Evergreen Health Frequently Asked Questions

Updated October 26, 2017

	Question	Response
	General Questions	
1	**Where can I find more information about the Evergreen Health (Evergreen) Receivership?**	Go to www.evergreenmd.org to see the receivership orders, Frequently Asked Questions (FAQs) and other notices. If you have additional questions, please contact us as follows: • If you are a provider, then call Provider Relations at 443-475-0105 or email providers@evergreenmd.org. • If you are a group program administrator or broker, then please call Sales & Enrollment at 443-863-8910 or email sales@evergreenmd.org. • If you are a policyholder or member, then please call 443-451-4979.
2	**September 30, 2017 seems a firm date for cancellation of Evergreen policies with no provision in this order for an extension or for Receivership liability for services after September 30, 2017. If that changes, please let us know in time to let the admission staff know before Sunday, October 1, 2017.**	The Receiver does not anticipate a change in the cancellation date for Evergreen policies. Any changes will be posted to the Evergreen website.
3	**What does liquidation mean for policyholders?**	All Evergreen policyholders must enroll with a new Health Maintenance Organization ("HMO") or carrier in order to continue health insurance coverage after September 30, 2017. If you have questions, please contact your group administrator. The liquidation order approved a special thirty (30) day open enrollment period for Evergreen group members beginning on September 1, 2017 and ordered cancellation of all Evergreen member policies effective 11:59 pm Eastern Daylight Time on September 30, 2017.
4	**Will I get credit for my deductible and out-of-pocket maximum amounts, already paid to Evergreen for this plan year?**	No

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5	**Will my deductible and out-of-pocket maximum reset with my new HMO? Will I have new copays and other member responsibility charges under my new HMO coverage?**	Yes, Evergreen will continue to process claims and apply cost-sharing for claims incurred while enrolled with Evergreen. Your new HMO will apply cost-sharing to claims incurred based on your enrollment period with them, under the terms and conditions of your new plan coverage. That means your copays, deductibles, covered services and prescriptions may change, based on the plan your group health administrator or broker has selected. If you have questions, please contact your group administrator.
6	**Evergreen members are not eligible for the protection afforded by the Maryland Life & Health Insurance Guaranty Corporation. Why and what does that mean?**	Evergreen is an HMO, and HMOs are not covered by the Maryland Life & Health Insurance Guaranty Corporation.
7	**When can I expect to get my Loss of Coverage and Proof of Creditable Coverage letters?**	Letters will be mailed out after the end of the open enrollment period.
Coverage Questions		
8	**I had a scheduled hospital stay that started before August 31, 2017 and ended after September 1, 2017; will it be covered?**	Yes this entire hospital stay will be covered by Evergreen.
9	**I have a scheduled hospital stay that will start before September 30, 2017 and end after October 1, 2017; will it be covered?**	Yes, this entire hospital stay will be covered by Evergreen if your group does not select a new carrier. If your group selects a new HMO with coverage retroactively effective to September 1, 2017 the hospital stay will be covered by the terms of your new plan coverage, or new HMO contract.
10	**I already have services that were previously authorized with Evergreen, will the authorization be honored?**	Yes. Maryland law requires new carriers to honor an approved prior authorization from Evergreen for procedures, treatments, medications, or services covered by the benefits offered by the receiving carrier for (1) the lesser of the course of the treatment or 90 days and (2) the duration of the three trimesters of a pregnancy and the initial postpartum visit. After this period passes, the new carrier will then perform its own determination of medical necessity.
11	**Will groups be allowed to have new hires or qualifying event members join their group plan?**	Yes

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Claim Questions		
12	**Please explain how September claims will be paid?**	• Claims with dates of service on or after September 1, 2017 for members of those groups that do not move to a new HMO effective September 1, 2017 will be paid by Evergreen in the normal course of business. • Claims for members whose groups do move effective September 1, 2017 will be paid by the new HMO at the amounts allowed by the new company.
13	**For groups who remain covered for September 1, 2017, is there any guarantee that claims will be paid?**	Claims for members of those groups that do not move to a new HMO effective September 1, 2017 will be paid by Evergreen in the normal course of business. However, there can be no guarantee that they can be paid in full. The Receiver is limited to the remaining funds of Evergreen for paying claims. At this time we estimate that funds will be available to pay the post receivership claims (dates of service on or after July 31, 2017).
14	**Please explain the difference between the pre-receivership claims and post receivership claims handling procedure.**	• **Post receivership claims** (dates of service on or after July 31, 2017) will be paid as administrative expenses and we estimate they will be paid at 100%. • **Pre receivership claims** (dates of service before July 31, 2017) will be paid as a part of the receivership claims process. Claimants will have to file a Proof of Claim form (more information about the Proof of Claim process will be published in the near future). After the claims filing deadline, which by statute will be a minimum of 6 months in the future, the Receiver will review the claims and make a recommendation to the court. When all of the claims have been approved, the Receiver will make a payment to the claimants. The amount of the payment will depend on the amount of Evergreen's remaining assets. If the funds

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		available are not sufficient to pay the claims at 100%, the claims will be paid at a lower percentage.
15	**When is the claim filing deadline, and how do I get a proof of claim form?**	The Receiver will file a motion asking the court to approve a claims filing deadline and a proof of claim form in the near future. Once approved by the court, the receiver will distribute the proof of claim form to all potential claimants.
16	**Will claims with a date of service after October 1, 2017 be paid?**	Claims with a date of service on or after October 1, 2017 will be paid by the new carrier or HMO if the group purchased new coverage. All Evergreen policies will be cancelled no later than September 30, 2017. Claims with a date of service after that date will only be paid by Evergreen in certain potential situations involving a hospitalization that began on or before September 30, 2017 and which extended into October.
17	**Evergreen had a "national" plan that used the Private Healthcare Systems (PHCS) network. How will those claims be paid?**	All claims will be paid in the same manner based on the dates of service in accordance with the terms of the contract. Claims with dates of service on or after July 31, 2017 will be paid now. Claims with dates of service prior to July 31, 2017 will be paid at a later date as a part of the receivership process.
18	**Are PHCS providers considered "in-network"? Will PHCS claims be covered for dates in September 2017?**	PHCS providers are considered Evergreen "in-network" providers. Claims from PHCS providers with dates of service on or after September 1, 2017 will be processed at amounts allowed by the new HMO, or if there is no new HMO, those claims will be processed by Evergreen as "in-network" providers.
19	**Is payment in full in the ordinary routine (a little over 30 days from date of service) for post-receivership services planned? The ordinary routine would have some payments begin about day 45, that is, about September 15, 2017. Staffing changes might slow this some. Is cash on hand limiting the Receiver's payments for post-Receivership services?**	The Receiver plans to pay the post receivership claims in the ordinary course of business as soon as possible. Neither staffing nor cash on hand is currently limiting payments.
20	**If payment in full in the ordinary routine for post-Receivership services is going to be delayed until, maybe the November 1 report, would the receiver consider some interim estimated payment on account of**	The Receiver does not anticipate any significant delay in the payment of post-receivership services.

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	post-Receivership services? It could be made anytime under the order, it appears.	
21	**Is there a preview range for the dividend for pre-receivership policy health care claims? General unsecured claims?**	We understand your question to be when the pre-receivership claims will be paid. The pre-receivership health care claims, and any general unsecured claims will be paid after the claims filing deadline set by the court. Those payments will be based on the amount of the remaining assets and the priority assigned by Maryland Statutes (Section 9-277) to the type of claim.
22	**I do not agree with how a claim was processed, should I file a claim reconsideration or appeal?**	Yes, please continue to claim reconsiderations and appeals as normal.
Open Enrollment Questions		
23	**How does the open enrollment period work?**	All groups can enroll with a participating HMO during the enrollment period, and if the group pays their September premium to the new HMO assuming coverage, the Evergreen coverage will be retroactively terminated effective 11:59 pm Eastern Daylight Time on August 31, 2017. The new HMO will then assume coverage and be responsible for claims with dates of medical service starting on September 1, 2017.
24	**Which HMOs are offering coverage during the open enrollment?**	• CareFirst BlueChoice, Inc. • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. • Aetna Health Inc. • Optimum Choice, Inc.
25	**Does the open enrollment apply to large as well as small groups?**	Yes, open enrollment applies to large and small groups.
26	**What is the deadline to apply for September 1, 2017? What are the carrier deadlines for October 1, 2017 effective dates?**	The deadline to apply for September 1, 2017 coverage in the open enrollment period is September 30, 2017. Group policies that choose to have an effective date of October 1, 2017 or later are not part of the open enrollment.
27	**What happens if the group does not make a premium payment to the new HMO in September?**	Coverage will remain in effect with Evergreen through 11:59 pm Eastern Daylight Time, September 30, 2017. At that time, coverage will expire and new coverage will need to have been obtained effective October 1, 2017. By court order, Evergreen will not be able to accept claims with dates of service after September 30, 2017.
28	**The September 1, 2017 open enrollment is important for groups that do not meet participation requirements. The question is if a group has a December 1, 2017**	Groups do not have to participate in the open enrollment period. All Evergreen policies will be cancelled on September 30, 2017. Due to continuity of care

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	renewal date and they meet all normal small group enrollment requirements, can they go with an October 1, 2017 new contract effective date?	issues, we encourage all groups to take advantage of the open enrollment period and move as soon as possible.
29	**What happens when the group that does not meet participation requirements renews for September 1, 2017?**	The participation requirements were waived for the current special open enrollment.
30	**What happens next year at renewal on September 1, 2018 and the group still does not meet participation requirements?**	Groups will need to contact the new HMO regarding future participation requirements.
31	**Will carrier participation requirements apply if a group moves October 1, 2017 instead of September 1, 2017?**	Yes. The participation requirements are waived during the open enrollment period. Policies with an effective date of October 1, 2017 are not part of the open enrollment.
32	**What if a company wishes to offer a dual option HMO and a non-HMO plan or a Point Of Service (POS) plan? Does that still qualify for the September 1, 2017 open enrollment? Do participation requirements apply for a POS plan?**	The four HMOs that are part of the open enrollment may offer any plan that was previously approved for that HMO by the Maryland Insurance Administration. Participation requirements were waived as a part of the open enrollment.
33	**If an employee opts to get individual coverage in lieu of taking the employer's newly selected carrier will that employee qualify for a Limited Open Enrollment Period to obtain individual coverage effective September 1, 2017 or October 1, 2017 as the case may be?**	Employees should discuss their options with the Group Administrator or contact the Maryland Health Benefit Exchange.
34	**Is the Evergreen cancellation a qualifying event for Individuals to apply on or off exchange?**	Yes, however Evergreen had no individual policies as of September 1, 2017.
35	**I am pregnant/have a serious illness or have treatment planned; what should I do? How do I make sure I have a plan with similar network and benefits?**	Your current Evergreen plan will remain in effect and your health care providers are required to accept it until 11:59 p.m. Eastern Daylight Time September 30, 2017. If your group has obtained new coverage and paid the premium in September, that coverage will become effective on September 1, 2017. Your group insurance administrator or broker will be able to help you determine the extent to which your new plan provides a similar network, drug formulary, and benefits to what you currently have today.
COBRA Coverage Questions		
36	**If I am enrolled in COBRA will I remain on the Evergreen Plan after September 30, 2017?**	No. There will be no policy holders on the Evergreen Plan after September 30, 2017. If you are currently enrolled in COBRA, your COBRA coverage will be with the new carrier your group selects to enroll with. If you have questions

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		please contact your group administrator.
CONTINUITY OF CARE/ BALANCE BILLING		
37	**Can I continue to see my Medical Provider?**	Yes. Maryland law contains a requirement for providers to see established patients for at least 90 days following a notice of coverage termination.
38	**My doctor's office said it will not accept my Evergreen plan anymore; can they do that? What should I do?**	No. Aside from the law requiring providers to treat established patients cited above, Paragraphs 23 and 25 of the liquidation order states that all providers must continue to provide services to Evergreen members as long as the members pay their premiums. Your providers must accept your Evergreen plan until September 30, 2017. Please contact Member Service at 443-451-4979 if your provider refuses to provide services.
39	**How should I respond when I am asked for proof of insurance coverage at the doctor's office after I have obtained new coverage through my group?**	Members may present their Evergreen Health card as proof of insurance through September 30, 2017. However, if a member receives proof of insurance from a new carrier prior to September 30, 2017, they should present that proof of insurance as soon as it is received.
40	**Please confirm the members are only responsible for their cost share. The Providers cannot balance bill what is owed by the carrier.**	If the provider is in-network with Evergreen, the member is only responsible for paying the member's cost share up front. This could be the copayment or any deductible or coinsurance. In-network providers must submit claims on the member's behalf. If the provider is not in-network with Evergreen, the provider may choose to bill up front for services. The member should submit claims for reimbursement if the provider does not submit the claim on the member's behalf. Maryland has statutory provisions that forbid providers from balance billing for covered services. All provider contracts have a "Hold Harmless" clause that applies to in-network providers. Non-contracted providers that are subject to Maryland law are effectively subject to the "Hold Harmless" provision as well. The liquidation order also forbids providers from billing members for amounts owed by Evergreen. Please

		see the last paragraph of the liquidation order.
41	**I have a client that is having problems with a provider due to the Evergreen receivership. Who can they contact for help?**	Please have the member call 443-451-4979.
42	**Who should members contact if doctors try to bill them for unpaid claims from prior to July 31, 2017? Members are getting notices from collection agencies from participating providers because they have not been paid by Evergreen. How does a member handle that?**	Please have the member call 443-451-4979 or contact the Maryland Attorney General's Health Education and Advocacy Unit at 410-528-1840 or heau@oag.state.md.us.
43	**Do the rules on continuity of care and balance billing apply to out of state providers?**	Depending on the circumstances, the terms of the liquidation order could apply to out of state providers. Please refer to the last paragraph of the order for more information.
44	**Since I am getting coverage from a new HMO effective September 1, 2017, but my group may not select that new HMO until well after that date, how will my medical providers bill for services? Do I need to worry about getting bills directly?**	All medical providers are being notified they should send all bills with dates of service during the open enrollment period to Evergreen. The Receiver will then process those claims as Evergreen claims if a member has not obtained group coverage with a new HMO, or otherwise send them to the new HMO for processing towards your new plan. You should not be receiving any bills directly from your medical providers, although you may receive bills for copays, deductibles, and other member responsibility payments. Please contact Member Service at 443-451-4979 if your provider attempts to bill you directly for services other than copay, deductible or other member responsibility payments.
Operational Questions		
45	**How should claims be submitted to Evergreen?**	Continue to submit claims through the normal process of EDI (Payer ID 93240) or mailing to Evergreen Health, Claims Processing Center, PO BOX 331429, Corpus Christi, TX 78463.
46	**Please check and let us know the eligibility confirmation system will be available after Saturday, September 30, 2017. I hear some hospitals average 14 days to get the initial claim paperwork done and some patients (especially those who received emergency care) take even longer to get the insurance information back to the provider. I understand that 180 days is the state limitation on claims.**	The eligibility confirmation system will continue to be available after September 30, 2017. We anticipate that the eligibility confirmation system will be available through the claims filing deadline set by the Court.

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47	**The claims review process (for both receivership purposes and ordinary medical billing and documenting purposes) may work smoother if the ordinary claims billing and appealing system is available for several months after the last Evergreen covered service on September 30, 2017. Please check and confirm what the receiver's plans are. Are the eligibility confirmation system and the claims processing system the same one from Evergreen's side?**	Both the claims billing system and appeal system will be available after September 30, 2017.
48	**For patients who are enrolled with one of the replacement HMOs, retroactively to September 1, 2017, will the eligibility confirmation via the Evergreen system be sufficient? Are their claims supposed to be submitted through the existing Evergreen billing portal? Is there a common planned date to switch legacy Evergreen patients to the replacement HMO's billing portal for new claims? Will old claims continue to be processed through the old Evergreen portal?**	The liquidation order provides that proof of insurance with Evergreen is sufficient to obtain health care services. If a member has received proof of insurance from their new HMO they should present that to the medical provider in order to obtain health care services. To expedite payments, providers are encouraged to hold bills for September dates of service until notification that a group has moved to a new HMO and then submit the bills directly to the new HMO. If a group does not purchase new coverage during the open enrollment the bills can be submitted to Evergreen for processing and payment. It is expected that the new HMO will provide billing instructions regarding Evergreen members that obtain new coverage with that HMO. Pre-receivership Evergreen claims can continue to be submitted through the Evergreen portal.
49	**Because coverage under a replacement HMO's policy will be retroactive to September 1, 2017, does that mean the replacement HMO's personnel will be taking over the processing of claims for services after September 1, 2017?**	Yes, the personnel at the new HMO will process claims on behalf of the new HMO.
50	**Please confirm that for the foreseeable future all claims for Evergreen related claims will continue to be processed through the current Evergreen claims system.**	Yes, all Evergreen related claims will continue to be processed through the current Evergreen claims system.
51	**How can I see how my claims are being processed?**	Your practice can access member eligibility, claims and prior authorization information through the Evergreen Health Provider Portal. To request access to the Portal, please visit https://ehcportal.valence.care/. For

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		assistance in accessing or using the Portal, please contact Evergreen Provider Relations at providers@evergreenmd.org.
September Premium Refunds		
52	**Will Evergreen refund September premium payments to the group if new coverage is obtained through another HMO before September 30, 2017?**	Yes. Proof of other enrollment will be requested prior to the refund being issued. The receiver will be establishing a process whereby proof of new coverage can be received to allow for payment of a refund.
53	**If a group moves to another carrier effective September 1, 2017 that is not one of the HMO products listed in the communication, will they still be eligible for a refund?**	Yes, as long as the group shows proof of coverage as of September 1, 2017.
54	**Regarding premiums refunded, will the employer receive a check? If premiums were paid through a Third Party Administrator (TPA), will the credit or check go back to the TPA and therefore the TPA credit payments to the employer?**	Premiums will be refunded to the employers that paid directly to Evergreen. Premiums for groups that paid through a broker or TPA will be refunded to that broker or TPA. Requests for refunds should be sent to: questions@evergreenmd.org and should include proof of new coverage. Refund requests will be validated and checks will be cut once a week.
Broker Questions		
55	**When will broker commissions be paid?**	There will be a Proof of Claim process which will enable brokers to file a claim for commissions. Maryland's Receivership Statutes place commission payments at a lower level than member and physician claims and claims of the federal government. Commission payments will be paid in liquidation only if funds of Evergreen are sufficient to pay all of the higher priority claims.
56	**Could brokers be open to any potential E&O (Errors & Omissions) exposure?**	The Receiver cannot give legal advice.
Explanation of Benefits and Rights (EOBR)		
57	**I received an Explanation of Benefits and Rights (EOBR) from Evergreen. What is this, and how is it different from Explanation of Benefits (EOBs) that I have received in the past?**	Your EOBR is similar to the EOBs that you have received because it provides information about how your claim was processed. It also informs you of any cost share that you may owe the provider of services. In accordance with the court order, however, payment has not yet been issued to the provider.

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58	**I disagree with the way that the claim has been processed. What can I do?**	You can contact Evergreen Health Member Services at (443) 451-4979 to discuss how the claim was processed and request reconsideration. You can file an appeal following the process described on the EOBR. For additional assistance or help preparing your appeal, you can also contact the Health Education and Advocacy Unit, which is part of the Consumer Protection Division of the Maryland Office of the Attorney General. You may do so by calling 877-261-8807, or visiting them online at the following link.
59	**My provider is billing me for more than the amount I owe on my EOBR. What can I do?**	Under Maryland law and the court order, providers are prohibited from billing you for more than the amount you owe on the EOBR. Please contact Evergreen Health Member Services at (443) 451-4979 so we may assist you in this matter.
Explanation of Pending Payments		
60	**I received an Explanation of Pending Payment (EOPP) from Evergreen. What is this?**	The EOPP is your remittance advice for all unpaid claims that Evergreen has received and processed for dates of service prior to the July 31, 2017 receivership order. It provides your practice with information about how these claims have been processed, as well as any member cost share that the member owes.
61	**How is the EOPP different from other Explanations of Payments (EOPs) that I have received in the past?**	The only difference is that your practice has not received payment from Evergreen. In accordance with the court order, Evergreen cannot pay pre-receivership claims at this time. The Receiver of Evergreen will be mailing instructions on how to file for payment of your pre-receivership claims in the near future.
62	**What can I bill members for?**	Your practice can bill members for their member cost sharing responsibility – deductibles, coinsurance and copayments. Your practice can also bill members for non-covered services. These amounts are defined on your EOPP. In accordance with the court order, your practice cannot bill members for balances owed by Evergreen. If Evergreen learns that your practice is balance billing in violation of the court

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		order, your practice will be referred to the Health Education and Advocacy Unit of the Maryland Office of the Attorney General.
63	**I disagree with the way that the claim has been processed. What can I do?**	You can contact Evergreen Health Provider Services at (443) 451-4979 to discuss how the claim was processed and request reconsideration. If you believe that the claim was incorrectly processed, you can submit a claim reconsideration by using the Provider Claim Reconsideration form available on website here. You can also submit a claim appeal request by using the Claim Appeal form available on our website here.
64	**I recently received an EOP from Evergreen where I was paid for claims. Why did you pay those claims but not the claims on my EOPP?**	Claims for dates of service on and after the July 31, 2017 receivership order are being paid in the ordinary course of business.