# *Your Member Handbook*

Evergreen Health Care/HMO

evergreen HEALTH

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Welcome to

# *EVERGREEN HEALTH*

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

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

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

**KEEP THIS HANDBOOK IN A SAFE PLACE FOR FUTURE REFERENCE.**

Also available online **www.evergreenmd.org/memberportal**

## II. Frequently Asked Questions

**Q: What is the Evergreen Health Member Portal?**

**A:** The online Member Portal helps you stay informed and lets us stay in touch with you. The Member Portal is the place where, if you have purchased your Plan directly from Evergreen Health rather than through your employer you can pay your premium. The Member Portal gives all Members on-line access to important forms, your owner's manual and Member Handbook, and information for your use as a Member of Evergreen Health. Visit: www.evergreenmd.org/memberportal

**Q: Where can I find a copy of my Plan Agreement?**

**A:** Your Plan Agreement can be viewed online in the Member Portal in your Owner's Manual. Please visit the Member Portal at www.evergreenmd.org/memberportal.

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

**A:** Your Member Identification (ID) Card is important to have with you to show you are a Member of Evergreen Health. You will present your Member ID Card when you receive care or fill a prescription. Always carry your Member ID Card with you. If you have lost your Member ID Card, you can print a copy of your Member ID Card on the Member Portal: www.evergreenmd.org/memberportal

**Q: What if I need to see a specialist?**

**A:** If you need care from a specialist, your Primary Care Provider (PCP) will help to determine where you can get the best specialty care. Your PCP will then authorize a Referral to the specialist (without a PCP Referral, specialist charges may apply).

**Q: Do I need a Referral for care?**

**A:** You do need a Referral to seek care from a provider other than your PCP–these providers are usually specialists. Your PCP will be responsible for issuing the Referral. If you seek care from a Non-Plan Provider/Out-Of-Network Provider, a denial of the benefits may result and you will be responsible for all charges.

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

A: Your benefits are detailed in your Plan Agreement. You may also contact Member Services at the number listed on the front of your Member ID Card to obtain specific information on applicable contract benefits such as medical care, prescription benefits, Pediatric Dental Care, etc.

## III. COVERED BENEFITS: HOW TO GET CARE

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

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

If you are seeking care from a provider other than your PCP, you will need to ask your PCP for a Referral. If the services are obtained from a Plan/Network without the Referral, you may be liable for all charges.

### ACCESS TO PRIMARY CARE AND SPECIALTY CARE

Evergreen Health HMO members must select a PCP from the Evergreen Health network. To select a PCP, go to **evergreenmd.org/provider-directory**. The Evergreen Health network includes providers directly contracted with Evergreen Health and providers contracted with our partner, PHCS.

You may choose one of the following PCP provider types:

- Family Practice Physician, General Practice Physician, Geriatric Physician, Allopathic or Osteopathic, Pediatrician, OB-GYN, Internal Medicine Physician, or Nurse Practitioner.

If you need care from a specialist, your PCP will help to determine where you can get the best specialty care. Your PCP will then authorize a Referral to the specialist (without a PCP Referral, specialist charges may apply).

If your condition is urgent and you cannot reach your PCP, see the information in the Emergency and Urgent Care section of this Member Handbook.

### SELF REFERRED SERVICES

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

- Dentist for covered pediatric services – certain procedures require a prior authorization
- Dialysis – participating dialysis facilities only
- Emergency Medicine – emergency care as defined in the Plan Agreement
- Optometry/Ophthalmology through the Block Vision network for covered routine pediatric and select adult services depending on your plan type
- Obstetric and Gynecological care – routine care and family planning
- Psychiatrist, Psychologist, Licensed Clinical Social worker – outpatient mental health participating providers

## MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Benefits are available for mental health and substance services from Plan Providers/Network Providers.

If you think you are in need of mental health or substance abuse services, you may call the number on your Member ID Card during normal business hours. A trained representative will explain your benefits and can assist you with locating a Plan Provider/Network Provider. For after-hours mental health or substance abuse services, **call 855-343-9027.**

If you experience a mental health crisis and feel that you are a danger to yourself or others, you should seek immediate emergency room evaluation and treatment.

Authorization must be obtained at least five (5) business days prior to an elective or scheduled admission for inpatient mental health or substance abuse services. Your Plan Provider/Network Provider will be responsible for obtaining prior authorization.

Your Plan's Schedule of Benefits and Coverage and Plan Agreement has more information about the specific provisions and limitations of your coverage.

## PHARMACY SERVICES

Your Plan includes certain retail and mail order prescription benefits, including insulin and birth control drugs, and refills for prescription eye drops in accordance with Evergreen Health's preferred drug list. At any time, you can access a copy of Evergreen Health's preferred drug list at: **evergreenmd.org/formulary**, or by contacting Catamaran, Evergreen Health's Pharmacy Benefit Manager (PBM), at **855-577-6516**.

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

Specialty drugs are also included on the formulary and all require prior authorization through Catamaran.

Prior authorization for specialty drugs is done by Catamaran who works with BriovaRx to help set up the Member's prescription. Members and providers may call BriovaRx pharmacy directly with questions at **800-850-9122**. However, prior authorization calls should be directed to Catamaran by calling **855-577-6516**.

If your Copayment exceeds the retail cost for the drug, you will be charged the retail cost for the drug. Any and all refills are subject to the same provisions and limitations as the original prescription.

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

## EMERGENCY AND URGENT CARE

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

In the event of an emergency, the Member may receive emergency services from a Plan Provider/Network Provider or a Non-Plan Provider/Out-Of-Network Provider.

**Emergency services provided in a hospital emergency department may be received:**

1. Without the need for any prior authorization determination, even if the emergency services are provided by a Non-Plan Provider/Out-Of-Network Provider;
2. Without regard to whether the health care provider furnishing the emergency services is a Plan Provider/Network Provider; and
3. If the emergency services are provided by a Non-Plan Provider/Out-Of-Network Provider, no administrative requirement or limitation on coverage will be imposed on the Member that is more restrictive than the requirements or limitations that apply to emergency services received from Plan Providers/Network Providers.

**Routine out-of-network follow-up treatment may be covered as in-network if:**

1. Required in connection with a covered out-of-network emergency care episode; and
2. The Plan determines that the Member could not reasonably be expected to receive such care from a Plan Provider/Network Provider.

***If the situation is an urgent condition, contact your physician or go directly to an Urgent Care center. Verify your network coverage by reviewing your Plan Agreement.***

**If a medical condition requires emergency surgery:**

a. Coverage shall be provided for services provided by the physician who performed the surgical procedure, for follow-up care that is:
    1. Medically Necessary;
    2. Directly related to the condition for which the surgical procedure was performed; and
    3. Provided in consultation with the Member's PCP, if applicable; and

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

## HOSPITAL OBSERVATION

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

## OBTAINING PRIOR AUTHORIZATION

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

services, the appropriateness of the facility requested, and the necessary length of admission or course of treatment. Services from Non-Plan Providers/Out-Of-Network Providers will be authorized only if there are no Plan Providers/Network Providers available to provide the requested service.

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

**Please refer to your Plan Agreement for details about services for which prior authorization is required.**

## IV. EXCLUSIONS

**CERTAIN PRODUCTS AND SERVICES ARE NOT INCLUDED IN YOUR COVERAGE. REFER TO YOUR PLAN AGREEMENT FOR A LIST OF COVERED PRODUCTS AND SERVICES.**

## V. NEW TECHNOLOGY ASSESSMENT

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

## VI. DEPENDENT COVERAGE

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

1. The legal spouse.
2. The domestic partner.
3. A child (including an adopted child) of the Subscriber, or a child of the spouse or domestic partner of the subscriber until the child's 26th birthday.
4. A child (including an adopted child) of the Subscriber, or a child of the spouse or domestic partner of the Subscriber, who is no longer eligible under paragraph 3), above, and meets each of the following requirements: (1) currently disabled; (2) became disabled while enrolled as a Dependent under paragraph 2), above, and (3) remains chiefly financially dependent on the Subscriber. An individual will be determined to be "disabled" if he or she: is mentally or physically incapable of earning his or her own living. In the event of a dispute concerning eligibility under this paragraph, the standard for determining disability under Title II of the Social Security Act will apply.
5. A child under the age of 26 years for whom the Subscriber, or the spouse or domestic partner of the Subscriber is the court appointed legal guardian. Proof of guardianship must be submitted to Evergreen Health prior to enrollment.
6. A child for whom the Subscriber has the legal obligation to provide coverage pursuant to court order, court-approved, or testamentary appointment.

7. A grandchild of the Subscriber who: 1) is unmarried; 2) is in the court-ordered custody of the insured, Subscriber; 3) resides with the Subscriber; 4) is the Dependent of the Subscriber; and 5) has not attained the limiting age under the terms of the contract.
8. Exception for newborns - Any Dependent child born while you are insured for medical insurance will become insured for medical insurance on the date of his or her birth, if you elect Dependent medical insurance no later than 31 days after the birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.
9. Exception for newborn grandchildren – Any child born to your Dependent child while you are insured for medical insurance will be covered for the first 31 days of his or her life. Coverage for such child will not continue beyond the 31st day and no benefits for expenses incurred beyond the 31st day will be payable. Reasonable evidence of eligibility may be required from time to time.

## VII. REIMBURSEMENTS AND CLAIMS PROCEDURES

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

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

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

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

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

## VIII. APPEALS AND GRIEVANCES

Evergreen Health has designed processes for Appeals and Grievances that will enable you to have your concerns about a denial of benefits or an authorization for services heard and resolved.

Before you file an Appeal or Grievance, be aware that claims denials or prior authorization requests may often be denied because of insufficient or incorrect information. If you have questions about a denied claim, Evergreen Health encourages you to contact the Member services department at the phone number on your Member ID Card. A Member services representative will help you identify why the claim was denied and resolve the problem if possible.

A Pre-Service Denial (also known as a prior authorization denial) will include information about who to call to discuss the Adverse Decision (a denial based on a clinical review). If, after talking with Evergreen Health representatives you are still dissatisfied, you should then file an Appeal or Grievance.

To file an Appeal or Grievance, you, your representative, or your provider, may submit a written request and any supporting record of medical documentation within 180 days of the denial to the following addresses:

| CATEGORY | VENDOR | CLINICAL GRIEVANCES | ADMINISTRATIVE APPEALS |
|---|---|---|---|
| Medical | **CoreSource** | PO Box 83301<br>Lancaster, PA 17608-3301 | PO Box 2907<br>Clinton, IA 52733-2907 |
| Mental Health and Substance Abuse | **ValueOptions** | Evergreen Health c/o ValueOptions<br>Attn: Angel Haskins<br>National Peer Advisor 12369-C<br>Sunrise Valley Reston, VA 20190 | PO Box 383<br>Latham, NY 12110 |
| Vision | **Block Vision** | 939 Elkridge Landing Rd Suite 200<br>Linthicum MD 21090 | 939 Elkridge Landing Rd Suite 200<br>Linthicum MD 21090 |
| Dental | **DentaQuest** | 12121 North Corporate Pkwy<br>Mequon, WI 53092<br>Attn: Appeals Dept | 12121 North Corporate Pkwy<br>Mequon, WI 53092<br>Attn: Appeals Dept |
| Retail Pharmacy | **Catamaran** | PO Box 5252<br>Lisle, IL 60532 | PO Box 5252<br>Lisle, IL 60532 |

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

**Health Education and Advocacy Unit**
**Consumer Protection Division**
**Office of the Attorney General**
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
410-528-1840 or 877-261-8807
Fax: 410-576-6571
E-mail: heau@oag.state.md.us

You will have the opportunity to submit written comments, documents, records, and any other information relating to your denial. Additionally, upon request, you will be given reasonable access to all documents and records relevant to your Appeal or Grievance. The Plan will take into account all such material, whether or not it was considered in the original determination.

In reviewing your Appeal or Grievance, the Plan will not give deference to the original decision, and the person reviewing your Appeal or Grievance will not be the same person who made the original determination, nor a subordinate thereof. In the event that your Grievance concerns a determination that a certain treatment or service was not Medically Necessary, the Plan will consult with a health care provider of the same specialty as the treatment under review. Additionally, the Plan will identify all persons who were consulted in arriving at the initial Adverse Decision and all documents reviewed in the Grievance.

Expedited Grievances involve care that has not yet occurred (pre-service) or is currently occurring (concurrent care). Evergreen Health's expedited Grievance process may be available if you or a covered family Member's condition is such that the time needed to complete a standard Grievance could seriously jeopardize the Member's life, health or ability to regain maximum function. If Evergreen Health confirms that the case meets

the Medical Necessity criteria for an expedited Grievance, the Plan will complete the review within 24 hours of receiving the request and any additional information that is submitted to support the request. To request an expedited Grievance, please call **855-776-8839**. In the event that the expedited request does not meet criteria, Evergreen Health will follow the process for a standard Grievance.

If the Appeal or Grievance results in the continued denial of the original request, a detailed explanation that references the Plan provision, rule, policy or guideline used to make the determination will be included in the denial letter. Also provided will be an explanation of the appropriate next steps a Member can take if he or she is not satisfied with the outcome of the Appeal process. Members have the right to an independent external review of any final Grievance determination. If you wish, you may contact the Maryland Insurance Administration (MIA) to file a complaint. The complaint must be sent to the MIA within four (4) months from the date on the Appeal or Grievance determination letter.  They can be contacted at:

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

When filing a complaint with the MIA, the Member or the Member's representative will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the complaint.

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

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

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

You may submit a written complaint concerning a quality of care issue to:

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

## IX. PROVIDER DIRECTORY

To access the Provider Directory visit: **evergreenmd.org/provider-directory**.

If you do not have access to a computer, please contact the Member services phone number on your Member ID Card, or call **855-475-0990.**

## X. AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Evergreen Health is committed to delivering the most effective care possible to every Member. This principle is the guiding force behind all decisions the Plan makes when it comes to patient care, including those surrounding Utilization Management (UM). Therefore, we are sharing this affirmative statement about incentives (specifically relating to UM).

**Evergreen Health affirms:**

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

## XI. MEMBERS' RIGHTS AND RESPONSIBILITIES, PRIVACY NOTICE

**MEMBERS HAVE THE RIGHT TO:**

- Receive information about Evergreen Health, its services, practitioners, and providers
- Understand their coverage and benefits they are receiving from Evergreen Health
- Be treated with respect and dignity no matter their race, national origin, age, sexual orientation, religion, gender, physical or mental disability, or type of illness or condition
- Have access to care no matter their race, national origin, age, sexual orientation, religion, gender, physical or mental disability, or type of illness or condition, including preexisting conditions
- Not be charged more for having a preexisting condition or illness
- Receive free preventive care including preventive screenings, vaccines directly related to preventive care, and services for women
- Use out-of-network emergency services without a penalty
- Have coverage that cannot be cancelled based on frivolous reasons such as honest mistakes on their Member application
- Know if they qualify for free or low-cost coverage through Medicaid or CHIP
- Have no yearly or lifetime limits on essential health benefits during enrollment
- Expect security and privacy of all medical records and information about their health including their treatments and examinations
- Request and receive a copy of their medical records and request their medical record be amended or corrected
- Choose their own PCP

- See an obstetrician or gynecologist for routine care without a Referral from a PCP
- Participate with practitioners in making decisions regarding Member's health care
- Discuss and understand appropriate or Medically Necessary treatment options including risks related to the illness and treatment
- Refuse any treatment by a provider and be made aware of the consequences should the Member refuse treatment
- Receive a second opinion from another doctor if the Member does not agree with the doctor's opinion about diagnosis or treatment
- Discuss treatment options regardless of the cost or Member's benefits coverage
- Have an advance directive, such as a living will, health care proxy, or durable power of attorney for health care, concerning treatment
- Designate someone who has the legal right to make health care decisions for the Member if the Member is unable to make their own wishes known
- File a complaint, Appeal, or Grievance with Evergreen Health for care provided and have it resolved in a reasonable amount of time
- File a complaint, Appeal, or Grievance against Evergreen Health
- Exercise their rights and know that such exercise will not result in retaliation such as adverse treatment from Evergreen Health or their providers
- Receive more information about Member's rights and responsibilities
- Make recommendations regarding Member rights and responsibilities to Evergreen Health

**MEMBERS HAVE THE RESPONSIBILITY TO:**

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

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

**Evergreen Health Cooperative Inc. is required by law (PPACA – 45 CFR 147.138) to provide its Members of their rights related to the designation of a PCP.**

**MEMBER RIGHTS**

- You can designate any participating PCP who is available to accept you or any Member enrolled in a Plan
- You can designate any participating physician who specializes in pediatrics as the PCP for a child enrolled in a Plan
- You can designate any participating physician who specializes in obstetrical or gynecological care as the PCP for a female Member
- Female Members who have not designated a participating physician who specializes in obstetrical or gynecological care as her PCP can access obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology without prior authorization or Referral. A health care professional who specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care. Futhermore, the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services by a participating health care professional who specializes in obstetrics or gynecology, must be treated by Evergreen Health as the authorization of the PCP.

## XIII. NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how Evergreen Health may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI.

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

### I. LEGAL DUTIES OF EVERGREEN HEALTH

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Maryland's Confidentiality of Medical Records Act (MCMRA) impose certain legal responsibilities on health plans and healthcare providers concerning the use and disclosure of PHI. This Notice of Privacy Practices is being provided to you so that you can be aware of and understand your rights regarding the ways in which Evergreen Health can use and disclose your PHI. PHI means any information or data that could connect you to information about your health; that is, not only does PHI encompass specific diagnoses and other clinical information, it also encompasses

non-clinical information such as your name, date of birth, social security number, or anything else that could link you to information about your health.

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

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

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

b. **Payment:** Payment includes any activities by Evergreen Health, our business associates, or any care providers to obtain payment, make Coverage Decisions, determine eligibility, or provide reimbursement. For example, we may use your information to determine if certain treatments are covered under your selected Plan, and how your claims will be paid.

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

### III. OTHER ALLOWABLE DISCLOSURES OF PHI

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

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

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

c. Disclosure to health oversight agencies: Evergreen Health may disclose PHI to health oversight agencies, such as the Maryland Healthcare Commission, for oversight activities such as audits, licensing, or investigations.

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

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

f. Reporting abuse, neglect, or domestic violence: Evergreen Health may disclose PHI to a public health authority authorized by law to receive reports of abuse, neglect, or domestic violence if Evergreen Health reasonably believes an individual is a victim, the victim agrees to the disclosure, or if the disclosure is expressly authorized by law.

g. Coroners, medical examiners, funeral directors, and organ donation: Evergreen Health may disclose PHI to a coroner or medical examiner for the purposes of identifying a deceased individual, determining a cause of death; to funeral directors to aid them in completion of services for you; and to organizations that manage organ and tissue donation.

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

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

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

## IV. USES AND DISCLOSURES REQUIRING AUTHORIZATION

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

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

## V. STATEMENT OF INDIVIDUAL RIGHTS

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

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

    ii. You have the right to ask Evergreen Health to restrict the use and disclosure of your PHI to only what is necessary to carry out treatment, payment, or health care operations, except for uses or disclosures required by law. We are not required to agree to a requested restriction, but if we do, we will abide by the agreement (except in an emergency). Any agreement to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement. We will not be liable for uses and disclosures made outside of the requested restriction unless the agreement to restrict is in writing. We may end the agreement to the requested restriction by notifying you in writing. You may request such restrictions by writing to Evergreen Health at the address at the bottom of this notice.

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

    i. If you believe that a disclosure of all or part of your PHI may endanger you, you have the right to request that we communicate with you in confidence about your PHI. This means that you may request that we send you information by alternative means, or to an alternate location Evergreen

Health must accommodate your request if: it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premiums and claims) will be handled. You may request such confidential communications by writing to Evergreen Health at the address listed at the end of this notice.

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

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

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

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

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

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

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

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

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

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

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

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

## VI. DUTIES OF EVERGREEN HEALTH

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

b. Evergreen Health periodically reviews this Notice of Privacy Practices and reserves the right to amend it. All revisions will be performed in accordance with applicable local and federal and notification of any changes will be sent to you.

## VII. GENERAL SAFEGUARDS FOR PHI

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

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

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

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

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

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

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

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

viii. All business associates and Plan sponsors of Evergreen Health are required to adopt Evergreen Health's HIPAA and NCQA compliant policies regarding physical and technical security of PHI.

ix. Members should refer to their individual owner's manual for information about the exchange of information between Evergreen Health and Plan sponsors.

## VIII. COMPLAINTS

a. In the event that you feel Evergreen Health is not in compliance with the laws discussed directly above or the contents of this privacy notice, you have a right to file a complaint with Evergreen Health, or with the Secretary of Health and Human Services (HHS), or any other officer or employee of HHS to whom the authority involved has been delegated.

b. In the event you feel that you feel Evergreen Health is not in compliance with the law or this Notice of Privacy Practices, you may contact:

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

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

## IX. CONTACT FOR FURTHER INFORMATION

If you have any questions about this Notice of Privacy Practices or your rights thereunder, you may contact:

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

## X. EFFECTIVE DATE

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

## XIV. GLOSSARY

**ADVERSE DECISION**–A utilization review determination by the Plan that a proposed or delivered health care service covered under the Member's contract is nor or was not Medically Necessary, appropriate, or efficient and may result in non-coverage of the health care service.

**APPEAL**–A protest filed by a Member, their representative or health care provider on behalf of the Member with the Plan through the Plan's internal appeal process regarding a Coverage Decision concerning the Member.

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

**COPAYMENT**–A fixed dollar amount (for example, $10) you pay for a Covered Service, owed when you get the service. The amount can vary by the type of Covered Service or Plan Provider/Network Provider. These amounts are in the Schedule of Benefits and Coverage for your health Plan.

**COST SHARE**–The responsibility of Members to assume a share of the costs of benefits provided under the plan. Cost sharing may include Coinsurance, Copayments, and Deductibles. Your Plan Agreement has more information about the cost sharing that applies to your Plan.

**COVERAGE DECISION**–Means: i) an initial determination by Evergreen Health or a representative of Evergreen Health that results in non-coverage of a health care service; ii) a determination by Evergreen Health that an individual is not eligible for coverage under the Plan; or iii) any determination by Evergreen Health that results in the rescission of an individual's coverage under the Plan. It includes nonpayment of all or any part of a claim. It does not include an Adverse Decision or a pharmacy inquiry.

**COVERED SERVICE**–A health care service included in the agreement and rendered to a Plan Member by: A) a provider under contract with the Plan, where the service is obtained in accordance with the terms of the agreement; or B) A Non-Plan Provider/Out-Of-Network Provider when the service is 1) obtained in accordance with the terms of the agreement; or 2) obtained pursuant to a verbal or written Referral, or prior authorization or otherwise approved either verbally or in writing by: a) the Plan; or b) a provider under written contract.

**DEDUCTIBLE**–The amount you owe for Covered Services before Evergreen Health begins to pay.

**DEPENDENT**–The Subscriber's lawful spouse, domestic partner or dependent child.

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

**EVERGREEN HEALTH**–Evergreen Health is a nonprofit consumer oriented and operated health Plan that offers an innovative, patient-centered alternative to traditional insurance Plans in Maryland.

**GRIEVANCE**–A protest filed by a Member, Member's representative, or health care provider on behalf of a Member with the Plan through the Plan's internal Grievance process regarding an Adverse Decision concerning the Member.

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

**MEDICALLY NECESSARY OR MEDICAL NECESSITY**–Health care services or supplies that a health care provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services are: A. In accordance with generally accepted standards of medical practice; B. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease; C. Not primarily for the convenience of a patient or health care provider; and D. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury or disease. E. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of health care providers practicing in relevant clinical areas, and any other relevant factors.

**MEMBER**–An individual who meets all applicable eligibility requirements, is enrolled in coverage, either as a Subscriber or Dependent, and for whom the premiums have been received by the Plan.

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

**NON-PLAN PROVIDER/ OUT-OF-NETWORK PROVIDER**–A physician or other health care practitioner or health care facility that has not entered into a contract as a Plan Provider/Network Provider to provide medical care to Members.

**PEDIATRIC DENTAL CARE**–Any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, or other condition of the human teeth, alveolar process, gums, jaw, or associated structure of the mouth. NOTE: Pediatric Dental Care coverage through Evergreen Health is limited to Members under age 19 years; check your Plan Agreement to determine if your Plan includes pediatric dental coverage.

**PHARMACY BENEFIT MANAGER (PBM)**–A company that administers, or handles, the drug benefit program for a health plan. PBMs process and pay prescription drug claims and are responsible for creating and updating the health plan's formulary.

**PLAN**–Evergreen Health Cooperative Inc. The package of benefits described in this Member Handbook and in the Plan Agreement document.

**PLAN AGREEMENT**–An agreement issued to the Subscriber, and contains the principal provisions affecting the enrolled Members and other provisions that explain the duties of Evergreen Health and those of the Subscriber. The agreement, in its entirety, is the complete contract between Evergreen Health and the Subscriber.

**PLAN PROVIDER/NETWORK PROVIDER**–A general term used to refer to any physician or other health care practitioner, hospital and other health care entity, or a health care vendor that has entered into a written agreement with the Plan from whom the Member is entitled to receive Covered Services.

**PRE-SERVICE DENIAL**–Is any case or service that the organization may deny, in whole or in part, in advance of the Member obtaining medical care or services.

**PRIMARY CARE PROVIDER (PCP)**–A Health Care Practitioner who is a Plan Provider/Network Provider, selected by a Member to provide Primary Care to a Member and to coordinate and arrange for other required services. This PCP is a health care practitioner who provides Primary Care.

**PROTECTED HEALTH INFORMATION (PHI)**–Information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**PROVIDER DIRECTORY**–A directory that identifies Plan Providers/Network Providers.

REFERRAL–An instruction given by your PCP that gives you the ability to see another Plan Provider/Network Providers for services that may be outside your PCP's scope of practice.

**SCHEDULE OF BENEFITS AND COVERAGE**–A summary of benefits covered under your Plan that states the Copayments, Coinsurance, or Deductible you must pay, and describes any limitations on your coverage.

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

**SUBSCRIBER**–The person who subscribes to the Plan by enrolling with the Maryland Health Benefit Exchange or directly with Evergreen Health.

**URGENT CARE**–Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency. Usually care needed for unforeseen illness, injury, or condition that occurs and does not give reasonable time to obtain care through your PCP or other Plan Provider/Network Provider.

**UTILIZATION MANAGEMENT (UM)**–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.


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