a Tier 1 Network Provider, your cost share will be less than if you receive care from a Tier 2 Network Provider. A Network Provider's tier relates only to your cost share for Covered Services, and does not imply that any physician, Health Care Practitioner, or health care facility is more or less qualified than another. Not all categories of Covered Services have Tier 1 Network Providers. A list of Tier 1 and Tier 2 Network Providers is available for your review on our website.

SERVICE	LIMITATIONS AND DESCRIPTION	In-Network TIER 1 Member Pays	In-Network TIER 2 Member Pays	Out-of-Network Member Pays
PREVENTIVE CARE SERVICES (Refer to Description of Covered Services for a full listing of services)				
Adult Physical Exam	One exam per year when provided by a PCP.	No Charge	No Charge	Not covered
Gynecological Preventive Exam (includes Cervical cancer screening)		No Charge	No Charge	Not covered
Well Child Visits		No Charge	No Charge	Not covered
Preventive Laboratory Services		No Charge	No Charge	Not covered
Annual Routine Mammography		No Charge	No Charge	Not covered
HIV and STD Screening and Counseling		No Charge	No Charge	Not covered
Immunization vaccines		No Charge	No Charge	Not covered
Preventive Family Planning Services		No Charge	No Charge	Not covered
Prenatal and Postnatal Care		No Charge	No Charge	Not covered
Preventive Medication (Includes contraceptives, folic acid for women. See formulary for a full list.)		No Charge	No Charge	Not covered
Other Preventive Care Services not specifically mentioned		No Charge	No Charge	Not covered
HOSPITAL INPATIENT SERVICES				
Hospital - Inpatient Stay				
Medical or Surgical Condition, Including Rehabilitation	See Description of Covered Services for additional information.	No Tier 1 Providers Available	10% after Deductible	Not covered
Behavioral Health Inpatient (for mental health and substance abuse)	See Description of Covered Services for additional information.	No Tier 1 Providers Available	10% after Deductible	Not covered
Hospice Care - Inpatient	See Description of Covered Services for additional information.	No Tier 1 Providers Available	10% after Deductible	Not covered
Inpatient Professional Fee		No Tier 1 Providers Available	10% after Deductible	Not covered

OFFICE VISITS				
Primary Care Provider (includes services for illness, injury, sickness, follow-up care and consultations)		$5 Copayment per visit; Deductible waived	$10 Copayment per visit; Deductible waived	Not covered
Behavioral Health Services (includes services for mental health and substance abuse)		$5 Copayment per visit; Deductible waived	$10 Copayment per visit; Deductible waived	Not covered
Specialty Care Services (includes services for illness, injury, sickness, follow-up care and consultations)		No Tier 1 Providers Available	$25 Copayment per visit; Deductible waived	Not covered
OUTPATIENT SERVICES AND SURGERY				
Outpatient Facility Fee				
Hospital Based Facility		No Tier 1 Providers Available	20% after Deductible	Not covered
Non-hospital Based Facility		No Tier 1 Providers Available	10% after Deductible	Not covered
Outpatient Professional Fees		No Tier 1 Providers Available	10% after Deductible	Not covered
Outpatient Mental and Substance Abuse (non-office visit)		No Tier 1 Providers Available	10% after Deductible	Not Covered
Lab, X-Ray and Diagnostics - Outpatient		10% after Deductible	20% after Deductible	Not covered
Imaging - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient		10% after Deductible	20% after Deductible	Not covered
Hospice Care - Outpatient		No Tier 1 Providers Available	10% after Deductible	Not covered
Outpatient Rehabilitative Services (Physical Therapy, Occupational Therapy, and Speech Therapy)	See Description of Covered Services for additional information.			
Hospital Based Facility		No Tier 1 Providers Available	$50 Copayment per visit; Deductible waived	Not covered
Non-hospital Based Facility		No Tier 1 Providers Available	$25 Copayment per visit; Deductible waived	Not covered

Habilitative Services – (Physical Therapy, Occupational Therapy, Speech Therapy, orthodontics, oral surgery, and otologic and audiological therapy)	For adults 19 years of age and older, limited to 30 visits per therapy type per injury or illness per Benefit Year.			
Hospital Based Facility		No Tier 1 Providers Available	$50 Copayment per visit; Deductible waived	Not covered
Non-hospital based facility		No Tier 1 Providers Available	$25 Copayment per visit; Deductible waived	Not covered
EMERGENCY / URGENT CARE				
Emergency Services		No Tier 1 Providers Available	10% after Deductible	10% after Deductible
Urgent Care Center Services	If in service area, out of network is not covered.	No Tier 1 Providers Available	$60 Copayment per visit; Deductible waived	$60 Copayment per visit if out of service area; Deductible waived
Ambulance Services				
Emergency		No Tier 1 Providers Available	10% after Deductible	10% after Deductible
Non-Emergency	Requires prior authorization	No Tier 1 Providers Available	10% after Deductible	Not covered
OTHER SERVICES				
Chiropractic Manipulation Services	Limited to 20 visits per condition per year	No Tier 1 Providers Available	$40 Copayment per visit; Deductible waived	Not covered
Inpatient Rehabilitation Facility Services/Skilled Nursing Facility	Limited to 100 days per Benefit Year. Prior authorization is required and medical necessity review for continued stay approval.	No Tier 1 Providers Available	10% after Deductible	Not covered
Infertility Services (includes In-vitro fertilization)	Limited to 3 in-vitro attempts per live birth	No Tier 1 Providers Available	10% after Deductible	Not covered
Home Health Care	See the Description of Covered Services for additional information.	No Tier 1 Providers Available	10% after Deductible	Not covered

Durable Medical Equipment	See Description of Covered Services in both covered services and exclusions for details.	No Tier 1 Providers Available	10% after Deductible	Not covered
Transplantation Services	See the Description of Covered Services for additional information.	No Tier 1 Providers Available	10% after Deductible	Not covered
Hair Prosthesis	Limited to one hair prosthesis per Benefit year. See Description of Covered Services for details.	No Tier 1 Providers Available	10% after Deductible	Not covered
Covered Services not specifically mentioned in this Schedule of Benefits		No Tier 1 Providers Available	10% after Deductible	Not covered
VISION AND HEARING				
Routine Eye Exam	One visit per Benefit Year.	No Tier 1 Providers Available	$10 Copayment per visit; Deductible waived	Not covered
Prescription Eyeglasses (under 19 year old)	One frame/one pair of lenses, OR one pair of contact lenses per Benefit Year.	No Tier 1 Providers Available	10% after Deductible	Not covered
Low vision (under 19 years old)	One exam every 60 months, four low vision follow-up visits in any 5-year period with optical devices.	No Tier 1 Providers Available	$40 Copayment per visit; Deductible waived	Not covered
Hearing Aids (under 19 years old)	Limited to one hearing aid for each hearing impaired ear every 36 months.	No Tier 1 Providers Available	10% after Deductible	Not covered
PEDIATRIC DENTAL SERVICES (under 19 years old)				
Diagnostic & Preventive- Class I (includes diagnostic and preventative services, and fillings)	See the Description of Covered Services for additional information.	No Tier 1 Providers Available	No Charge	Not covered
Basic Restorative - Class II (includes extractions and basic periodontal treatment)	Subject to medical necessity	No Tier 1 Providers Available	10% after Deductible	Not covered
Major Restorative – Class III (includes major services including crowns, dentures, bridges)	Subject to medical necessity	No Tier 1 Providers Available	50% after Deductible	Not covered
Orthodontia Services – Class IV	Subject to medical necessity	No Tier 1 Providers Available	50% after Deductible	Not covered

PRESCRIPTION DRUGS -				
Generic retail	30-Day Supply Limit	No Tier 1 Providers Available	$5 Copayment per script; Deductible waived	Not covered
Generic (retail and mail order)	90-Day Supply Limit	No Tier 1 Providers Available	$15 Copayment per script; Deductible waived	Not covered
Preferred retail	30-Day Supply Limit	No Tier 1 Providers Available	$30 Copayment per script; Deductible waived	Not covered
Preferred (retail and mail order)	90-Day Supply Limit	No Tier 1 Providers Available	$90 Copayment per script; Deductible waived	Not covered
Non-Preferred retail*^^	30-Day Supply Limit	No Tier 1 Providers Available	50% after Deductible	Not covered
Non-Preferred (retail and mail order)*^^	90-Day Supply Limit	No Tier 1 Providers Available	50% after Deductible	Not covered
Specialty retail	30-Day Supply Limit	No Tier 1 Providers Available	10% after Deductible	Not covered
Specialty (retail and mail order)	90-Day Supply Limit	No Tier 1 Providers Available	10% after Deductible	Not covered

* Non-preferred drugs are covered at the preferred drug level if, in the judgment of the authorized prescriber: (1) there is no equivalent preferred drug; or (2) an equivalent preferred drug has (i) been ineffective in treating the disease or condition or (ii) caused or is likely to cause an adverse reaction or other harm.
^^ Non-formulary drugs are covered at the non-preferred drug level if, in the judgment of the authorized prescriber: (1) there is no equivalent prescription drug or device in the Plan's formulary; or (2) an equivalent prescription drug or device in the Plan's formulary: (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member.
NOTE: Non-formulary drugs are not covered at the preferred drug level.

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BENEFIT DETERMINATION AND APPEAL AND GRIEVANCE PROCEDURES

These Benefit Determination and Appeals and Grievance Procedures ("Procedures") contain certain terms that have a specific meaning as used herein. These terms are capitalized and defined in Section A below, and/or in the Individual Plan Agreement or Small Group Plan Contract to which this document is attached.

These procedures replace all prior procedures issued by the Plan, which afford Members recourse pertaining to denials and reductions of claims for benefits by the Plan.

These procedures only apply to Claims for Benefits. Notification required by these procedures will only be sent when a Member requests a benefit or files a claim in accordance with the Plan's procedures.

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A. DEFINITIONS

The following terms shall have the meaning ascribed to such terms whenever such terms are used in these Claims Procedures.

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Adverse Decision means a utilization review determination that:

1. A proposed or delivered health care service covered under the Member's contract is or was not Medically Necessary, appropriate, or efficient; and

2. May result in non-coverage of the health care service. Adverse Decision does not include a Coverage Decision.

3. A denial by the Plan of a request by a Member for an alternative standard or a waiver of a standard to satisfy the requirements of a bona fide wellness program as defined in Maryland Insurance Article § 15-509.

Appeal means a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan under its internal appeal process regarding a Coverage Decision.

Appeal Decision means final determination by the Plan that arises from an Appeal.

Claim for Benefits means a request for a Plan benefit or benefits made by a Member in accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

Claim Involving Urgent Care means any claim for medical care or treatment that involves an Emergency Case or an Urgent Medical Condition. Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Member's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

Claims Procedures means, collectively, the procedures governing the filing of benefit claims, Notification of benefit determinations, and Grievances and Appeals of Adverse Benefit Determinations for Members.

Compelling Reason means a showing that the potential delay in receipt of a health care service until after the Member, the Member's Representative or Health Care provider acting on behalf of the Member exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the

Member remaining seriously mentally ill with symptoms that cause the Member to be in danger to self or others.

Complaint means a protest filed with the Maryland Insurance Commissioner involving an Adverse Benefit Determination, Appeal Decision or Grievance Decision.

Contract: means the Individual Plan Agreement or Small Group Plan Contract to which this document is attached. The term Contract includes all documents that form part of the Individual Plan Agreement or Small Group Plan Contract, including, but not limited to, the Evidence of Coverage.

Coverage Decision means:

1. An initial determination by the Plan that results in non-coverage of a health care service;

2. An determination by the Plan that that an individual is not eligible for coverage under the Contract; or

3. A determination by the Plan that results in the Rescission of an individual's coverage under the Contract.

A Coverage Decision includes nonpayment of all or part of a Claim for Benefits. A Coverage Decision does not include an Adverse Decision or a Pharmacy Inquiry.

Designee of the Commissioner means any person to whom the Commissioner has delegated the authority to review and decide Complaints, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

Emergency Case means medical services are necessary to treat a condition or illness that, without immediate medical attention, would either (i) seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, or (ii) cause the Member to be in danger to self or others.

Filing Date means the earlier of:

1. 5 days after the date of mailing; or
2. The date of receipt.

Grievance means a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member through the Plan's internal Grievance process regarding an Adverse Decision.

Grievance Decision means a final determination by the Plan that arises from a Grievance.

Health Advocacy Unit means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article, Annotated Code of Maryland.

Health Care Provider, as used in these Procedures, means:

1. An individual who is licensed under the Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the Member; or

2. A hospital as defined in Title 19 Subtitle 3 of the Health-General Article.

Member, as used in these Procedures, means an individual entitled to receive health care benefits under the Contract.

Member's Representative means an individual who has been authorized by a Member to file a Grievance, Appeal or a Complaint on behalf of a Member.

Notice or Notification means the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

Pharmacy Inquiry means an inquiry submitted by a pharmacist or pharmacy on behalf of a Member to the Plan or pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under the Plan.

Plan means Evergreen Health Cooperative Inc. or any entity that has been delegated authority by Evergreen Health Cooperative Inc. to perform any duties required to be performed by Evergreen Health Cooperative Inc. under these Appeals and Grievance Procedures.

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim.

Pre-Service Claim means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Relevant. A document, record, or other information shall be considered Relevant to a Member's claim if such document, record, or other information:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

3. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or

4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions towards the cost of coverage. Coverage may only be rescinded for fraud or intentional misrepresentation.

Urgent Medical Condition means a condition that satisfies either of the following:

1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:

a. Placing the member's life or health in serious jeopardy;
b. The inability of the member to regain maximum function;

c. Serious impairment to bodily function;

d. Serious dysfunction of any bodily organ or part; or

e. The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or

2. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

B. SCOPE

The Plan's Claims Procedures were developed in accordance with Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims For Benefits by Members.

C. CLAIMS PROCEDURES

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeals and Grievances of Adverse Benefit Determinations (hereinafter collectively referred to s Claims Procedures) for Members.

These Claims Procedures do not preclude a Member's Representative or Health Care Provider acting on behalf of a Member from acting on behalf of such Member in pursuing a Claim for Benefits, Grievance or Appeal of an Adverse Benefit Determination, or a Complaint to the Maryland Insurance Commissioner. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member.

These Claims Procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations and Adverse Benefit Determinations are made in accordance with governing Plan documents and, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Members.

D. CLAIMS PROCEDURES COMPLIANCE

1. Failure to follow Pre-Service Claims Procedures. In the case of a failure by a Member or a Member's Representative to follow the Plan's procedures for filing a Pre-Service Claim the Member or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. Written Notification shall be provided to the Member, the Member's Representative, or Health Care Provider acting on behalf of the Member, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure.

   The above shall apply only in the case of a failure that:

a. Is a communication by a Member, the Member's Representative, or Health Care Provider acting on behalf of the Member that is received by the person or organizational unit designated by the Plan that handles Claims for Benefits; and

b. Is a communication that names a specific Member; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

2. Civil Action. A Member is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA.

E. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

1. In general. Except as provided in paragraph E.2 below, if a claim is wholly or partially denied, the Member shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan, unless it is determined that special circumstances require an extension of time for processing the claim (for example, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or the claim is not clean and the specific information necessary for the claim to be considered a clean claim). If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Member prior to the termination of the initial 30-day period. In no event shall such extension exceed a period of 30 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.

2. The Member shall be notified of the determination in accordance with the following, as appropriate.

a. Expedited Notification of benefit determinations relating to Claims Involving Urgent Care. In the case of a Claim Involving Urgent Care, the Member shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim unless the Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Member shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Member shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Member shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

i. Receipt of the specified information, or

ii. The end of the period afforded the Member to provide the specified additional information.

b. Concurrent care decisions. If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:

i. Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Member shall be notified in accordance with paragraph E.2.e herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

ii. Any request by a Member to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Member shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and an Appeal shall be governed by paragraphs G.2, G.3 and G.4 herein as appropriate.

iii. If a health care service for a Member has been preauthorized or approved by the Plan, the Plan may not deny reimbursement to the Health Care Provider for the preauthorized or approved service delivered to the Member unless:

1) The information submitted regarding the service was fraudulent or intentionally misrepresentative;

2) Critical information required by the Plan was omitted such that the Plan's determination would have been different had it known the critical information;

3) A planned course of treatment for the Member was not substantially followed by the Health Care Provider; or

4) On the date the preauthorized service was delivered:

a) the Member was not covered by the Plan;
b) the Plan maintained an automated eligibility verification system that was available to the Provider by telephone or via the Internet; and

c) according to the verification system, the Claimant was not covered by the Plan.

iv. Continued coverage will be provided pending the outcome of an appeal.

c. Other claims for health care benefits. In the case of a claim that is not an urgent care claim or a concurrent care decision the Member shall be notified of the benefit determination in accordance with the below "Pre-Service Claims" or "Post-Service Claims," as appropriate.

i. Pre-Service Claims. In the case of a Pre-Service Claim, the Member shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan determines that such an extension is necessary due to matters beyond its control, and notifies the Member, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph G. herein.

Authorization of Pre-Service Claims. The Plan will determine whether to authorize or certify a Pre-Service Claim within 2 working days following receipt of all necessary information. If information is needed to make a decision which was not included in the initial request for authorization or certification, the Plan will notify the Health Care Provider within 3 calendar days of the initial request that additional information is needed.

ii. Post-Service Claims. In the case of a Post-Service Claim, the Member shall be notified, in accordance with paragraph G. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan determines that such an extension is necessary and notifies the Member, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary, the Plan will send a Notice of receipt and status of the claim that states the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim. The Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

d. Rescission determinations. The Plan shall provide 30-days advance written Notice of any proposed Rescission of coverage for any individual.

e. Calculating time periods. For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2 above due to a Member's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information.

F. MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

1. This section sets forth the manner and content of Notifications by the Plan of Adverse Benefit Determinations.

2. In the case of an Adverse Decision, the Plan shall send a Member, the Member's Representative or Health Care Provider acting on behalf of the Member written or electronic Notification of any Adverse Benefit Determination. In the case of an Adverse Decision relating a Claim for Benefits that is not a Claim Involving Urgent Care, the Plan shall send the written or electronic Notification within 5 working days after the Adverse Decision has been made. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider:

   a. The identity of the claim involved (including the date of service, the Health Care Provider, and the claim amount (if applicable)).

   b. The specific reason or reasons for the Adverse Decision;

   c. Reference to the specific Plan provisions on which the Adverse Decision is based;

   d. A description of any additional material or information necessary for the Member, Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

   e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following an Adverse Decision;

   f. The Medical Director's name, business address and business telephone number;

   g. If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision , either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar

criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision and that a copy of such rule, guideline, protocol, diagnosis code (and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or

h. If the Adverse Decision is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances.

i. In the case of an Adverse Decision by the Plan concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

j. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plans Grievance Decision;

k. That a Complaint may be filed without first filing a Grievance if

   i. The Plan notifies the Member in writing that it has waived the requirement that its internal grievance process be exhausted before filing a Complaint with the Commissioner;

   ii. The Plan has failed to comply with any of the requirements of the internal grievance procedure described in these Procedures; or

   iii. the Member, the Member's Representative or Health Care Provider acting on behalf of the Member filing a Grievance on behalf of the Member can demonstrate a Compelling Reason to do so as determined by the Commissioner;

l. The following address, telephone number, and facsimile number for the Appeals and Grievance Unit of the MIA:

   [Maryland Insurance Administration
   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 TTY: 1-800-735-2258
   Fax: 410-468-2270 or 410-468-2260 (Life and Health/Appeals and Grievance)]

m. A statement that the Health Advocacy Unit is available to assist the Member, the

Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance; and

n. The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

3. In the case of a Coverage Decision, the Plan must within 30 calendar days provide Member, Member's Representative and the treating Health Care provider, a written Notice of the Coverage Decision. The statement must state in detail, in clear, understandable language, the specific factual basis for the Plan's decision and must include the following information:

a. Where applicable, the identity of the claim involved (including the date of service, the Health Care Provider and the claim amount).

b. The specific reason or reasons for the Coverage Decision;

c. Reference to the specific Plan provisions on which the Coverage Decision is based;

d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following a Coverage Decision;

f. That the Member, Member's Representative or Health Care Provider acting on behalf of the Member has a right to file an Appeal with the Plan;

g. In the case of a Coverage Decision by the Plan concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

h. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Appeal Decision;

i. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves a Claim Involving Urgent Care which has not been rendered;

j. The Commissioner's address, telephone number, and facsimile number;

k. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing an Appeal; and

l. The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

4. Adverse Benefit Determinations are made under the direction of the Medical Director.

G. APPEALS AND GRIEVANCES OF ADVERSE BENEFIT DETERMINATIONS

1. To file an Appeal or Grievance of an Adverse Benefit Determination, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member, may contact the Plan at the address and telephone number located on the Member's ID Card; or submit a written request and any supporting record of medical documentation within 180 days of receipt of the written Notification of the Adverse Benefit Determination to the following:

Attention HealthCare Management Department
PO Box 83301
Lancaster, PA 17608-3301

The Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance or Appeal. See Section K for additional information.

a. A Member has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;

b. A Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Member's Claim for Benefits;

c. The Plan shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

2. In addition to the requirements of paragraphs G.2.a through c herein, the following apply:

a. The Plan shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an individual who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor the subordinate of such individual;

b. In deciding a Grievance of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/Investigational, or not Medically Necessary or appropriate, the Plan shall consult with a Health Care Provider with the same specialty as the treatment under review.

c. Upon request, the Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Member's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

d. A Health Care Provider engaged for purposes of a consultation under paragraph G.3.b herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor subordinates of any such individuals; and

e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal or Grievance of an Adverse Benefit Determination may be submitted orally or in writing by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member; and the Plan must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its determination in writing within 24 hours of receipt of the expedited request for Appeal or Grievance.

3. Full and fair review. The Plan shall allow a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to review the claim file and to present evidence and written testimony as part of the internal claims and Appeals and Grievances process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:

a. The Plan shall provide the Member, the Member's Representative or Health Care Provider acting on behalf of the Member, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Grievance Decision or Appeal decision is required to be provided under paragraph H or I. herein, to give the Member a reasonable opportunity to respond prior to that date; and

b. Before the Plan issues a Grievance Decision or an Appeal Decision based on a new or additional rationale, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Appeal Decision or Grievance Decision is required to be provided under paragraphs H and I. herein, to give the Member, the Member's Representative or Health Care Provider acting on behalf of the Member a reasonable opportunity to respond prior to that date.

H. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (GRIEVANCE DECISIONS)

1. The Plan shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its benefit determination on review of an Adverse Decision in accordance with the following, as appropriate.

a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J. herein, of the Grievance Decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the Member's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 24 hours of the orally communicated Grievance Decision.

b. Pre-service claims. In the case of a Pre-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J herein, of the Grievance Decision within a reasonable period of time appropriate to the medical circumstances. Oral Notification shall be provided not later than 30 days after the filing date of the Member, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.

c. Post-service claims. In the case of a Post-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with item J herein, of the Grievance Decision within a reasonable period of time. Oral Notification shall be provided not later than 45 working days after the filing date of the Member's, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.

2. If the Plan does not have sufficient information to complete its Grievance Decision, the Plan must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within five (5) working days after the Filing Date of the Grievance by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan. The Plan Notification shall:

a. Notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member that it cannot proceed with reviewing the Grievance unless additional information is provided; and

b. Assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in gathering the necessary information without further delay.

3. The Plan may extend the 30-day or 45-working day period required for making a Grievance Decision under paragraph H.1.b., c. with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member, the Plan may extend the period for making a final decision for an additional period of not longer than 30 working

days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.

4. Calculating time periods. For purposes of Section H. herein, the period of time within which a Grievance Decision shall be made begins at the time a Grievance is received by the Plan , without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph H.2 herein due to a Member's, the Member's Representative's or Health Care Provider 's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member until the date on which the Member, the Member's Representative or Health Care Provider acting on behalf of the Member responds to the request for additional information.

5. In the case of Grievance, upon request, the Plan shall provide such access to, and copies of relevant documents, records, and other information described in paragraphs G.2, G.3, and G.4 herein as is appropriate.

I. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS)

1. The Plan shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its Appeal Decision no later than 60 working days after the filing date of the Member, the Member's Representative's or Health Care Provider's Appeal. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 30 days of the Appeal Decision.

2. Calculating time periods. For purposes of Section I. herein, the 60-working day period within which a benefit determination on review shall be made begins at the time an Appeal is received by the Plan, without regard to whether all the information necessary to make an Appeal Decision accompanies the filing.

J. MANNER AND CONTENT OF NOTIFICATION OF GRIEVANCE DECISION OR APPEAL DECISION

The Plan shall provide a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with written or electronic Notification after it has provided oral communication of the Grievance Decision or Appeal Decision. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member:

1. The identity of the claim involved (including the date of service, the Health Care Provider and the claim amount (if applicable)).

2. The specific factual basis for the adverse determination;

3. Reference to the specific criteria and standards, including interpretive guidelines, on which the benefit determination is based;

4. A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Member's Claim For Benefits;

5. A statement describing any voluntary Appeal or Grievance procedures offered by the Plan and the Member's right to obtain the information about such procedures, and a statement of the Member's right to bring an action under Section 502(a) of the Act; and

    a. If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination, either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, diagnosis code (and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or

    b. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

    c. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available it so contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

6. In the case of a Grievance involving an Adverse Decision, a statement that includes the following information:

    a. The name, business address and business telephone number of the Medical Director who made the decision;

    b. That the Member, the Member’s Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Grievance Decision;

    c. The Commissioner’s address, telephone number, and facsimile number;

    d. A statement that the Health Advocacy Unit is available to assist the Member, the Member’s Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

    e. The Health Advocacy Unit’s address, telephone number, facsimile number and electronic mailing address;

f. The Employee Benefit Security Administration's telephone number and website address; and

g. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

7. In the case of an Appeal involving a Coverage Decision, a statement that includes the following information:

a. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Appeal Decision; and

b. The Commissioner's address, telephone number, and facsimile number;

c. The Employee Benefit Security Administration's telephone number and website address; and

d. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

e. The Health Advocacy Unit's address, telephone number, facsimile number and electronic mailing address; and

f. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

8. Grievance Decisions and Appeal Decisions are made under the direction of Dr. Mathew Zawilinski, Chief Medical Officer:

Attention: HealthCare Management Department
PO Box 83301
Lancaster, PA 17608-3301

K. FILING OF COMPLAINT AFTER RECEIPT OF NOTIFICATION OF GRIEVANCE DECISIONS OR APPEAL DECISIONS

1. Within 4 months after the date of receipt of an Appeal Decision or a Grievance Decision, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner for review of the Grievance Decision or Appeal Decision.

2. A Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint without first exhausting the Plan's internal Grievance or Appeals process if:

   a. In the case of an Adverse Decision:

      i. The Plan waives the requirement that the internal Grievance process be exhausted before filing a Complaint with the Commissioner;

      ii. The Plan has failed to comply with any of the requirements of the internal Grievance process;

      iii. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member provides sufficient information and supporting documentation in the Complaint to demonstrate a Compelling Reason.

   b. In the case of a Coverage Decision, the Complaint involves an Urgent Medical Condition for which care has not been rendered.

3. The remaining provisions of this paragraph K. apply to Complaints regarding Adverse Decisions and Grievance Decisions.

   a. The Commissioner shall notify the Plan of the Complaint within five working days after the date the Complaint is filed with the Commissioner.

   b. Except for an Emergency Case (Claim Involving Urgent Care), the Plan shall provide to the Commissioner any information requested by the Commissioner no later than seven working days from the date the Plan receives the request for information.

4. Except as provided in paragraph K.4.b below, the Commissioner shall make a final decision on a Complaint:

   a. Within 45 days after a Complaint is filed regarding a Pre-Service Claim;

   b. Within 45 days after a Complaint is filed regarding a Post-Service Claim; and

   c. Within 24 hours after a Complaint is filed regarding a Claim Involving Urgent Care.

   The Commissioner may extend the period within which a final decision is to be made under paragraph.K.4.a. for up to an additional 30 working days if:

   a. the Commissioner has not yet received information requested by the Commissioner; and

   b. the information requested is necessary for the Commissioner to render a final decision on the Complaint.

5. The Commissioner shall seek advice from an independent review organization or medical expert for Complaints filed with the Commissioner that involve a question of whether a Pre-Service Claim or a Post-Service Claim is Medically Necessary. The Commissioner shall select an independent review organization or medical expert to advise on the Complaint in the manner set forth in Section 15-10A-05 of the Insurance Article.

6. The Plan shall have the burden of persuasion that its Adverse Decision or Grievance Decision, as applicable, is correct during the review of a Complaint by the Commissioner or Designee of the Commissioner, and in any hearing held regarding the Complaint.

7. As part of the review of a Complaint, the Commissioner or Designee of the Commissioner may consider all of the facts of the case and any other evidence deemed Relevant.

8. Except as provided below, in responding to a Complaint, the Plan may not rely on any basis not stated in its Adverse Benefit Determination.

    a. The Commissioner may allow the Plan, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to provide additional information as may be relevant for the Commissioner to make a final decision on the Complaint.

    b. The Commissioner shall allow the Member, the Member's Representative or Health Care Provider acting on behalf of the Member at least 5 working days to provide the additional information.

    c. The Commissioner's use of additional information may not delay the Commissioner's decision on the Complaint by more than five working days.

9. The Commissioner may request the Member or a legally authorized designee of the Member to sign a consent form authorizing the release of the Member's medical records to the Commissioner or Designee of the Commissioner that are needed in order for the Commissioner to make a final decision on the Complaint.

10. Subject to paragraphs H, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner if the Member, the Member's Representative or Health Care Provider acting on behalf of the Member does not receive the Plan's Grievance Decision within the following timeframes:

    a. Within 30 days after the filing date of a Grievance regarding a Pre-Service Claim;

    b. Within 45 working days after the filing date of a Grievance regarding a Post-Service Claim; and

    c. Within 24 hours after the receipt of a Grievance regarding a Claim Involving Urgent Care.

Note: the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance.

Contact the Health Advocacy Unit 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

L. MEMBER COMMENTS AND QUALITY COMPLAINTS

The Plan provides Members an opportunity to present comments or any other questions or concerns with regard to operations or administration of the Plan, and file a quality complaint regarding the quality of any Plan service. All comments and quality complaints should be addressed to the Member Services Department. In the event that you are dissatisfied with a determination of the Member Services Department, the procedures listed below must be followed.

Inquiries, comments, and complaints concerning the nature of your medical care should also be addressed to the Member Services Department. That department will also assist you in filing a quality complaint after all other avenues of resolution have been exhausted.

A Member may complain to the Department of Health and Mental Hygiene, Office of Licensing and Certification Programs regarding the operation of The Plan. The address and telephone number of the Department is available through our Member Services Department. The Member may also contact the Maryland Insurance Administration at:

Maryland Insurance Administration
Inquiry and Investigation, Life and Health
200 St. Paul Place, Suite 2700
Baltimore, MD 21202-2272
410-468-2244

M. DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEAL PROCESS

If the Plan fails to adhere to the minimum requirements for Claims Procedures relating to Claims for Benefits by Members or Section 15-10A-02 of the Insurance Code, Annotated Code of Maryland, the Member is deemed to have exhausted the internal appeals and grievance processes of paragraph G through J herein. Accordingly the Member may initiate an external review under paragraph K of this section. The Member is also entitled, where applicable, to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the Claim for Benefits. If a Member, where applicable, chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the Claim for Benefits, Grievance, or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

These Procedures are issued to be attached to the Contract. These Procedures do not change the terms and conditions of the Contract, unless specifically stated herein.

Evergreen Health Cooperative Inc.