evergreen HEALTH

2017 Member Handbook

Evergreen Health Select

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Welcome to

EVERGREEN HEALTH

Thank you for trusting us with your health and that of your loved ones. At Evergreen Health, nothing matters more than our members. When you chose Evergreen Health, you chose a health plan committed to providing you with smart, honest, affordable high-quality health care choices.

We know that healthcare plays a critical role in your quality of life, and that navigating the healthcare system can be tricky. With that in mind, we're dedicated to providing the guidance and assistance you need to get the care you deserve. Along the way, you can trust Evergreen Health to listen and do everything we can to provide you with exceptional service.

This handbook is designed to help you make the most of your coverage. It includes information about your plan, along with definitions of specific terminology and directions for seeking care. While this book offers useful information about your plan and benefits, please understand that 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, which you can find at our online member portal.

Should you have any questions not answered by this handbook or should you need language interpretation services, please contact Member Services at **(855) 978-3282**. You can also find this phone number listed on the front of your member identification card. DD/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 at **evergreenmd.org/memberportal**

Updated: *December 29, 2016*

II. Frequently Asked Questions

Q: What is the member portal?

A: The online member portal keeps you informed and helps us stay in touch with you. If you purchased your plan directly from Evergreen Health (rather than through your employer), the portal is where you can pay your premium. You can also use the portal to access important forms, the Member Handbook and other information about your Evergreen Health membership. Visit **evergreenmd.org/memberportal**.

Q: Where can I find a copy of my plan agreement?

A: Your plan agreement can be found on the member portal. Please visit the member portal at **evergreenmd.org/memberportal**.

Q. How do I make changes to my plan or update my information with Evergreen Health?

A. You may need to change your contact information, add family members to your plan, cancel your plan, or make other changes during the plan year. Please note that after you have enrolled in an Evergreen Health plan, you cannot enroll in a different Evergreen Health plan during the current plan/benefit year.

If you purchased your coverage through Maryland Health Connection (sometimes called "the Exchange"), you must update your information through them by calling **(855) 642-8572**. You also need to contact our Member Services team at **(855) 978-3282** to ensure changes are properly updated. If you did not purchase your plan through Maryland Health Connection, please call Member Services at **(855) 978-3282** to make changes.

Q. Why do I need my member identification card?

A. Your card proves you are enrolled with Evergreen Health and should be presented whenever you receive care or fill a prescription. Always carry your member ID with you.

Q. I haven't received my member ID card. What should I do?

A. Your member ID card will be mailed to you seven to 10 days after you enroll and make your first payment. If you have not have received your member ID card in the mail after 10 days, call Member Services at **(855) 978-3282.**

Q. How can I get a copy of my member ID card?

A. There are two ways to get a copy of your card: (1) Call Member Services at **(855) 978-3282** to have a copy emailed, faxed or mailed to you. (2) Login to our member portal, where you can download and print a copy.

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

A: Your benefits are detailed in your Description of Covered Services and Schedule of Benefits documents. You may also contact Member Services at **(855) 978-328**2 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 PROVIDES AN OVERVIEW OF YOUR BENEFITS AND HOW TO SEEK AND RECEIVE CARE. SEE YOUR DESCRIPTION OF COVERED SERVICES AND SCHEDULE OF BENEFITS DOCUMENTS FOR MORE DETAILED INFORMATION.

To enroll in a Select plan, members must live or work in Anne Arundel County, Baltimore City, Baltimore County, Howard County, Somerset County, Washington County, Wicomico County, and Worcester County. Select members must receive care from one of the four Evergreen Health Primary Care Offices (PCOs) located in Baltimore City, Greenbelt, White Marsh, and Columbia, or from medical staff at Anne Arundel Medical Center, Greater Baltimore Medical Center, St. Agnes Hospital, Meritus Health, or Peninsula Regional Medical Center.

Benefit payments are based on the allowed amount determined by Evergreen Health for various services and providers. If you are seeking specialist care, your primary care provider (PCP) can help you determine the best provider for your needs.

Certain covered services require prior authorization. Network providers should obtain the prior authorization from Evergreen Health.

ACCESS TO PRIMARY CARE

Select plan members are required to choose a PCP. If you do not select a PCP, one will be assigned to you. You may change your PCP at any time by calling Member Services. Your network includes providers directly contracted with Evergreen Health.

Services received from an unassigned primary care provider are subject to a higher cost-share as described in your Schedule of Benefits.

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
- Nurse Practitioner

For information about emergency and urgent care go to page 6.

MENTAL HEALTH AND SUBSTANCE USE SERVICES

Benefits are available for mental health and substance abuse services from Beacon Health Options, our behavioral health provider network.

If you think you need mental health or substance abuse services, call the number on your member ID card. A trained representative will explain your benefits and can assist you with locating a network provider.

Services are available 24 hours a day, seven days a week. For after-hours mental health or substance abuse services, call **(855) 343-9027**. Please tell the customer service representative if you need an interpreter to discuss your benefits, a provider who speaks a language other than English or help translating any correspondence you receive regarding your care.

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

Authorization must be obtained at least five (5) business days before an elective or scheduled admission for inpatient mental health or substance abuse services. Your network provider is responsible for obtaining prior authorization. Your Description of Covered Services and Schedule of Benefits documents contain 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, birth control and prescription eye drop refills on Evergreen Health's formulary. You can access Evergreen Health's preferred drug list online at **evergreenmd.org/formulary** or by contacting OptumRx, our pharmacy benefit manager, at **(855) 577-6516**.

Specialty drugs, which are also listed in the formulary, require prior authorization through OptumRx in collaboration with BriovaRx. If you or your provider have questions, please call BriovaRx directly at **(800) 850-9122**. However, prior authorization calls should be directed to OptumRx by calling **(855) 577-6516**.

If your copayment exceeds the retail cost for the drug, you will be charged the retail cost. Any and all refills are subject to the same provisions and limitations as the original prescription. Your Description of Covered Services and Schedule of Benefits documents contain more information about the specific provisions and limitations regarding your prescription benefits.

DRUG PLAN SUPPLY LIMITS:

For certain drugs, Evergreen Health covers only a limited amount.

Evergreen Health might limit how much of a drug you can get with each prescription refill and how long the drug is covered. For example, if only one pill per day for a certain drug is considered safe, we may limit prescription coverage to that amount. Some drugs, such as antibiotics, may be limited to a less than 30-day supply. Specialty drugs are limited to a 30-day supply regardless of tier placement.

EXCEPTIONS

If your provider prescribes a drug not listed in the formulary or is not approved to treat your condition, the provider must receive prior authorization from Evergreen Health before you can get that medicine. Without prior authorization, the pharmacy will not be able to fill your prescription. We will review and approve the provider's request only if we find the drug is medically necessary and:

- There is no similar prescription drug in the formulary
- A similar drug in the formulary has been ineffective
- A similar drug in the formulary may have or is likely to harm to your health.

Your Description of Covered Services and Schedule of Benefits documents have 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, you may receive emergency services from a network provider or an out-of-network provider.

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

- Without prior authorization, even if the emergency services are provided by an out-of-network provider
- Regardless of whether the health care provider conducting the emergency services is a network provider
- If emergency services are provided by an out-of-network provider, no administrative requirements or coverage limitations will be imposed that are more restrictive than the requirements or limitations that apply to emergency services received from a network provider.

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

- The service is required in connection with a covered out-of-network emergency care episode
- Evergreen Health determines that you could not reasonably be expected to receive such care from a network provider

When a medical condition requires emergency surgery, follow-up care provided by the physician who performed the surgical procedure will be covered if the services are:

- Medically necessary
- Directly related to the condition for which the surgical procedure was performed
- Provided in consultation with your PCP

YOU ARE RESPONSIBLE FOR THE SAME COPAYMENT OR COINSURANCE FOR FOLLOW-UP VISITS AS FOR A VISIT TO A NETWORK PROVIDER FOR SIMILAR CARE.

HOSPITAL OBSERVATION

If the medical condition that brought you to an emergency room requires intensive treatment and close observation by a physician to determine if an acute inpatient admission is required, you could be placed under observation status while in an acute facility.

Please remember that any outpatient cost shares will be applied. Most observation stays are less than 24 hours, but should not exceed 48 hours. If an observation stay exceeds 24 hours, your provider must receive prior authorization from Evergreen Health.

If you have questions about your status, Evergreen Health recommends speaking with your treating physician regarding your available options. Whenever possible, the hospital physician should consult with your PCP about your treatment.

OBTAINING PRIOR AUTHORIZATION

For certain services, the network provider must receive prior authorization from Evergreen Health before coverage is approved. Authorization must be obtained at least five (5) business days before the anticipated date upon which treatment will begin or the admission date for an elective or planned hospitalization.

When using an out-of-network provider, you must call **(855) 530-1212** to obtain prior authorization. Evergreen Health will review such requests to determine medical necessity, facility appropriateness and the necessary length of admission or course of treatment. Services from out-of-network providers will be authorized only if there are no network providers available to provide the service.

If prior authorization is denied, you may file a grievance with Evergreen Health. Grievances are 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 your treating physician and a board certified specialist of the type requested. Any grievances following such decisions should follow Evergreen Health's standard Appeals and Grievance procedure.

Please refer to your Description of Covered Services and Schedule of Benefits documents 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 DESCRIPTION OF COVERED SERVICES AND SCHEDULE OF BENEFITS DOCUMENTS FOR A LIST OF COVERED PRODUCTS AND SERVICES.

V. NEW TECHNOLOGY ASSESSMENT

To ensure that you can access safe and effective care, Evergreen Health has a formal process for reviewing and making decisions about how and whether to cover both new and existing medical technologies. This process involves guidance from medical personnel and government agencies, along with reviews of established best practice and scientific research.

VI. DEPENDENT COVERAGE

TO BE ELIGIBLE FOR COVERAGE UNDER YOUR PLAN, A DEPENDENT MUST BE ONE OF THE FOLLOWING:

1. Your legal spouse
2. Your domestic partner
3. Your child (including an adopted child) or the child of your spouse or domestic partner (until the child's 26th birthday). Dependents who turn 26 mid-plan year may keep their coverage until the plan year ends.
4. 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:

5. 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;
6. The child receives 50 percent or more of his or her support and maintenance from the subscriber or the subscriber's lawful spouse; and
7. The subscriber provides the Plan proof of the child's incapacity and dependency within 60 days after requested by the Evergreen Health.
8. A child under the age of 26 years for whom you or your spouse or domestic partner is the court-appointed legal guardian. Proof of guardianship must be submitted to Evergreen Health before enrollment.
9. A child for whom you are legally obligated to provide coverage pursuant to court order, court-approved or testamentary appointment.
10. Your grandchild who:
    - Is unmarried
    - Is in the subscriber's court-ordered custody
    - Resides with the subscriber
    - Is the subscriber's dependent and
    - Has not attained the limiting age under the terms of the contract
11. **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.
12. **Exception for newborn grandchildren:** Any child born to your dependent child while you are insured will be covered for the first 31 days of his or her life. Coverage for the child will end after the 31st day, and no benefits for expenses incurred beyond the 31st day will be payable.

VII. REIMBURSEMENTS AND CLAIMS PROCEDURES

If you receive care from an out-of-network provider, your benefits may still apply, but you may need to submit the claim to Evergreen Health yourself, or have your health care provider do so on your behalf. You will be liable for any deductible, copayment or coinsurance applicable to your claim.

To file a claim, download and complete the member claim form online at **evergreenmd.org/members/claims**, and mail it to:

Evergreen Health Claims Processing Center
PO Box 331429
Corpus Christi, TX 78463

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

Questions? Call the Member Services phone number **(855) 978-3282**

VIII. APPEALS AND GRIEVANCES

Evergreen Health uses a formal appeals and grievances process to ensure your concerns about benefit denials or service authorizations are heard and resolved.

Before filing an appeal or grievance, please understand that claims and prior authorization requests are often denied because of insufficient or incorrect information. If you have questions about a denied claim, Evergreen Health encourages you to contact our Member Services department using the phone number on your member identification card. A member services representative can identify why your claim was denied and help you resolve the problem if possible.

A pre-service denial (also known as a prior authorization denial) includes directions on who to contact should you wish to discuss an adverse decision (i.e., a denial based on a mismatch between the service that was requested and the standard of care). If you are still dissatisfied after contacting an Evergreen Health representative, you should then file an appeal or grievance.

To file an appeal or grievance, either you, your representative or your provider may submit a written request along with any supporting medical records within 180 days of the denial to the following addresses, depending on the nature of the claim:

CATEGORY	VENDOR	CLAIMS SUBMISSION	CLINICAL GRIEVANCES	ADMINISTRATIVE APPEALS
Medical	**Evergreen Health**	**Evergreen Health** Claims Processing Center P.O. Box 331429 Corpus Christi, TX 78463 **Additional Payer ID#:** 93240 **Phone:** [855] 978-3282	**Evergreen Health** Claims Processing Center P.O. Box 331429 Corpus Christi, TX 78463 **Additional Payer ID#:** 93240 **Phone:** [855] 978-3282	**Evergreen Health** Claims Processing Center P.O. Box 331429 Corpus Christi, TX 78463 **Additional Payer ID#:** 93240 **Phone:** [855] 978-3282
Behavioral Health	**Beacon Health Options (formerly known as ValueOptions)**	**Beacon Health Options** P.O. Box 383 Latham, NY 12110 Phone: [855] 816-7622	**Beacon Health Options** National Peer Advisor 12369-C Sunrise Valley Drive Reston, VA 20190	**Beacon Health Options** P.O. Box 1347 Latham, NY 12110
Vision	**Superior Vision (formerly known as Block Vision)**	**Superior Vision** Claims Department 939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090 **Phone:** 800 243-1404, ext. 2065 410-752-0121, ext. 2065	**Superior Vision** Claims Department 939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090 cag@superiorvision.com	**Superior Vision** Claims Department 939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090 cag@superiorvision.com
Pediatric Dental Claims **(before 1/1/2016)**	**Evergreen Health Dental**	**Evergreen Health Dental** Dental Claims Processing Center P.O. Box 331429 Corpus Christi, TX 78463 **Phone:** [855] 978-3282	**Evergreen Health Dental** Dental Clinical Services Department P.O. Box 8658 Portland, ME 04104-8658	**Evergreen Health Dental** Dental Claims Appeals P.O. Box 8658 Portland, ME 04104-8658

Pediatric Dental **Claims after 1/1/2016** **Small Group Markets Only**	**LIBERTY Dental Plan (AKA Guardian)**	**LIBERTY Dental Plan** P.O. Box 401086 Las Vegas, NV 89140 **Phone:** (888) 700-1246	**LIBERTY Dental Plan** Attn: Quality Management Department P.O. Box 26110 Santa Ana, CA 92799-6110	**LIBERTY Dental Plan** Attn: Quality Management Department P.O. Box 26110 Santa Ana, CA 92799-6110
Retail Pharmacy	**OptumRx (formerly known as Catamaran)**	**OptumRx** P.O. Box 968022 Schaumburg, IL 60196-8022 Phone: (855) 577-6516 **Rx BIN:** 610011 **PCN:** IRX **Rx Group:** **Individual & Small Group:** EVCOOP **Large Group:** EVCLG	**OptumRx** P.O. Box 5252 Lisle, IL 60532 Fax: (866) 511-2202	**OptumRx** P.O. Box 5252 Lisle, IL 60532 Fax: (866) 511-2202

The Maryland Health Education and Advocacy Unit can also 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 have the opportunity to submit written comments, documents, records and any other information related to your denial. Upon request, you will also receive reasonable access to all documents and records relevant to your appeal or grievance. Evergreen Health takes into account all such material, despite whether it was considered in the original determination.

When reviewing your appeal or grievance, Evergreen Health gives no deference to the original decision, and the person reviewing your appeal or grievance will be neither the original reviewer, nor a subordinate thereof. Should your grievance conclude with a determination that the treatment or service in question was medically unnecessary, we will consult with a health care provider who specializes in same discipline as the treatment or service under review. Additionally, we will identify all persons involved in the initial adverse decision, along with all documents considered 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 the time needed to complete a standard grievance could jeopardize either your own or a covered family member's life, health or ability to regain maximum function. If Evergreen Health confirms that the

case meets medical necessity criteria for an expedited grievance, we will review the request and any supporting information within 24 hours.

To request an expedited grievance, please call **(855) 978-3282.**

If an 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, the denial letter will include a detailed explanation referencing the provision, rule, policy or guideline used to make the determination. An explanation of the appropriate next steps you can take if you are not satisfied with the outcome of the appeal process. You 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, you or your representative will be required to authorize the release of any medical records that may be needed to reach a decision. If you need assistance filing such a complaint, the Maryland Health Education and Advocacy Unit can assist you.

Evergreen Health is forbidden by law from retaliating against you in any way and will not do so under any circumstance. Further information about the appeals and grievance process is available in your Plan Agreement.

Evergreen Health also investigates complaints about the quality of care and services offered by providers in our networks and takes action when appropriate. When responding to your complaint, Evergreen Health will contact the provider in question for additional information. At the conclusion of our investigation, we will advise both you and the provider about the findings and resolution.

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

Evergreen Health
Clinical Services Department
P.O. Box 4800
Baltimore, MD 21211

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] 978-3282**.

X. AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Evergreen Health is committed to ensuring you receive the most effective care possible. This principle is the guiding force behind all decisions made when it comes to patient care, including those surrounding Utilization Management (UM). With that in mind, please know that Evergreen Health affirms that:

- UM decisions are made using recognized criteria. Our decisions are based on the existence of coverage and on the propriety of care and services rendered.
- We do 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

AS AN EVERGREEN HEALTH MEMBER, YOU HAVE THE RIGHT TO:

- Receive information about Evergreen Health, its services, practitioners and providers
- Understand the coverage and benefits you receive from Evergreen Health
- Respectful, dignified treatment, regardless of race, national origin, age, sexual orientation, religion, gender, physical or mental disability or type of illness or condition
- Access care regardless of 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
- Use out-of-network emergency services without a penalty
- Coverage that cannot be canceled based on certain reasons, such as honest mistakes on your member application
- Know if you qualify for free or low-cost coverage through Medicaid or CHIP
- No yearly or lifetime limits on essential health benefits during enrollment
- Expect security and privacy of all medical records and information about your health, including treatments and examinations
- Request and receive a copy of your medical records and request that your medical record be amended or corrected
- Choose your own PCP
- See an obstetrician or gynecologist for routine care without a referral from a PCP
- Participate with practitioners in making decisions regarding your health care
- Discuss and understand what constitutes 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 of refusing treatment

- Receive a second opinion from another doctor if you disagree with your doctor's opinion about your diagnosis or treatment
- Discuss treatment options regardless of the cost or your benefits coverage
- Have an advance directive concerning your treatment, such as a living will, health care proxy or durable power of attorney for health care
- Designate someone who has the legal right to make health care decisions if you are or become unable to make your wishes known
- File a complaint, appeal or grievance with Evergreen Health for care provided and have it resolved in a timely manner
- File a complaint, appeal or grievance against Evergreen Health
- Exercise your rights without retaliation, including adverse treatment from Evergreen Health or your providers
- Receive more information about your member rights and responsibilities
- Make recommendations regarding your member rights and responsibilities to Evergreen Health

MEMBERS HAVE THE RESPONSIBILITY TO:

- Be truthful about your health, including unexpected changes in health, medications you have used or are currently using, previous 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 you
- Follow the plans and care instructions agreed upon by you and your practitioner or provider
- Understand your health problem(s) and related treatments and participate in developing treatment goals with your practitioner or provider, including the consequences of refusing treatment or not following medical advice
- Provide a copy of your advance directive if you have one
- Pay copayments or coinsurance at the time of service
- Be on time for appointments
- Notify practitioners and providers when an appointment must be canceled
- Read the Member Handbook so you can understand the services provided, your member rights 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 your PCP and to Evergreen Health
- Be courteous and respectful to Evergreen Health employees, healthcare providers and office staff
- Report any known or suspected fraud and abuse related 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 inform members of their rights related to the designation of a PCP.

Those rights include the ability to:

- Choose any participating PCP who is available to accept you or any member enrolled in a plan
- Choose any participating physician who specializes in pediatrics as the PCP for a child enrolled in a plan
- Choose any participating physician specializing in obstetrical or gynecological care as the PCP for a female member
- Female Members who have not chosen a participating physician who specializes in obstetrical or gynecological care as her PCP can access obstetrical or gynecological care from 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. Furthermore, obstetrical and gynecological care and related obstetrical and gynecological items and services must be treated by Evergreen Health as authorized by the PCP, when provided by a participating health care professional who specializes in obstetrics or gynecology.

XIII. NOTICE OF PRIVACY PRACTICES

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 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 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, calling to request that we send a revised copy by 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 provided to you so that you can know and understand your rights regarding how Evergreen Health can use and disclose your PHI.

PHI includes any information or data connected to information about your health. Not only does PHI encompass specific diagnoses and other clinical information, it also includes non-clinical information such as your name, date of birth, social security number or anything else linked to information about your health.

Evergreen Health–and any entities that we contract with to provide you care–are legally required to maintain the privacy and security of your PHI, as well as keep you updated 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 explains how we'll use your information and information how to exercise your rights regarding your PHI. While you should keep this copy for your records, you can request a new copy from Evergreen Health at any time.

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

a. Treatment includes any activities 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 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 include 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 PHI DISCLOSURES

a. Disclosures required by law will be made in compliance with any applicable law. If such a 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, if that entity is required by law to collect such information.

   i. For example, Maryland collects data related to the types of claims that arise in the state from year to year.

   ii. Some disclosures may be made to public health entities to prevent or control disease or to report child abuse.

   iii. Disclosures may be made to the FDA for the purposes of reporting product defects or other adverse events.

c. **Disclosure to health oversight agencies:** Evergreen Health 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 ordered by a court to provide certain information, Evergreen Health will comply with the order only once provided with a subpoena.

e. **Law enforcement purposes:** Evergreen Health may be required to disclose PHI to law enforcement officials if 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 we reasonably believe 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 and determining a cause of death; to funeral directors to aid in planning 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 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 consent when individual authorization is not required or when 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 about your PHI in confidence. 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 (including 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 for 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. 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 the 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 before 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
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 electronically from Evergreen Health, 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 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. Evergreen Health employees and contracted network providers stringently safeguard the confidentiality of all records concerning patients who receive 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 that information to serve you, who have been trained to properly protect and handle such information and who have signed statements acknowledging they understand the legal penalty for unauthorized disclosure. Evergreen Health security measures prohibit access to member PHI for Evergreen Health employees whose responsibilities do not require it.

    ii. Evergreen Health makes efforts to limit the number of hard copies containing identifying health care information. When retaining hard copy files is necessary, that information is stored in locked file cabinets within a 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 between employees and with anyone else involving member PHI, except among authorized employees and clinicians working together for you. Violating this policy carries serious penalties for the employee.

v. All Evergreen Health employees undergo HIPAA security and privacy training and periodically must take refresher courses and pass appropriate compliance evaluations.

vi. Evergreen Health maintains a log of disclosures of identifying health care information that do not fall within the parameters of HIPAA and vigorously investigates unauthorized disclosures.

vii. Any Evergreen Health staff who violates our policies regarding PHI will face 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. If you believe 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, with the Secretary of Health and Human Services (HHS) or with any other officer or employee of HHS to whom the authority involved has been delegated.

b. If you believe that 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. Evergreen Health is bound by law not to retaliate against any individual who makes a complaint about a HIPAA violation by Evergreen Health, Evergreen Health is bound by law not to retaliate against said individual and shall not do so under any circumstance.

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 Notice of Privacy Practices was adopted by Evergreen Health on January 1, 2015 and is valid until any revisions are made, of which notice shall be given.

XIV. GLOSSARY

Adverse Decision: A determination that a proposed or delivered health care service covered under the Member's contract is not or was not medically necessary, appropriate or efficient, potentially resulting in non-coverage of the health care service.

Appeal: A protest filed with Evergreen Health by a member or by their representative or health care provider on their behalf 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 percent) 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 listed in the Schedule of Benefits for your health plan.

Copayment: A fixed dollar amount (for example, $10) paid for a covered service and owed at the time of service. The amount varies by the type of covered service or network provider. These amounts are in the Schedule of Benefits for your health plan.

Cost Share: A member's responsibility to assume a share of the benefits costs provided under the plan. Cost sharing may include coinsurance, copayments and deductibles. Your Plan Agreement has more information about cost sharing required under your plan.

Coverage Decision: 1.) an initial determination by Evergreen Health or a representative of Evergreen Health that results in non-coverage of a health care service, 2.) a determination by Evergreen Health that an individual is not eligible for coverage under the plan; or 3.) any determination by Evergreen Health that results in the cancellation or revocation of an individual's coverage. This includes nonpayment of all or any parts 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 Evergreen Health, when the service is obtained in accordance with the terms of the agreement, or B.) An out-of-network provider when the service is either obtained in accordance with the terms of the agreement, or obtained pursuant to a verbal or written referral, or prior authorization or otherwise approved either verbally or in writing by Evergreen Health or by 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 provided to aged or disabled individuals in a protective, institutional or home- type environment.

Evergreen Health: Evergreen Health is a health plan that offers an innovative, patient-centered alternative to traditional insurance plans in Maryland.

Grievance: A protest filed by a member, the member's representative or a health care provider on behalf of a member with Evergreen Health through the organization's internal grievance process regarding an adverse decision concerning the member.

Medical Emergency: The 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 that 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
C. Considered effective for a patient's illness, injury or disease
D. Not primarily for the convenience of a patient or health care provider
E. Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results when applied to a patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence and 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, along with 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 Evergreen Health.

Member Handbook: Manual describing the services available to you based on your plan, your rights and responsibilities, included and excluded coverage, and conditions for coverage.

Network Provider: A general term used to refer to any physician, health care practitioner, hospital, health care entity or other health care vendor that has entered into a written agreement with Evergreen Health and from whom the member is entitled to receive covered services.

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 and jaw or associated structure of the mouth. Note: Pediatric dental care coverage through Evergreen Health is limited to members under age 19. 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 the Plan Agreement document.

Plan Agreement: An agreement issued to the subscriber containing 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.

Pre-Service Denial: 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 selected by a member to provide primary care and to coordinate and arrange for other required services.

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 network providers.

Referral: An instruction given by your PCP that enables you to see another network provider for services that may be outside your PCP's scope of practice.

Schedule of Benefits: A summary of benefits covered under your plan that lists the copayments, coinsurance or deductible you must pay and describes any limitations on your coverage.

Skilled Nursing Facility: An inpatient extended care facility that operates 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. This usually means care needed for unforeseen illness, injury or conditions that occurs without allowing for reasonable time to obtain care through your PCP or other network provider.

Utilization Management (UM): The process of evaluating and determining the appropriateness of using covered medical services, including prior authorization, concurrent review, retrospective review, discharge planning and case management.

evergreen HEALTH

For more information, call us at
(855) 978-3282
or visit us online at
evergreenmd.org/members

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