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

EVERGREEN 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" or "the Plan") and those of the Subscriber. The Agreement, in its entirety, is the complete contract between Evergreen and the Subscriber.

The Subscriber accepts and agrees to the Agreement by making payment to Evergreen as required under the Agreement. Evergreen agrees to the Agreement when it is issued to the Subscriber. The Subscriber's payment and Evergreen's issuance make the Agreement's terms and provisions binding on Evergreen 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 bylaws of Evergreen. Each individual covered under this Agreement will be a Member of Evergreen. Evergreen 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, lives or works in the service area.

[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.

SECTION 1
DEFINITIONS

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

1.1 **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.

1.2 **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.

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

1.4 **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.

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

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

B. A Non-Plan 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.

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.

1.6 **Dependent** means the Subscriber's lawful spouse or Dependent Child.

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

1.8 **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.

1.9 **Health Care Facility** means, with respect to a facility or agency operating within the State of Maryland, a Health Care Facility as defined in Health General Article § 19-114, Annotated Code of Maryland.

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

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

1.12 **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.

1.13 **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.

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

1.15 **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.

1.16 **Non-Plan Provider** refers to a physician or other Health Care Practitioner or Health Care Facility that has not entered into a contract as a Plan Provider to provide medical care to Members.

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

1.18 **Plan Physician** means a Health Care Practitioner who:

A. Is a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.);

B. Has entered into a contract to provide medical care to Members; and

C. Has been designated by the Plan as a Plan Physician under the Agreement.

1.19 **Plan Provider** is a general term used to refer to any physician or other Health Care Practitioner or Health Care Facility that has entered into a contract to provide medical care to Members and which has been designated by the Plan as a Plan Provider under the Agreement.

1.20 **Primary Care** means services rendered by a Health Care Practitioner in general internal medicine, family practice medicine, pediatrics or obstetrics/gynecology.

1.21 **Primary Care Physician** means the Plan Physician selected by the Member to provide Primary Care to the Member and to coordinate and arrange for other required services.

1.22 **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.

1.23 **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

D. located in subacute beds in an inpatient psychiatric facility for an adult Member.

1.24 **Service Area** means the geographic area within which the Plan's services are available. The Service Area is the State of Maryland. The Plan may amend the defined Service Area at any time by notifying the Subscriber.

1.25 **Specialist** means a physician who is certified or trained to practice in a specified field of medicine and who is not designated as a Primary Care Physician.

1.26 **Specialty Services** means care provided by a Health Care Practitioner who is not providing Primary Care.

1.27 **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, guardian enrolling only a minor under this Plan, assumes all of the subscriber responsibilities on behalf of the minor.

1.28 **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.

1.29 **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.

1.30 **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.

1.31 **Type of Coverage** means Individual, which covers the Subscriber only, or family, under which an Individual may also enroll his or her Dependents. Type of Coverage categories may include Individual and Adult, or Individual and Child(ren).

1.32 **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. For example, if you and your spouse work for the same employer, you cannot be covered as a Subscriber and, at the same time, be covered as a Dependent through your spouse.

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.

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.

B. 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.

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

A. A biological child, stepchild, or grandchild or foster child of the Subscriber;

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

C. 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

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

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.

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.

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

1. was born out of wedlock;

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

3. does not reside with the Subscriber; or

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

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

1. send the non-insuring custodial parent ID cards, claim forms, the applicable Agreement 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 parent;

b. the provider of the Covered Services; or

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

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, a special enrollment period of sixty (60) days will be provided through the MHBE for triggering events including marriage, birth, adoption or placement for adoption . 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 who was not previously a citizen, national or lawfully present individual gains such status;

C. a qualified individual'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 enrollee 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 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. The MHBE must permit individuals whose existing coverage through an employer-sponsored plan is no longer affordable to gain access to a qualified health plan through the MHBE prior to the end of coverage through the employer-sponsored plan;

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

G. an Indian, as defined by section 4 of the Indian Health Care Improvement Act; and

H. a qualified individual 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 fifteenth 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 sixteenth and last day of the month, the MHBE must ensure a coverage effective date of the first day of the second following month.

1. The effective date of coverage for an individual enrolled during a special enrollment period due to birth, adoption, or placement for adoption shall be the date of birth, adoption, or placement for adoption. Coverage is automatic for the first 31 days after the birth, adoption or placement for adoption, or for a guardianship that is granted by a court or a 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.

2. In the case of birth, adoption or placement for adoption, 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.

3. In the case of marriage or in the case where a qualified individual loses minimum essential coverage, the MHBE must ensure coverage is effective on the first day of the following month.

SECTION 3
PREMIUMS AND PAYMENTS

3.1 **Premiums** 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 fifteenth of the month prior to the effective month of coverage. .

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.

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.

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.

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 at midnight on the last day of the grace period.

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

3.3 **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:

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

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

3.4 **Notice of Renewal** The Plan shall issue a notice of renewal to the Subscriber at least 45 days before the expiration of this Agreement. 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.

3.5 **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;

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 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.

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.

1. If the termination occurs because the Member is no longer eligible for coverage through a Qualified Health Plan through the MHBE, 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.

E. 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.

1. 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 coverage will be terminated.

2. If the Member (or a person seeking coverage on the Member's behalf) performs an act, practice, or omission that constitutes fraud, or unless 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 and benefits related the act, practice, omission that constitutes fraud or the intentional misrepresentation of material fact will be rescinded In

3. In the event of the Subscriber's death, 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** 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:

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

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

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. 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

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 **Working or 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 works or resides 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 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 Plan are determined before or after those of another Plan. The benefits of this Evergreen Plan:

    a. Shall not be reduced when, under the Order of Determination Rules, this Evergreen 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 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.

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 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.

Evergreen Plan means this Agreement.

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.

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) the medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts; and g) 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.)

The term Plan does not include:

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

2. Accident only coverage;

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

4. Specified accident coverage;

5. 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;

6. Benefits payable under an automobile policy; and

7. An elementary and or secondary school insurance program sponsored by a school or school system.

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

1. When this Evergreen Plan is a Primary Plan, its benefits are determined as if the secondary plan or plans did not exist.
2. 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.

3. When this Evergreen 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.

4. When there are more than two Plans covering the Member, this Evergreen 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.

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**

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

a. The other Plan has rules coordinating benefits with those of this Evergreen Plan; and

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

2. **Rules**

This Evergreen 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:

1) Secondary to the Plan covering the person as a dependent, and

2) 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 Plan and another Plan cover the same child as a dependent, the order of benefits shall be determined as follows:

1) 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.

2) 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 the parent's spouse does, that parent's spouse's Plan is the Primary Plan. This paragraph does not apply with respect to any claim for services rendered before the entity has actual knowledge of the terms of the court decree.

This rule also shall apply if: (i) a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage; or (ii) a court decree states that the parents have joint custody without specifying that

one parent has responsibility for the health care expenses or coverage of the dependent child.

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

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

(ii) The Plan of the spouse of the parent with the custody of the child;

(iii) The Plan of the parent not having custody of the child; and then

(iv) The Plan of the spouse of the parent who does not have custody of the child.

3) 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.

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:

1) First, the benefits of a Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent);

2) Second, the benefits under the continuation coverage.

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.

f. 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.

3. **Effect on the Benefits of this Evergreen Plan**

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

b. **Reduction in this Evergreen Plan's Benefits** When this Evergreen Plan is the Secondary Plan, the benefits under this Evergreen 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 Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Evergreen Plan.

c. **Right to Receive and Release Needed Information** Certain facts are needed to apply these COB rules. Evergreen 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 need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Evergreen Plan must give Evergreen any facts it needs to pay the claim.

d. **Facility of Payment** A payment made under another Plan may include an amount that should have been paid under this Evergreen Plan. If it does, this Evergreen 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 Plan. This Evergreen 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.

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

1) The persons it has paid or for whom it has paid.

2) Insurance companies; or

3) 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**

This provision applies to Members who are eligible for or enrolled in benefits 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 Agreement. Benefits that are covered by Medicare are subject to the provisions in this section.

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

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.

5.5 **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.

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 Plan Providers and Non-Plan Ambulance 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 Plan Provider or Non-Plan Ambulance Service Provider may bill the Member directly for such amounts.

When a Member receives Covered Services from Non-Plan Providers, the benefit payment will be made by the Plan directly to the Non-Plan Provider and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance 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 Non-Plan Provider may bill the Member directly for such amounts. If the Member has paid the health care provider for services rendered, benefits will be payable to the Member.

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 Plan Providers will be made available to Subscriber participants 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 Physicians

A. A Member may select any Primary Care Physician from the Plan's current list of Plan Physicians to be his or her Primary Care Physician. If the Primary Care Physician selected by the Member is not available, the Plan will assist the Member in making

another selection. If a change in Primary Care Physicians is required under this paragraph, the Plan will notify the Member in advance.

B. Members may change Primary Care Physicians at any time 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 Physician if the Member's Primary Care Physician is no longer available as a Primary Care Physician under the coverage provided by the Agreement.

D. The Plan may require a Member to change to a different Primary Care Physician 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 Physician due to any of the following:

1. The Member refused to follow a treatment procedure recommended by his or her Primary Care Physician and the Primary Care Physician 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.

If a change in Primary Care Physicians is required under Section 6.5.C., the action is effective upon written notice to the Member. However, if the Primary Care Physician 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 Physician 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 **Privacy Statement** 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 to Plan Physicians and Other Plan Providers** Plan Physicians and Plan Providers are independent individuals or organizations and are related to the Plan by contract only. Plan Physicians and Plan 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. Plan Physicians 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 Plan Physicians, Plan 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 12 months of continuous Subscriber coverage. Notwithstanding, premiums shall be fixed for the entire benefit year. The Subscriber will be given at least 45 days written notice prior to the changes mentioned above that are initiated by the Plan.

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 even 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 the 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 12:01 a.m. on that date.

C. When reference is made to termination being effective on a particular date, this means 12:00 midnight on that date.

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

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. The notice will be effective on the date mailed, 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 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. If claim forms are not sent within fifteen (15) days after the Plan's receipt of the 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.

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.

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

EVERGREEN INDIVIDUAL PLAN AGREEMENT
ATTACHMENT A
DESCRIPTION OF COVERED SERVICES

This Attachment to your Individual Plan Agreement describes the services eligible for benefits. Benefits will be provided for the services listed in Attachment B, Schedule of Benefits. It is important to refer to Attachment B to determine the payments the Plan will make; the charges for which the Member will be responsible; and any specific limits on the number of services that will be covered.

Evergreen Health Cooperative Inc.

[Signature]

_____
[Name]
[Title]

SECTION 1
GENERAL PROVISIONS

1.1 **Benefits Overview** This Section summarizes the basic features of the benefits program. Detailed information about these features can be found in the Schedule of Benefits, including specific terms and amounts and any special exceptions.

1.2 **Overview of Cost Sharing and Maximum Amounts** This Section summarizes the basic cost sharing and maximum amounts of your benefits program. Detailed information about these features can be found in the Schedule of Benefits, including specific terms and amounts and any special exceptions.

A. **Coinsurance** The percentage of the Allowed Benefit allocated between Evergreen and you, whereby Evergreen and you share in the payment for Covered Services.

B. **Copayment** A Copayment is similar to Coinsurance, except that Copayments are set as a fixed dollar amount, rather than as a percentage of expenses.

C. **Deductible** The amount of Covered Services based on the Allowed Benefit that must be incurred by an individual or a family per Benefit Year before Evergreen begins payment. The Schedule of Benefits provides additional information about the Deductible, including the amount of your Deductible and a list of the services that are subject to the Deductible.

D. **Out-of-Pocket Limit** The maximum amount that you will have to pay in Deductible, Coinsurance and Copayments in any given Benefit Year. Once the Out-of-Pocket Limit is met, the Member is no longer required to pay the Copayment or Coinsurance for the remainder of that Benefit Year. The Out-of-Pocket Limit is stated in the Schedule of Benefits.

1.3 **Benefits Under the Plan.** Benefits apply when Covered Services are provided by the Member's Primary Care Physician or obtained from other Plan Providers with prior authorization by the Primary Care Physician. Except for Emergency Services, Urgent Care Services, OB/GYN visits or for a referral to a Specialist or Non-physician Specialist who is not a Plan Provider, services must be provided or arranged by the Member's Primary Care Physician and obtained from a Plan Provider. Benefit payments are based on the Allowed Benefit as determined by the Plan for various types of services and providers.

Allowed Benefit is used as a basis of payment for services and supplies provided and billed by providers. For a Plan Physician or Plan Provider, the Allowed Benefit for a Covered Service is the lesser of, a) the provider's actual charge which, in some cases, will be a rate set by a regulatory agency; or b) the benefit amount, according to the Evergreen rate schedule, for the Covered Service that applies on the date that the service is rendered.

The benefit payment is made directly to the Plan Physician or Plan Provider and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits. The Member is responsible for any applicable Deductible, Copayment or Coinsurance and the Plan Physician or Plan Provider may bill the Member directly for such amounts. This Agreement does not provide benefits for services provided by Non-Plan Providers except for Emergency Services and Urgent Care Services as set forth in this Agreement.

However, if the Member has obtained a referral from a Plan Provider to obtain services from a Non-Plan Provider, for example, if a Plan Provider is not available to provide the service, payment will be issued in accordance with Section 19-710.1 of the Health General Article. The payment will be issued to either the Member or the Non-Plan Provider and is considered to be payment in full, except for any applicable Deductible, Copayment or Coinsurance amounts stated in the Schedule of Benefits.

1.4 **Utilization Management Requirements**. Certain Covered Services are subject to review and approval under Utilization Management requirements established by the Plan. Section 1.16 and Section 1.17 of this Agreement further describe Evergreen's Utilization Management program and Covered Services subject to prior authorization.

1.5 **Care Which is Provided by Plan Physicians** Members receive benefits for covered Outpatient Medical Services when care is provided or arranged by the Member's Primary Care Physician except in the case of OB/GYN visits, as specified in Section 1.12. 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 Attachment B, Schedule of Benefits).

1.6 **Care Which is not Provided by Plan Physicians** Except for Emergency Services or Urgent Care Services, benefits for services provided by Non-Plan Physicians or Providers will not be covered by Evergreen, unless prior written authorization is specifically given to the Member by the Primary Care Physician 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 in Section 1.14.

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

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 a Non-Plan Provider;

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

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

Emergency Services mean, with respect to an Emergency Medical Condition:

1. 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

2. Such further medical examination and treatment, to the extent they are within the capability 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)).

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 average knowledge of health and medicine, could reasonably expect the absence of 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.

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. Charges for care outside the Service Area required as a result of circumstances which, in the judgment of the Plan could have been foreseen by the Member prior to departing from the Service Area, except for Controlled Clinical trials as specified in Section 2.23.

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

3. Routine follow-up treatment within the Service Area provided by non-Plan Physicians. Follow-up treatment outside the Service Area is covered if required in connection with a covered out-of-area Emergency Care episode and the Plan determines that the Member could not reasonably be expected to return to the Service Area for such care.

1.8 **Follow-up Care after Emergency Surgery**

If the Plan authorizes, directs, refers, or otherwise allows a Member to access a hospital emergency facility or other Urgent Care Facility for a medical condition that requires emergency surgery:

A. 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:

1. Medically Necessary;

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

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

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

1.9 **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 Plan Provider

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

1.10 **Laboratory and Radiology Services**

In order for laboratory and radiology services to be covered, Members are required to have the services performed only by Plan laboratory and radiology providers. Services rendered by Plan laboratory and radiology providers will be covered even if ordered by providers who are not Plan Providers.

1.11 **Imaging Services**

In order for imaging services (CT/PET scans, MRIs) to be covered, Members are required to have the services performed only by Plan imaging providers. Services (CT/PET scans, MRIs) rendered by Plan imaging providers will be covered even if ordered by providers who are not Plan Providers.

1.12 **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 Plan Provider authorized under the Health Occupations Article to provide obstetric and gynecological services without a visit to the Primary Care Physician first. This care includes the ordering of related obstetric and gynecological items and services. The Plan Provider shall consult with an obstetrician/ gynecologist with whom the Plan 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 Member Deductible, Copayments and Coinsurance (see Attachment B, Schedule of Benefits).

1.13 **Standing Referral to a Specialist**

A Member may receive a standing referral to a Specialist who is a Plan Physician if:

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

B. The Member has a condition or Disease that:

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

2. Requires specialized medical care.

C. The Specialist:

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

2. Is a Plan Physician.

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

1. The Primary Care Physician;

2. The Specialist; and

3. The Member.

E. 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 Physician regarding the treatment and health status of the Member.

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

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

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

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

1. Evergreen 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

2. Evergreen 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 will treat the services received by the non-Plan Specialist or Non-physician Specialist as if the services were rendered by a Plan Physician or Plan Provider.

C. A decision by Evergreen 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.

1.15 **Direct Access to Plan 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 Plan 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.

1.16 **Utilization Management Requirements**

A. **Generally** Except for Urgent Care, Emergency Services and follow-up care after emergency surgery, it is the provider's responsibility to obtain prior authorization for all services that require prior authorization. Subsection 1.16F below lists those services. Through Utilization Management, Evergreen will: (i) review Member care and evaluate requests for approval of coverage in order to determine the Medical Necessity for the services; (ii) review the appropriateness of the hospital or facility requested; and (iii) determine the approved length of confinement or course of treatment in accordance with Evergreen established criteria.

In addition, Utilization Management may include additional aspects such as prior authorization, second surgical opinion and/or pre-admission testing requirements, concurrent review, discharge planning, disease management and case management.

B. **Plan Provider Responsibility** Plan Providers are encouraged to work with the Member to ensure that the necessary Utilization Management approvals have been obtained on the Member's behalf for services that require prior authorization.

C. **Procedures** To initiate Utilization Management review, providers or the facility that is involved in the Member's care will directly contact Evergreen. Evergreen will provide additional information regarding Utilization Management requirements and procedures, including telephone numbers and hours of operation, at the time of enrollment and, additionally, at any time upon the Member's request.

D. **Concurrent Review and Discharge Planning** Following timely notification as described, Evergreen will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment.

E. **Disease Management** Evergreen will help a Member with a chronic disease follow recommended testing and exams and understand medication regimens to improve the Member's ability to care for him or herself. Chronic diseases include, but may not necessarily be limited to, diabetes, heart failure, coronary artery disease, chronic obstructive pulmonary disease, and asthma.

F. **Case Management – Care Coordination** This is a feature of this health benefit plan for a Member with a chronic condition, serious illness, or complex health care needs. Evergreen will initiate and perform case management services, as deemed appropriate by Evergreen, which may include the following:

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

2. Education of individual/family regarding disease, treatment compliance and self-care techniques;

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

4. Assistance in arranging for a principal physician to deliver and coordinate the Member's care, and/or consultation with physician Specialists; and

5. Referral of Member to community resources.

H. **Appealing a Utilization Management Decision** If the Member, the Member's representative or the Member's provider disagrees with a Utilization Management decision, Evergreen will review the decision upon the Member's request. A Utilization Management appeal will be reviewed and decided upon by the Evergreen 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 Member's case with the Member's physician and/or request the opinion of a Specialist board certified in the same specialty as the treatment under review. Any non-certification or penalty may be appealed pursuant to Evergreen's appeals and grievance procedures.

I. **Evergreen Personnel Availability for Prior Authorization** Evergreen shall have personnel available to provide prior authorization at all times when such prior authorization is required.

1.17 **Covered Services Subject to Utilization Management**

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

A. **Hospital Inpatient Services** All elective inpatient hospital admissions (except for maternity and emergency admissions) require prior authorization. The provider must contact Evergreen (or, on the Member's behalf, have the provider contact Evergreen) 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 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:

1. 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.

2. For emergency admissions, Evergreen 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's emergency admission requirements.

B. **Inpatient Mental Health and Substance Abuse Services** Evergreen must be contacted for prior authorization at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because care is required immediately due to the Member's condition, Evergreen 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 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'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 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 provider network activities administered by or on behalf of Evergreen 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 In-Network mental health providers. The Member is responsible to obtain prior authorization for all other providers.

C. **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 Member must contact Evergreen or have his or her physician, psychologist or other provider contact Evergreen's Mental Health Management Program for prior authorization at least five (5) business days prior to admission to a Related Institution.

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

E. **Ambulance Services** Prior authorization is required for air ambulance services only, except for Medically Necessary air ambulance services in an emergency.

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

1. Hospital Inpatient Services, including Acute rehabilitation and Long-Term Acute Hospitals;
2. Inpatient Mental Health and Substance Abuse Services;
3. Related institution;

4. Transplants;
5. Ambulance Services;
6. Home Health Services by HHA (PT/OT/ST/RN);
7. Diagnostic Imaging (PET scans, MRAs, MRIs);
8. Interventional Radiology;
9. Nuclear Cardiology;
10. Intensity Modulated Radiation Therapy (IMRT);
11. Durable Medical Equipment is generally on a rent to own basis. Not all DME requires prior authorization. Members need to call the 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 - rental 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. Wound vacs 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 (ie E1399)

    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.

12. Other services:
    a. Inpatient hospice, sub-acute and skilled nursing facility;
    b. Outpatient procedures - not all outpatient tests and services require prior authorization. Members need to call the Member Services number to check to see if Plan approval is required.
    c. Out of service area provider requests (other than ER/Urgent);
    d. Hospital outpatient observation greater than twenty-four (24) hours;
    e. Chiropractic services;
    f. Infertility services;
    g. Genetic testing during pregnancy and for pediatric members and adults;
    h. Rehabilitative services: physical, occupational, speech therapy and cardiac and pulmonary rehabilitation;

i. Podiatry;
j. Prosthetics;
k. Medical Nutritional Counseling;
l. Home Infusion Services;
m. Home services by Specialist;
n. Ancillary labs or tests performed as in home services;
o. Home Hospice;
p. Medical Food;
q. Partial hospitalization for mental health services;
r. Intensive Outpatient (IOP) services;
s. Residential services for substance abuse.

Evergreen 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 will notify the Member of these changes at least forty-five (45) days in advance.

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 Agreement, including Section 3, ***Exclusions*** and, where applicable, the Utilization Management and other requirements described in Section 1.

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

2.2 Inpatient hospital services.

2.3 Outpatient hospital services.

2.4 Mental health and substance abuse services set forth below, subject to the limitations and exclusions set forth in this Section 2.4.

A. 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:

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

a. diagnostic evaluation;

b. crisis intervention and stabilization for acute episodes;

c. medication evaluation and management (pharmacotherapy);

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

e. diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;

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

2. Electroconvulsive therapy;

3. Inpatient professional fees;

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

5. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility;

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

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

1. Room and board, such as:

a. 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;

b. General nursing care;

c. Meals and special diets.

2. Services provided by a hospital or residential treatment center.

C. Outpatient hospital services such as partial hospitalization or intensive day treatment programs.

D. Outpatient services and supplied billed by a hospital for emergency room treatment.

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

1. Services by pastoral or marital counselors;

2. Therapy for sexual problems;

3. Treatment for learning disabilities and intellectual disabilities;

4. Telephone therapy;

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

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

7. Marriage counseling;

8. Services that are not Medically Necessary.

2.5 Emergency Services and Urgent Care Services (see definitions, limitations and exclusions in Section 1.7).

2.6 Detoxification in a hospital or Related Institution.

2.7 Medically necessary ambulance services to or from the nearest hospital where needed medical services can appropriately be provided.

2.8 Home Health Care services as follows:

A. As an alternative to otherwise Covered Services in a hospital or Related Institution; and

B. For Members who receive less than 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:

1. one home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient Health Care Facility; and

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

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

A. 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

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

2.9 Hospice Care, as defined in 42 U.S.C. §1395x(dd).

2.10 Durable Medical Equipment, as defined, 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.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that:

A. can withstand repeated use;

B. is primarily and customarily used to serve a medical purpose;

C. generally is not useful to an individual in the absence of a disability, illness, or injury; and

D. is appropriate for use in the home.

2.11 Outpatient laboratory and diagnostic services, including bone mass measurement for a qualified individuals for the prevention, diagnosis and treatment of osteoporosis.

A. 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.

B. Qualified Individual means

1. an estrogen deficient individual at clinical risk for osteoporosis;

2. an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic 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;

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

4. an individual with primary hyperparathyroidism; or

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

2.12 Outpatient Rehabilitative Services, as defined, subject to any additional limitations set forth in Schedule of Benefits, Attachment B, for a maximum of:

A. 30 physical therapy visits per condition per year;

B. 30 speech therapy visits per condition per year; or

C. 30 occupational therapy visits per condition per year.

Outpatient Rehabilitative Services means occupational therapy, speech therapy and physical therapy provided to Members not admitted to a hospital or Related Institution.

2.13 Chiropractic services, which are limited to 20 visits per condition per Benefit Year.

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

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

A. Primarily engaged in providing:

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

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

B. 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.

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

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

A. The patient is a covered Member;

B. The patient's oocytes are fertilized with the patient's spouse's sperm;

C. 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;

D. 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

E. 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.

Limitations on in vitro fertilization benefit – Coverage for in vitro fertilization is limited to three (3) in vitro fertilization attempts per live birth.

2.16 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.

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.

2.17 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.

2.18 Family planning services, 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.

2.19 Habilitative Services, as defined.

A. **Habilitative Services** for members age 0-19, means services for the treatment of congenital and genetic birth defects, including cleft lip and cleft palate, orthodontics, oral surgery, otologic therapy, audiological therapy, occupational therapy, physical therapy, and speech therapy to enhance the a person's ability to function.

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

C. Habilitative Services for adults (age 19 and older), subject to any additional limitations set forth in Attachment B, are provided for a maximum of:

1. 30 physical therapy visits per condition per year;

2. 30 speech therapy visits per condition per year; or

3. 30 occupational therapy visits per condition per year.

2.20 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.

2.21 Pregnancy and maternity services.

A. 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.

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

C. If the mother's hospital stay is shorter than described above in Subsection A., benefits will be provided for one home health care visit scheduled to occur within 24 hours of discharge and an additional visit if prescribed by the Plan Physician.

D. 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.

E. 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. For non-high deductible plans, no co-payment, coinsurance or deductible will be assessed; only the deductible will be applied to high deductible plans as defined by Section 812(a)(3) of the Maryland Insurance Article.

2.22 Prescription drugs subject to the provisions of this Section 2.22 and the limitations in Schedule of Benefits, Attachment B.

A. **Definitions** For purposes of this Section 2.22, the following terms have the prescribed Meanings:

1. **Brand Name Drug** A Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and that may be used and protected by a trademark.

2. **Generic Drug** Any Prescription Drug approved by the FDA that has the same bio-equivalency as a specific Brand Name Drug.

3. **Maintenance Drug** A Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.

4. **Non-Preferred Brand Name Drug** A drug that the Plan has not designated as a preferred drug.

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

6. **Preferred Drug List** The list of Brand Name Drugs, Generic Drugs and Specialty Drugs issued by the Plan and used by Health Care Practitioners when writing, and pharmacists, when filling, prescriptions. The Plan may change this list periodically without notice to Members. A copy of the Preferred Drug List is available to the Member upon request.

7. **Specialty Drugs** High cost prescription drugs used to treat or diagnose rare or complex conditions. Specialty Drugs are subject to prior approval under the Utilization Management program.

B. The Plan covers prescription drugs and devices, including insulin and birth control drugs, and refills for prescription eye-drops in accordance with our Preferred Drug List guidelines when a Plan Provider prescribes drugs in accordance with the Plan's Preferred Drug List. Prescription drugs includes up to a 90-day supply of Maintenance Drugs dispensed in a single dispensing of a prescription drug. Each prescription refill is subject to the same conditions as the original prescription. A prescription for medication in the health plan formulary will be covered if it is issued by a non-plan provider. Note that the Plan will not impose a copayment or coinsurance for a covered prescription drug or device when the retail price does not exceed the retail price of that prescription drug or device.

1. 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.

2.23 Controlled Clinical Trials, as defined.

Controlled Clinical Trials means a treatment that is:

A. Approved by an Institutional Review Board;

B. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and

C. is a study or investigation that is approved or funded by one or more of the following:

1. The Food and Drug Administration;

2. The National Institutes of Health;

3. The Centers for Disease Control and Prevention;

4. The Agency for Health Care Research and Quality;

5. The Centers for Medicare & Medicaid Services;

6. Cooperative group or center of any of the entities described in clauses 1-5 above or the Department of Defense or the Department of Veterans Affairs;

7. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

D. The clinical trial will be covered if:

1. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

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

Member's treating physicians are not required to obtain a referral or prior authorization by the Primary Care Physician or other providers for a service to be covered. Services incurred in a Controlled Clinical Trial may be rendered outside the Plan's Service Area.

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

2.25 Diabetes treatment, equipment and supplies.

A. Diabetes equipment includes glucose monitoring equipment under the durable medical equipment coverage for Insulin-Using Beneficiaries. Insulin pumps are included if Medically Necessary when: a) needed for normal wear; or b) the changes in the member's condition warrant an additional or different insulin pump based on clinical documentation. 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.

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

2.26 Reconstructive breast surgery and breast prosthesis.

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

B. 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.

1. Coverage will also be provided for physical complications of all stages of mastectomy, including lymphedemas.

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

A. 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

B. 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.

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.

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

2.28 The cost to beneficiaries of hearing aids for covered Members ages zero to eighteen (0 to 18) years of age for each hearing-impaired ear every thirty-six (36) months.

2.29 The surgical treatment of Morbid Obesity.

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.

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.

A. Utilization Management review is required for the surgical treatment of Morbid Obesity.

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

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

2. Designated by Evergreen.

C. 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.

2.30 Cardiac Rehabilitation.

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, as defined by Evergreen.

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:

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

2. 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.

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

2.31 In addition to any other preventive benefits provided in this Agreement, Evergreen 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:

A. 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;

B. 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;

C. 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

D. With respect to women, such additional preventive care and screenings, not described in paragraph A 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.

2.32 Pulmonary rehabilitation services are covered as follows:

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

B. Coverage is provided for all Medically Necessary pulmonary rehabilitation services, as defined by Evergreen.

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:

1. Services must be provided by a provider at an Evergreen approved place of service equipped and approved to provide pulmonary rehabilitation services.

2. 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.

3. Pulmonary rehabilitation services are limited to one (1) program per lifetime and must be authorized in advance under Utilization Management program.

2.33 Treatment of obesity benefits are provided for Members under age nineteen (19) as follows:

A. Well child care visit for obesity evaluation and management.

B. Office visits for the treatment of childhood obesity.

C. Benefits for treatment of Obesity are available to the same extent as office visit benefits provided for preventive care services.

2.34 Pediatric vision benefits for children up to age nineteen (19) as follows:

A. One routine eye examination, including dilation if professionally indicated, each year;

B. One pair of prescription eyeglass lenses each year;

C. One frame each year;

D. In lieu of eyeglasses, one pair of contact lenses each year; and

E. 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.

2.35 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.

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

2.36 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.

2.37 Patient-Centered Medical Home (PCMH) Program Benefits as set forth in this Section 2.37.

A. For purposes of this Section 2.37, the following terms have the prescribed meanings:

1. **Care Coordination Team** means the Health Care Providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

2. **Care Plan** means the plan directed by a Health Care Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

3. **Health Care Provider** means a physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services described in this Section 2.37.

4. **Patient-Centered Medical Home Program** means medical and associated services directed by the PCMH team of medical professionals to:

a. Foster the Health Care Provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;

b. Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and

c. Exchange medical information with Evergreen, other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.

5. **Qualifying Individual** means a Member with a chronic condition, serious illness or complex health care needs, requiring coordination of health services and who agrees to participate in the Patient-Centered Medical Home Program.

B. Patient-Centered Medical Home Program benefits will be provided for associated costs for coordination of care for the Qualifying Individual's medical conditions, including:

1. Liaison services between the Qualifying Individual and the Health Care Provider(s), nurse coordinator, and the Care Coordination Team;

2. Creation and supervision of the Care Plan, inclusive of an assessment of the Qualifying Individual's medical needs;

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

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

C. Benefits provided through the Patient-Centered Medical Home Program are available only when provided by an Evergreen-approved Health Care Provider who has elected to participate in the PCMH.

D. Except for an Agreement used in conjunction with a Health Savings Account (HSA), Patient-Centered Medical Home Program benefits are not subject to the Deductible. There is no Copayment or Coinsurance for benefits provided under this Section 2.37.

2.38. Hair prosthesis, subject to the conditions and limitations of this Section.

A. Hair prosthesis services are covered only for a Member whose hair loss results from chemotherapy or radiation treatment for cancer.

B. To be covered under this Section, a hair prosthesis must be prescribed by the oncologist in attendance.

The plan will provide coverage under this Agreement for only one hair prosthesis.

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.

Medical Necessity or Medically Necessary means health care services or supplies that a 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 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. 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 the views of providers practicing in relevant clinical areas and any other relevant factors.

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, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury. This exclusion does not apply to the pediatric vision benefit for children up to age nineteen (19) set forth in Section 2.34.

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:

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

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.

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 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 2.38 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 related to an abortion.

3.50 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.

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

ATTACHMENT B
SCHEDULE OF BENEFITS
Evergreen Health Insurance – Gold Plus Plan

ANNUAL DEDUCTIBLE	
For individual coverage the In-Network Deductible per Benefit Year is:	$1,500
For individual coverage the Out-of-Network Deductible per Benefit Year is:	$3,000
For family coverage the In-Network Deductible per Benefit Year is:	$3,000
For family coverage the Out-of-Network Deductible per Benefit Year is:	$6,000
Copayments and Coinsurance amounts may be used to satisfy the Deductible. Amounts incurred for failure to comply with the Utilization Management Program requirements may not be used to satisfy the Deductible.	
The annual Deductible applies to all Covered Services, except for preventative care or any service, drug, or supply that has no charge to member. For family coverage the annual Deductible may be met entirely by one Member or by combining eligible expenses of two or more family Members.	
OUT-OF-POCKET LIMIT	
For individual coverage the In-Network Out-of-Pocket Limit per Benefit Year is:	$3,500
For individual coverage the Out-of-Network Out-of-Pocket Limit per Benefit Year is:	$7,000
For family coverage the In-Network Out-of-Pocket Limit per Benefit Year is:	$7,000
For family coverage the Out-of-Network Out-of-Pocket Limit per Benefit Year is:	$14,000
The In-Network Deductible and Out-of-Network Deductible apply separately. An amount paid toward either the In-Network Deductible or Out-of-network Deductible does not apply against the other Deductible. The In-Network Out-of-Pocket Limit and Out-of-Network Out-of-Pocket Limit apply separately. An amount paid toward either the In-Network Out-of-Pocket Limit or Out-of-Network Out-of-Pocket Limit does not apply against the other Limit. 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 the 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.

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

REDUCED COST-SHARING FOR 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.

SERVICES SUBJECT TO MEMBER COST-SHARING			
SERVICE	**LIMITATIONS**	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Inpatient Services			
Hospital Inpatient		$1000 per admission	50% Coinsurance
Behavioral Health Inpatient		$1000 per admission	50% Coinsurance
Physician (Medical and Behavioral) Hospital Inpatient Services		No charge	50% Coinsurance
Outpatient Services			
Primary Care Services		$20 Copayment per visit	Not Covered
Specialty Care Services		$40 Copayment per visit	50% Coinsurance
Behavioral Health Care Services		$20 Copayment per visit	50% Coinsurance
Outpatient Facility Fee		20% Coinsurance	50% Coinsurance
Outpatient Services or Surgery		20% Coinsurance	50% Coinsurance

SERVICES SUBJECT TO MEMBER COST-SHARING			
SERVICE	**LIMITATIONS**	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Outpatient Laboratory and Radiological Services; Diagnostic Services, including Maternity Diagnostic		$25 Copayment	50% Coinsurance
Imaging Services (CT/PET scans, MRIs)		$100 Copayment	50% Coinsurance
Urgent Care Services		$40 Copayment	50% Coinsurance if in service area $40 Copayment if out of service area
Home Health Care Services		$40 Copayment per visit	50% Coinsurance
Hospice Care Services		10% Coinsurance	50% Coinsurance
Durable Medical Equipment		20% Coinsurance	50% Coinsurance
Ambulance Services		20% Coinsurance	50% Coinsurance
Office Visits			
Office Visits for Illness/Injury (Non-preventive Office Visit)		$20 Copayment per visit (Primary Care Services) $40 Copayment per visit (Specialty Care Services)	Primary Care Services Not Covered 50% Coinsurance for Specialty Care Services
Outpatient Rehabilitative Services			
Physical Therapy	30 visits, per condition, per Benefit Year. Up to 60 additional visits per Benefit Year for cardiac rehabilitation.	$40 Copayment per visit	50% Coinsurance
Speech Therapy	30 visits, per condition, per Benefit Year. Up to 60 additional visits per Benefit Year for cardiac rehabilitation.	$40 Copayment per visit	50% Coinsurance

SERVICES SUBJECT TO MEMBER COST-SHARING			
SERVICE	**LIMITATIONS**	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Occupational Therapy	30 visits, per condition, per Benefit Year. Up to 60 additional visits per Benefit Year for cardiac rehabilitation.	$40 Copayment per visit	50% Coinsurance
Habilitative Services			
Physical Therapy	Adult (Age 19 and Over) Limited to 30 visits, per condition, per Benefit Year.	$40 Copayment per visit	50% Coinsurance
Speech Therapy	Adult (Age 19 and Over) Limited to 30 visits, per condition, per Benefit Year.	$40 Copayment per visit	50% Coinsurance
Occupational Therapy	Adult (Age 19 and Over) Limited to 30 visits, per condition, per Benefit Year.	$40 Copayment per visit	50% Coinsurance
Other Services			
Emergency Room		$250 Copayment	$250 Copayment
Preventive Services (includes preventative care, well woman exam and mammogram, immunizations and screening)		No Charge	50% Coinsurance
Chiropractic Services	Limited to 20 visits per condition, per Benefit Year.	$40 Copayment per visit	50% Coinsurance
Well Child Visits		No Charge	50% Coinsurance
Infertility Services (including in vitro fertilization)	3 in vitro fertilization attempts per live birth.	20% Coinsurance	50% Coinsurance

SERVICES SUBJECT TO MEMBER COST-SHARING			
SERVICE	**LIMITATIONS**	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Prenatal and Postnatal Care		No Charge	50% Coinsurance
Professional Nutritional Counseling and Medical Nutritional Therapy		$40 Copayment per visit	50% Coinsurance
Skilled Nursing Facility Services	Limited to 100 days per Benefit Year.	$1000 per admission	50% Coinsurance
Family Planning		$40 Copayment per visit	50% Coinsurance
Pulmonary Rehabilitation	One Program Per Lifetime	20% Coinsurance	50% Coinsurance
Covered Services not specifically mentioned in this Schedule of Benefits		20% Coinsurance	50% Coinsurance
Hair Prosthesis		20% Coinsurance	50% Coinsurance
Pediatric Vision and Hearing (<19 years old)			
Eye Exam (child)		$10 Copayment	50% Coinsurance
Prescription Eyeglasses (child)	One frame/one pair of lenses, OR one pair of contact lenses per Benefit Year.	20% Coinsurance	50% Coinsurance
Low vision (child)	One exam every 60 months, four low vision follow-up visits in any 5-year period and optical devices.	20% Coinsurance	50% Coinsurance
Hearing Aids (Child)	One device per ear every 36 months	20% Coinsurance	50% Coinsurance
Prescription Drugs			
Generic retail ***	30-Day Supply Limit	$5 Copayment	50% Coinsurance
Generic mail	90-Day Supply Limit	$15 Copayment	50% Coinsurance
Preferred retail **	30-Day Supply Limit	$20 Copayment	50% Coinsurance
Preferred mail	90-Day Supply Limit	$60 Copayment	50% Coinsurance
Non-Preferred retail	Minimum payment of $60 per prescription***	80% Coinsurance*	Not Covered
Non-Preferred mail	Minimum payment of	80% Coinsurance*	Not Covered

SERVICES SUBJECT TO MEMBER COST-SHARING			
SERVICE	**LIMITATIONS**	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
	$180 per prescription***		
Specialty retail	Plan covers costs that exceed $250 per prescription	20% Coinsurance	50% Coinsurance
Specialty mail	Plan covers costs that exceed $250 per prescription	20% Coinsurance	50% Coinsurance
Preventive Medication (see list)		No Charge	50% Coinsurance

***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.**

****Maintenance medications will be available in a 90-Day Supply Limit for generic and preferred retail.**

*****Member is responsible for minimum payment.**

Evergreen Health Cooperative Inc.
3000 Falls Road, Suite 1
Baltimore, Maryland 21211
443-475-0090

EVERGREEN INDIVIDUAL PLAN AGREEMENT
OUT-OF-NETWORK BENEFIT AMENDMENT

This amendment is effective as of the effective date of the Agreement to which it is attached. Under this amendment and for an additional premium, Members are entitled to receive services other than Primary Care Services from any Plan Provider or Non-Plan Provider, subject to the terms and conditions of this amendment. Members must still receive Primary Care Services from an Evergreen Primary Care Physician. Under this amendment, Members may receive Covered Services other than Primary Care Services from any Plan Provider (In-Network) or from Non-Plan Providers outside the Evergreen Plan Provider network (Out-of-Network). Out-of-Network Benefits will be provided for all services and supplies listed as covered in Section 2 of the Description of Covered Services, Attachment A, as well as those found in any additional benefits riders or amendments, if applicable. Attachment B, Schedule of Benefits, provides the Member's cost-sharing requirements for both In-Network and Out-of-Network benefits.

SECTION 1: GENERAL PROVISIONS

1.1 **Evergreen Health Plan Network Requirements** Under the Evergreen Individual Plan Out-of-Network Benefits option, the Member may receive benefits for a particular service, other than Primary Care Services, either from any Plan Provider participating in the Evergreen Health Plan provider network or from a Non-Plan Provider. When Covered Services are received from a Plan Provider, the Member is eligible for a higher level of benefits than the Out-of-Network benefits.

A. **In-Network Benefits** To obtain In-Network benefits, Members must receive Covered Services from Plan Providers. In-Network benefits also apply to covered Emergency Services as described in Section 1.7, Follow-up Care after Emergency Surgery as described in Section 1.8, Urgent Care Services as described in Section 1.9, and Referral to a Specialist or Non-physician Specialist as described in Section 1.14 of the Description of Covered Services (Attachment A), whether received from a Plan Provider or Non-Plan Provider. Plan Providers will handle any Utilization Management requirements on the Member's behalf as stated in the Description of Covered Services, Attachment A, Section 1.4.

1. When the Member uses a Plan Provider, benefits are based on the appropriate Allowed Benefit. The level of benefits is reflected in

Attachment B, Schedule of Benefits. Plan Providers will accept 100% of the Allowed Benefit as full payment for Covered Services minus any applicable Deductible, Copayment or Coinsurance that may apply.

2. Plan Providers will submit claims for Covered Services rendered directly to Evergreen.

3. Services rendered by Plan Providers will be covered as In-Network. Services rendered by Non-Plan Providers will be covered as Out-of-Network except for the services described in Sections 1.7, 1.8, and 1.12 of the Description of Covered Services (Attachment A), which will be covered as In-Network.

4. Certain In-Network Covered Services require prior authorization that will be obtained by the physician.

B. **Out-of-Network Benefits** Out-of-Network benefits will be provided when Covered Services are provided by a Non-Plan Provider, except as otherwise authorized by Evergreen. When Out-of-Network benefits apply, Covered Services are eligible for Out-of-Network benefits as stated in the Schedule of Benefits. When the Member uses a Non-Plan Provider, benefits are based on the appropriate Allowed Benefit (except for those services listed in Section 1.1 A). The Allowed Benefit may be substantially less than the provider's actual charge to the Member. The Non-Plan Providers must accept the Allowed Amount from the Plan and cannot balance bill the Member. However, Non-Plan Providers may collect from the Member any applicable Deductibles, Copayment and Coinsurance amounts as well as any charges for non Covered Services.

1. Members are required to submit claims for Covered Services rendered by Non-Plan Providers to receive benefits. Members may have claims submitted by the Non-Plan Provider on their behalf. A claim submitted by a Non-Plan Provider on behalf of a Member must be submitted within 180 days from the date of service. Refer to Section 5 of this amendment for claims submission requirements.

2. Members are responsible for providing all information requested by Evergreen with respect to claims for Covered Services provided by Non-Plan Providers, including, but not limited to, medical records.

SECTION 2: UTILIZATION MANAGEMENT REQUIREMENTS

Except for Urgent Care, Emergency Services and follow-up care after emergency surgery, it is the Member's responsibility to obtain prior authorization for all services that require prior authorization. Members must make arrangements with Evergreen to obtain Utilization Management authorizations and approvals required for Covered Services received from both Plan Providers and Non-Plan Providers. Refer to Sections 1.15 and 1.16 of the Description of Covered Services (Attachment A) Agreement for a full description of Utilization Management requirements and for Covered Services that require prior authorization.

SECTION 3: COVERED SERVICES

3.1 **Covered Benefits** Except as provided in Section 3.2, Out-of-Network Benefits will be provided for all services and supplies listed as covered in Section 2 of the Description of Covered Services (Attachment A), as well as those found in the additional benefits rider, if applicable, which is attached. However, benefits for Emergency Services and Urgent Care Services, as described in Section 1.7, Follow-up Care after Emergency Surgery as described in Section 1.8, and Referral to a Specialist or Non-physician Specialist as described in Section 1.14 of the Description of Covered Services (Attachment A) will be provided under the In-Network option, whether received from a Plan Provider or Non-Plan Provider. When Covered Services are received under the Out-of-Network component, benefits will be provided at the level described in Attachment B, Schedule of Benefits. Out-of-Network benefits are subject to benefit limits as described in Attachment B, Schedule of Benefits. Benefit limits are applied separately to the In-Network and Out-of-Network services, they are not combined.

3.2 **Services Not Covered** Out-of-Network benefits will not be provided for:

A. Any service or supply, which is listed as an excluded service under the Description of Covered Services (Attachment A).

B. Any service or supply to the extent that benefits are limited under the Description of Covered Services (Attachment A) or Section 3.1. Benefit limits are applied separately to the In-Network and Out-of-Network services they are not combined.

SECTION 4: OUT-OF-NETWORK BENEFITS

4.1 **Definitions** In addition to the definitions contained in the Agreement, the bolded terms below has the following meaning when capitalized:

Allowed Benefit The Allowed Benefit for providers who are not under written contract with Evergreen will be based on the rate defined in Section 4.2.

4.2 For a Non-Plan Provider that is a hospital in the State of Maryland, the Allowed Benefit for a Covered Service is a rate set by the state regulatory agency.

For a Non-Plan 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 In-Network Ambulance Service Providers.

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

Except for Covered Services rendered by a Non-Plan hospital in the State of Maryland or a Non-Plan Ambulance Service Provider, the Allowed Benefit for a Covered Service rendered by an Non-Plan 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.

Payments for Covered Services will be made by Evergreen directly to Non-Plan Providers. The Member is responsible for any applicable Deductible, Copayment and Coinsurance amounts. If the Member has paid a Non-Plan Provider for Covered Services rendered, benefits will be payable to the Member.

SECTION 5: FILING CLAIMS

5.1 **Member Responsibility to File Claims** When services are covered under the Out-of-Network component, Members are required to submit claims or have claims filed by their provider in order to receive benefits. Written proof of loss must be furnished to Evergreen as described in Section 5.3. If the Non-Plan Provider does not directly submit the claim for Covered Services to Evergreen, Members are required to submit claims for Covered Services rendered by Non-Plan Providers to receive benefits. The Member will be liable for any applicable Deductible, Copayment or Coinsurance.

5.2 **Claim Forms** A Member may request a claim form by writing or calling Evergreen. Evergreen, upon receipt of a notice of a claim, will send the Member claim forms. If claim forms are not sent within thirty (30) days after Evergreen's receipt of the notice of claim, the Member shall be considered to have complied with the requirements of the Agreement as to proof of loss upon submitting 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 a claim is made. Benefits will be paid within 30 days after receipt of written proof of loss.

5.3 **Proof of Loss** When a Member obtains Covered Services under the Out-of-Network component, written proof of loss must be furnished to Evergreen within 180 days following the date of services. Failure to furnish proof within the time required does 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, not later than one (1) year from the time proof is otherwise required.

SECTION 6: OTHER TERMS AND CONDITIONS

6.1 All terms, conditions, limitations and exclusions of the Agreement apply to the benefits provided by this amendment, except as specifically changed by this amendment. Without limiting the foregoing, the referral requirements of the Agreement apply to In-Network benefits provided by this amendment.

Evergreen Health Cooperative Inc.

[Signature]

_____

[Name]

[Title]

Evergreen Health Cooperative Inc.
[3000 Falls Road, Suite 1]
[Baltimore, Maryland 21211]
[410-475-0990]

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.

TABLE OF CONTENTS

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.