Advantage Point of Service Plan

Benefit Plan Summary – Evergreen Health Plan, Inc.

P.O. Box 790, Columbus, GA 31902-0790

***Annual / Lifetime Maximum Benefit- $2,000,000 / $5,000,000**

Features	POS In-network	POS Out-of-network
Annual deductible	$0	$500 for Individual / $1,000 Family
PCP or OB/GYN office visits	100% after $15 co-payment per PCP visit and $25 co-payment per OB/GYN visit.	60% after [$500/$1,000] annual deductible is met.
Specialist office visits	100% after $25 co-payment per visit.	60% after [$500/$1,000] annual deductible is met.
Maternity care (includes pre-natal and post-natal care, delivery and newborn care)	100% after first visit co-payment of $25; PCP management is not necessary but services must be provided by a participating physician in a participating facility.	60% after [$500/$1,000] annual deductible is met.
Co-payments and Co-insurance	$15 co-payment required for office visit to the PCP, $25 co-payment for specialist and $25 co-payment for routine gynecological exam. Physician office visits **are not** subject to the deductible. Co-payments for all other covered services are listed below.	Member is responsible [$500/$1,000] annual deductible and 40% of Evergreen's Usual -Customary –Reasonable (UCR) Charges after deductible is met.
Coverage after co-payments	100%	60% after [$500/$1,000] annual deductible is met.
Personal Physician case management	The PCP or other participating physician is responsible for obtaining any required Pre-Authorization for all inpatient care and outpatient procedures.	The member is responsible for obtaining any required Pre-Authorization for all inpatient care and outpatient procedures.
Annual out-of-pocket maximum (the most the member will pay for co-payments for covered services in one contract year)	$1,000 per member, not to exceed $3,000 per family. The out-of-pocket maximum can not be satisfied with co-payment for family planning, infertility, hearing, and vision services or transplant services.	$5,000 per member, not to exceed $15,000 per family. Maximum per year is based on Evergreen's Usual-Customary-Reasonable (UCR) Charges. The out-of-pocket maximum can not be satisfied with co-payment for family planning, infertility, hearing, and vision services or transplant services.
Vision examination	If your vision exam is performed at the PCP's office or participating optometrist's office, you pay $15 co-payment, if performed at specialist's office, you pay $25 co-payment. Vision exam is limited to biennial benefit maximum: each covered person is limited to one refraction every 24 months. **Corrective devices are excluded.**	Vision services are not available out-of-network.
Inpatient hospital care	100% for after $200 co-payment for Pre-Authorized hospital care. See "Rehabilitative Services" for coverage of inpatient physical, occupational, and speech therapy. See "Substance abuse services" for coverage of the diagnosis, detoxification and treatment of the medical complications of substance abuse on an inpatient basis. See "Mental health" for coverage of inpatient mental health services.	60 % after [$500/$1,000] annual deductible for Pre-Authorized hospital stay. See "Rehabilitative Services" for coverage of inpatient physical, occupational, and speech therapy. See "Substance abuse services" for coverage of the diagnosis, detoxification and treatment of the medical complications of substance abuse on an inpatient basis. See "Mental health" for coverage of inpatient mental health services.
Outpatient surgery	100% of Pre-Authorized outpatient surgical procedures.	60% of Pre-Authorized outpatient surgical procedures after [$500/$1,000] annual deductible is met.
Urgent Care	100% after $35 co-payment.	60% after [$500/$1,000] annual deductible is met.
Emergency care	100% after $100 co-payment per visit to an emergency room for services which meet the prudent layperson definition of care; co-payment is waived if the member is admitted to the hospital. **Non-emergency use of the emergency room is not covered.**	100% after $100co-payment per visit to an emergency room for services which meet the prudent layperson definition of care. ; Co-payment is waived if the member is admitted to the hospital. **Non-emergency use of the emergency room is not covered.**

Features	POS In-network	POS Out-of-network
Ambulance transportation	100% if life-or limb threatening emergency.	100% if life-or limb threatening emergency after [$500/$1,000] annual deductible is met.
Laboratory, X-ray and other diagnostic services	100% of lab services when ordered by a participating physician and performed at a participating facility.	60% after [$500/$1,000] annual deductible is met.
Preventive health services consistent with nationally accepted standards including routine pediatric immunizations and routine health screenings.	100% after $15/$25 co-payment; no office visit co-payment required for immunizations only.	60% after [$500/$1,000] annual deductible is met. Children age 5 and under: 60% of allowed amount; not subject to annual deductible.
Allergy Testing - once per lifetime **Allergy Extract** **Allergy Injections**	100% with Pre-Authorization and $25 co-payment. 100% with Pre-Authorization. 100% per visit.	60% after [$500/$1,000] annual deductible is met. Testing and Extract require Pre-Authorization.
Hearing examination	If your hearing exam is performed at the PCP's you pay $15 co-payment, if performed at specialist's office you pay $25 co-payment. One examination every 24 months up to age 17; services must be obtained from a participating provider. **Hearing aids are excluded.**	Hearing exams are not covered out-of-network.
Family planning	100% after $15 co-payment from PCP or after $25 co-payment from OB/GYN. 100% for Elective sterilization (tubal ligations and vasectomies); **reversals are not covered.**	60% after [$500/$1,000] annual deductible is met. 60% after annual deductible is met for Elective sterilization (tubal ligations and vasectomies); **reversals are not covered**.
Infertility diagnosis and some treatment	100% after $25 co-payment per visit; limited to $2,000 annual maximum.	60% after [$500/$1,000] annual deductible is met; limited to $2,000 allowed charges annual maximum benefit.
Durable medical equipment	100% after $25 co-payment per device for equipment Pre-Authorized by Evergreen.	60% after [$500/$1,000] annual deductible is met.
Home health services and hospice care	100% for Pre-Authorized treatment; **custodial care is not covered.**	60% after [$500/$1,000] annual deductible is met; **custodial care is not covered.**
Skilled nursing facility care	100% for up to 30 days of Pre-Authorized skilled nursing care per contract year within 3 days following hospital discharge; **custodial care is not covered.**	60% after [$500/$1,000] annual deductible is met for up to 30 days of Pre-Authorized skilled nursing care per contract year within 3 days following hospital discharge; **custodial care is not covered.**
Mental health (services for the crisis intervention and diagnosis and treatment of conditions responsive to short term therapy; services include individual, family and marital therapy)	100% after $25 co-payment per visit for Pre-Authorized outpatient care, limited to 25 visits per contract year; 100% after $100 co-payment per day for Pre-Authorized inpatient care, limited to 30 inpatient days per contract year.	60% after [$500/$1,000] annual deductible is met for Pre-Authorized outpatient care, limited to 25 visits per contract year; 60% after annual deductible is met for Pre-Authorized inpatient care, limited to 30 inpatient days per year.
Substance abuse services (for the diagnosis, detoxification, and treatment of the medical complications of substance abuse)	100% after $100 per day co-payment for Pre-Authorized inpatient services; limited to 15 inpatient days per contract year. 100% after $25 co-payment for Pre-Authorized outpatient services; limited to 25 outpatient visits per contract year.	60% after [$500/$1,000] annual deductible is met for Pre-Authorized inpatient services; limited to 15 inpatient days per contract year. 60% after [$500/$1,000] annual deductible is met for Pre-Authorized outpatient services; limited to 25 visits per contract year.
Rehabilitative services (short term physical, occupational and speech therapies)	100% per course of treatment for outpatient services, limited to 30 visits per year; inpatient treatment limited to 30 inpatient days per year. Pre-Authorization is required for outpatient and inpatient services.	60% after [$500/$1,000] annual deductible is met for outpatient services, limited to 30 visits per year; inpatient treatment limited to 30 inpatient days per year. Pre-Authorization is required for outpatient and inpatient services.
Transplants	100% after a $5,000 co-payment for non-experimental transplants Pre-Authorized by the Medical Director and performed at an Evergreen Pre-Authorized facility.	Not Covered when provided by out-of-network providers.