

Option Plan A

**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	Option Plan A
Annual deductible	None
Annual Maximum Out-of-Pocket (the most the member will pay for co-payments for covered services in one contract year)	Evergreen will pay 100% of allowed amount for covered services when the maximum out of pocket amount has been met. \$1,500 per member or \$3,000 per family The out-of-pocket maximum can not be satisfied with co-payments for family planning, infertility, hearing, vision services, and transplant services
Co-payments	\$15 co-payment required for office visit to the PCP \$25 co-payment for specialist; \$25 co-payment for routine gynecological exam. Inpatient Hospital Admission co-pay \$300 per admission Outpatient Hospital Surgery co-pay \$100 Outpatient Testing co-pay \$50 per test Physical Therapy co-pay \$15 per visit Preventive Care Option \$15 limited to annual wellness visit
Coverage after co-payments	100% after co-payments.
PCP or OB/GYN office visits	100% after \$15 co-payment per PCP visit and \$25 co-payment per OB/GYN visit.
Specialist office visits	100% after \$25 co-payment per visit. A referral from the PCP is not required if it is an in-network specialist.
Maternity care (includes pre-natal and post-natal care, delivery and newborn care)	100% after applicable co-payment(s) of \$25 for physician services, and Inpatient Hospital co-payment of \$300 when admitted to hospital for delivery; PCP referral is not necessary but services must be provided by a participating physician in a participating facility.
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.
Vision examination	If your vision exam is performed at the optometrist's office you pay \$10 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, and fitting for contact lenses is not covered.
Inpatient hospital care	100 % after \$300 co-payment per admission 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% after \$100 co-payment of Pre-Authorized outpatient hospital surgical procedure. This includes all surgical procedures done as outpatient hospital procedures, gastrointestinal endoscopy, and cardiac catheterization if done outpatient. Surgical procedures performed in the physician's office are not subject to this co-pay.
Urgent Care	100% after \$35 co-payment.

Features	Option Plan A
Emergency care	100% after \$100 co-payment per visit to an emergency room; co-payment is waived if the member is admitted to the hospital.
Ambulance transportation	100% if life-or limb threatening emergency.
Laboratory	100% of lab services when ordered by a participating physician and performed at a participating facility.
X-ray and other diagnostic services	100% after \$50 co-payment per test. This includes MRIs, CTs, PETs, SPECTSs, DEXAs, Myelograms, and GI contrast studies.
Preventive health services consistent with nationally accepted standards (e.g. Routine pediatric immunizations and routine health screenings)	100% after \$15 co-payment per physician office visit, no office visit co-payment required for immunizations only.
Allergy Testing - once per lifetime	100% with Pre-Authorization and \$25 co-payment.
Allergy Extract	100% with Pre-Authorization.
Allergy Injections	100% per visit.
Hearing examination	If your hearing exam is performed at the PCP's office 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; a referral from the PCP is necessary, but services must be obtained from a participating provider. Hearing aids are excluded.
Family planning	100% after \$15 co-payment from PCP or \$25 co-payment from OB/GYN. 100% after \$25 co-payment for specialist for Elective sterilization (tubal ligations and vasectomies) authorized by the PCP or OB/GYN; reversals are not covered. Procedures performed at outpatient hospital are subject to the \$100 co-payment.
Infertility diagnosis and some treatment (PCP or OB/GYN referral is required)	100% after \$25 co-payment per physician office visit; subject to x-ray and diagnostic service co-pay and/or outpatient surgery co-payment if applicable. Limited to \$2,000 annual maximum.
Durable medical equipment	100% after \$25 co-payment per device for equipment Pre-Authorized by Evergreen.
Home health services and hospice care	100% after Pre-Authorization for treatment; custodial care is not covered.
Skilled nursing facility care and/or In-Patient Rehabilitative services	100% after the Inpatient Admission Co-payment of \$300 for up to 30 days of Pre-Authorized skilled nursing care and rehab services 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 [\$20, \$25] co-payment per visit for Pre-Authorized outpatient care, limited to 25 visits per contract year; 100% after \$50 co-payment per day for Pre-Authorized inpatient care limited to 30 inpatient days per contract year.
Substance abuse services (for the diagnosis, detoxification, and treatment of the medical complications of substance abuse)	100% after \$25 co-payment for outpatient services; limited to 25 visits per contract year. 100% after \$50 co-payment for Pre-Authorized inpatient services; limited to 15 inpatient days per contract year.
Rehabilitative services (short term physical, occupational and speech therapies)	100% after a [\$10, \$15] co-payment per visit for outpatient services, limited to 30 visits per year; Pre-Authorization is required.
Transplants	100% after co-payment of \$5,000 for non-experimental transplants Pre-Authorized by the Evergreen Medical Director and performed at an Evergreen Pre-Authorized facility.