Samaritan Health Plans

Samaritan Choice Plans
Your Samaritan Employee Health Plans

Summary of material modifications and notice of required disclosures

The Employee Retirement Income Security Act (ERISA) requires that Samaritan Health Plans notify employees each time a material change is made to the health benefit plan.

This document provides changes made to your medical, pharmacy and vision benefits effective Jan. 1, 2021. Previous documents that also explain your current benefits include the 2020 Samaritan Choice Medical and Pharmacy Member Handbook and 2020 Choice Vision Member Handbook.

Keep this notice with your 2020 Samaritan Choice Plans' Medical, Pharmacy and Vision Plan documents. This is a legal part of your Member Handbook.

Please read this notice carefully and keep it where you can find it. This notice has important information about changes to your Medical, Pharmacy and your Vision Plan documents. You can request all plan documents by calling Customer Service at 541-768-4550, toll free 800-832-4580 (TTY 800-735-2900), Monday through Friday, from 8 a.m. to 8 p.m. You can also visit our member website at **choice.samhealthplans.org** to view or download these documents.

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Member resources

The Samaritan Health Plans office in Corvallis, Oregon is maintained to meet your needs. We look forward to serving you!

Come see us:

- **In person**
  8 a.m. to 5 p.m., at 2300 NW Walnut Blvd., Corvallis, Oregon 97330, Monday through Friday.

Contact us:

For questions, Customer Service is available to assist you, Monday through Friday:

- **By phone**
  8 a.m. to 8 p.m., at 541-768-4550 or toll free 800-832-4580 (TTY 800-735-2900).

- **By email**
  8 a.m. to 5 p.m., at SHSChoicePlansTeam@samhealth.org

- **By mail**
  PO Box 1310, Corvallis, OR 97339

Member website offers 24/7 access to Plan details:

Go to **choice.samhealthplans.org** to take advantage of your online tools:
- Find Care: Search In-Network for doctors and specialties near you.
- Search Drug List: Search for your drug coverage and costs.
- Member Materials: Look at the Plan materials.

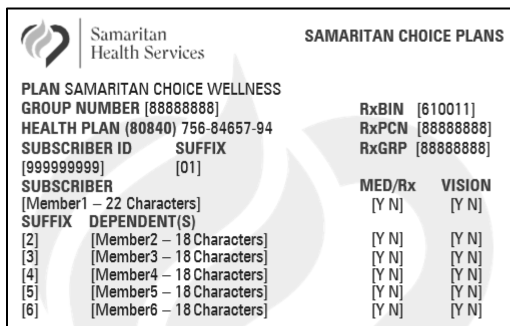
Member portal offers 24/7 access to Claims information:

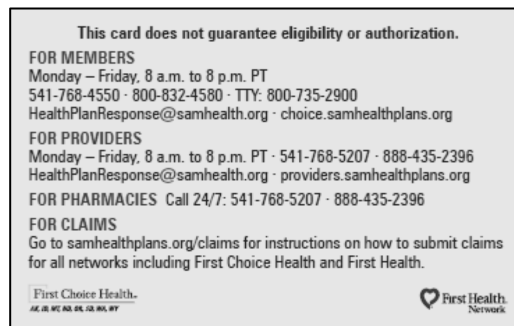
Go to **MyHealthPlan.samhealthplans.org** to take advantage of the following online tools:
- View Claims processed by your health Plan.
- View details about your eligibility with the health Plan, including the amount you have met toward your Deductibles and your Plan limits.

Member ID card:

Your new member ID card(s) will be mailed to you within 14 days of your enrollment into the Plan. In the meantime, you may contact Customer Service to inquire about your member ID number when receiving Services. If you need additional member ID card(s) for additional members in the household, please contact Customer Service to request additional cards.

Here's an example of what your ID card looks like:





This section replaces language in the Out-of-Pocket Limits and Deductibles section on pages 2-3 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook.

Out-of-Pocket Limits and Deductibles

Please refer to the additional information throughout this document for further explanations of your benefits including limitations and exclusions.

Your annual Out-of-Pocket Limit

This Plan has an Out-of-Pocket Limit to protect you from excessive medical expenses. The Schedule of Benefits shows your Plan's annual Out-of-Pocket Limit. If you Incur covered expenses over that amount, this Plan will pay 100% of Eligible Charges for the rest of the Calendar Year. Those Services that do not apply to your Out-of-Pocket Limit will not be covered at 100% after your Out-of-Pocket Limit has been met. Regular Cost Sharing will apply to these benefits.

Samaritan Choice Wellness Plan: Integrated Medical and Pharmacy Out-of-Pocket Limit:

- In-Network Providers: $7,200 per person / $14,400 per family per Calendar Year.
- Out-of-Network Providers: Unlimited.
- Once the applicable In-Network Out-of-Pocket Limit has been met, this Plan will pay 100% of the Allowed Amount for Covered Services at the applicable In-Network benefit level, for the rest of that Calendar Year.
- The Pharmacy benefit has an integrated Out-of-Pocket Limit with the medical Plan.

Samaritan Choice HSA Eligible High-Deductible Plan: Integrated Medical and Pharmacy Out-of-Pocket Limit:

- In-Network Providers: $5,000 per person / $10,000 per family per Calendar Year.
- Out-of-Network Providers: Unlimited.
- Once the applicable In-Network Out-of-Pocket Limit has been met, this Plan will pay 100% of the Allowed Amount for Covered Services at the applicable In-Network benefit level, for the rest of that Calendar Year.
- The Pharmacy benefit has an integrated Out-of-Pocket Limit with the medical Plan.

Expenses for the following DO NOT count toward your Out-of-Pocket Limit:

Samaritan Choice Wellness Plan:

- Air ambulance.
- Bariatric surgery Copays.
- Benefits paid in full by the Plan (for example, vision hardware).
- Charges in excess of the Maximum Plan Allowable (MPA).
- Incurred charges that exceed Allowed Amounts under this Plan.
- Non-Covered Services, including those where a third-party is responsible (COB, settlements, motor vehicle Claims).
- Non-Medically Necessary Services, such as Excluded Services or those deemed to be not Medically Necessary by the Plan.
- Panniculectomies.
- Value-Based Service Copays.
- Other Services that are specifically called out in this document.

Samaritan Choice HSA Eligible High-Deductible Plan:

- Benefits paid in full by the Plan (for example, vision hardware).
- Charges in excess of the Maximum Plan Allowable (MPA).
- Incurred charges that exceed Allowed Amounts under this Plan.
- Non-Covered Services, including those where a third-party is responsible (COB, settlements, motor vehicle Claims).
- Non-Medically Necessary Services, such as Excluded Services or those deemed to be not Medically Necessary by the Plan.
- Other Services that are specifically called out in this document.

Information about your Deductible

The Deductible amount for individuals and families is listed in the Schedule of Benefits. No family will have to satisfy more than the annual Family Deductible each Calendar Year.

The following DO NOT count towards the Deductible:

Samaritan Choice Wellness Plan:

- SOME Preventive Services do not apply to your Deductible obligation.
- Bariatric surgery Copays.
- Value-Based Service Copays.
- Panniculectomies.
- Other Services outlined in this document.

Samaritan Choice HSA Eligible High-Deductible Plan:

- SOME Preventive Services do not apply to your Deductible obligation.

This section replaces language in the Schedule of Benefits section on pages 3-8 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook.

Schedule of Benefits: Samaritan Choice Wellness Plan

The table below summarizes the medical benefits for the Samaritan Choice Wellness Plan. Please refer to other sections of this document for a detailed description of your benefits. This schedule does not replace your Summary of Benefits and Coverage (SBC) document. **Please note: You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a Provider for the difference between the Provider's charge and what your Plan pays (Balance Billing).**

	In-Network: Member pays	**Out-of-Network: Member pays**
Deductible - Per Calendar Year - Medical - Some Services do not apply to the Deductible, as indicated below	$450/individual; $1,350/family	Amounts assessed for In-Network and Out-of-Network Services apply toward the same Deductible, when the Deductible applies
Out-of-Pocket Limit - Per Calendar Year - Medical and pharmacy	$7,200/individual; $14,400/family	Unlimited
All Copay costs shown in this chart are after your Deductible has been met, if a Deductible applies.		
Preventive Services		
Well baby care	No charge, deductible does not apply	30%, deductible does not apply
Routine physicals	No charge, deductible does not apply	30%, deductible does not apply
Routine gynecological exams	No charge, deductible does not apply	30%, deductible does not apply
Immunizations	No charge, deductible does not apply	30%, deductible does not apply
Colorectal screening	No charge, deductible does not apply	30%, deductible does not apply
Professional Services		
Primary care visits [1]	$25, deductible applies	30%, deductible applies
In-office procedures	$25, deductible applies	30%, deductible applies

Schedule of Benefits: Samaritan Choice Wellness Plan

The table below summarizes the medical benefits for the Samaritan Choice Wellness Plan. Please refer to other sections of this document for a detailed description of your benefits. This schedule does not replace your Summary of Benefits and Coverage (SBC) document. **Please note: You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a Provider for the difference between the Provider's charge and what your Plan pays (Balance Billing).**

Service	In-Network: Member pays	Out-of-Network: Member pays
All Copay costs shown in this chart are after your Deductible has been met, if a Deductible applies.		
Professional Services (continued)		
Specialist visits	$40, deductible applies	30%, deductible applies
In-office procedures	$40, deductible applies	30%, deductible applies
Telehealth visit	No charge, deductible does not apply	30%, deductible applies
Urgent care center visits	$40, deductible applies	$40, deductible applies
Surgery professional (at hospital or ASC)	$60, deductible applies	30%, deductible applies
Care Coordination Services: For asthma, diabetes, congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD).		
Office visit	No charge, deductible applies	30%, deductible applies
Education services		
Office visit for specified education services	No charge, deductible applies	30%, deductible applies
Hospital / Inpatient services		
Inpatient room and board (SHS facility)	$175/day, up to $875 maximum per stay, deductible applies	N/A
Inpatient room and board (non-SHS facility)	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Inpatient rehabilitative care (SHS facility)	$175/day, up to $875 maximum per stay, deductible applies	N/A
Inpatient rehabilitative care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Skilled nursing facility care	No charge, deductible applies	30%, deductible applies
Bariatric surgery [2]	$5,000, deductible does not apply (Does not apply to OOP limit)	Not covered
Outpatient services		
Outpatient surgery (does not include in-office procedures) (SHS designated facilities)	$150, deductible applies	N/A
Outpatient surgery (does not include in-office procedures) (non-SHS facility)	$250, deductible applies	30%, deductible applies
Emergency department visits (unless admitted to hospital)	$150, deductible applies	$150, deductible applies
Radiology	$25, deductible applies	30%, deductible applies
Electrocardiogram (ECG/EKG)	$25, deductible applies	30%, deductible applies
Lab	No charge, deductible applies	30%, deductible applies

Schedule of Benefits: Samaritan Choice Wellness Plan

The table below summarizes the medical benefits for the Samaritan Choice Wellness Plan. Please refer to other sections of this document for a detailed description of your benefits. This schedule does not replace your Summary of Benefits and Coverage (SBC) document. **Please note: You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a Provider for the difference between the Provider's charge and what your Plan pays (Balance Billing).**

Service	In-Network: Member pays	Out-of-Network: Member pays
All Copay costs shown in this chart are after your Deductible has been met, if a Deductible applies.		
Value-Based Services		
Specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis) [3, 4]	$400, deductible does not apply (Does not apply to OOP limit)	30%, deductible does not apply (Does not apply to OOP limit)
High-tech imaging services [3, 4] (CT scans, MRIs and PET scans)	$200, deductible does not apply (Does not apply to OOP limit)	30%, deductible does not apply (Does not apply to OOP limit)
Substance Use Disorder		
Office visits	$40, deductible applies	30%, deductible applies
Inpatient care (SHS facility)	$175/day, up to $875 maximum per stay, deductible applies	N/A
Inpatient care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Outpatient intensive services and programs (including partial hospitalization) for Substance Use Disorder	30%, deductible applies	Not covered
Residential programs	30%, deductible applies	30%, deductible applies
Mental health		
Office visits	$25, deductible applies	30%, deductible applies
Inpatient care (SHS facility)	$175/day, up to $875 maximum per stay, deductible applies	N/A
Inpatient care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Partial hospitalization	30%, deductible applies	30%, deductible applies
Residential programs	30%, deductible applies	30%, deductible applies
Other Covered Services		
Physical therapy (SHS physical therapy providers)	$30, deductible applies	N/A
Physical therapy (non-SHS physical therapy providers)	$35, deductible applies	30%, deductible applies
Occupational therapy	$35, deductible applies	30%, deductible applies
Speech therapy	$35, deductible applies	30%, deductible applies
Allergy injections (most) [5]	$15, deductible applies	30%, deductible applies
Injectables and other drugs administered in the office (other than oral medications) [5]	20%, deductible applies	20%, deductible applies

Schedule of Benefits: Samaritan Choice Wellness Plan

The table below summarizes the medical benefits for the Samaritan Choice Wellness Plan. Please refer to other sections of this document for a detailed description of your benefits. This schedule does not replace your Summary of Benefits and Coverage (SBC) document. **Please note: You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a Provider for the difference between the Provider's charge and what your Plan pays (Balance Billing).**

Service	In-Network: Member pays	Out-of-Network: Member pays
All Copay costs shown in this chart are after your Deductible has been met, if a Deductible applies.		
Other Covered Services (continued)		
Ambulance, ground	30% after $100 copay, deductible applies	30% after $100 copay, deductible applies
Ambulance, air	30%, deductible applies (Does not apply to OOP limit)	30%, deductible applies, plus, any balance billing (Does not apply to OOP limit)
Durable Medical Equipment (DME), prosthetics, orthotics, and medical supplies	30%, deductible applies	50%, deductible applies
Continuous glucose monitors [6]	No charge, deductible applies	50%, deductible applies
Home health care	$30, deductible applies	30%, deductible applies
Hospice	No charge, deductible applies	30%, deductible applies
Hearing aids	Covered up to $1,000/year, deductible applies No limit for children ages 20 and under	Covered up to $1,000/year, deductible applies No limit for children ages 20 and under
Acupuncture	$35, deductible applies	35%, deductible applies
Chiropractic [7]	$25, deductible applies Covered up to $850/year	30%, deductible applies Covered up to $850/year
Panniculectomy [8]	50%, deductible does not apply (Does not apply to OOP limit)	Not covered

[1] Primary care provider visit is defined as services provided by a pediatric, family medicine, and internal medicine or OB-GYN provider.

[2] Bariatric surgery is covered only at in-network/designated facilities and subject to its policies and surgical criteria.

[3] Value-based copays do not apply if coded as emergency room services. Cost shares will default to normal benefit for emergency room services.

[4] Value-based copays do not count towards annual deductibles and out-of-pocket (OOP) limits. Other applicable copay or coinsurance must be separately paid as applicable (e.g., office visits, lab, services, etc.).

[5] Contact Customer Service to determine your copay or coinsurance levels and applicable services. Please refer to the **Member Resources section** for contact information.

[6] Procedure codes that apply to the continuous glucose monitor benefit are as follows: A9276, A9277, A9278, K0553, and K0554.

[7] Chiropractic benefit only includes manipulations and exams. This benefit does not include x-rays, labs, radiology or other services that are not considered to be a manipulation treatment.

[8] Panniculectomy coinsurance does not apply to the out-of-pocket limit or deductible. Services will only be covered when bariatric surgery has been performed at an in-network provider facility and will only be allowed after bariatric surgery has been authorized and performed by an in-network/designated facility.

Schedule of Benefits: Samaritan Choice HSA Eligible High-Deductible Plan

The table below summarizes the medical benefits for the Samaritan Choice HSA Eligible High-Deductible Plan. Please refer to other sections of this document for a detailed description of your benefits. This schedule does not replace your Summary of Benefits and Coverage (SBC) document. **Please note: You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a Provider for the difference between the Provider's charge and what your Plan pays (Balance Billing).**

	In-Network: Member pays	Out-of-Network: Member pays
Deductible - Per Calendar Year - Medical and pharmacy - Some Services do not apply to the Deductible, as indicated below	$2,800/individual; $5,600/family	Amounts assessed for In-Network and Out-of-Network Services apply toward the same Deductible, when the Deductible applies
Out-of-Pocket Limit - Per Calendar Year - Medical and pharmacy	$5,000/individual/ $10,000/family	Unlimited
All Copay costs shown in this chart are after your Deductible has been met, if a Deductible applies.		
Preventive Services		
Well baby care	No charge, deductible does not apply	30%, deductible does not apply
Routine physicals	No charge, deductible does not apply	30%, deductible does not apply
Routine gynecological exams	No charge, deductible does not apply	30%, deductible does not apply
Immunizations	No charge, deductible does not apply	30%, deductible does not apply
Colorectal screening	No charge, deductible does not apply	30%, deductible does not apply
Professional Services		
Primary care visits [1]	$25, deductible applies	30%, deductible applies
In-office procedures	$25, deductible applies	30%, deductible applies
Specialist visits	$40, deductible applies	30%, deductible applies
In-office procedures	$40, deductible applies	30%, deductible applies
Telehealth visit	No charge, deductible applies	30%, deductible applies
Urgent care center visits	$40, deductible applies	$40, deductible applies
Surgery professional (at hospital or ASC)	$60, deductible applies	30%, deductible applies
Care Coordination Services: For asthma, diabetes, congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD).		
Office visit	No charge, deductible applies	30%, deductible applies
Education services		
Office visit for specified education services	No charge, deductible applies	30%, deductible applies
Hospital / Inpatient services		
Inpatient room and board (SHS facility)	$175/day, up to $875 maximum per stay, deductible applies	N/A
Inpatient room and board (non-SHS facility)	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Inpatient rehabilitative care (SHS facility)	$175/day, up to $875 maximum per stay, deductible applies	N/A
Inpatient rehabilitative care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Skilled nursing facility care	No charge, deductible applies	30%, deductible applies
Bariatric surgery [2]	$5,000, deductible applies	Not covered

Schedule of Benefits: Samaritan Choice HSA Eligible High-Deductible Plan

The table below summarizes the medical benefits for the Samaritan Choice HSA Eligible High-Deductible Plan. Please refer to other sections of this document for a detailed description of your benefits. This schedule does not replace your Summary of Benefits and Coverage (SBC) document. **Please note: You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a Provider for the difference between the Provider's charge and what your Plan pays (Balance Billing).**

Service	In-Network: Member pays	Out-of-Network: Member pays
All Copay costs shown in this chart are after your Deductible has been met, if a Deductible applies.		
Outpatient services		
Outpatient surgery (does not include in-office procedures) (SHS designated facilities)	$150, deductible applies	N/A
Outpatient surgery (does not include in-office procedures) (non-SHS facility)	$250, deductible applies	30%, deductible applies
Emergency department visits (unless admitted to hospital)	$150, deductible applies	$150, deductible applies
Radiology	$25, deductible applies	30%, deductible applies
Electrocardiogram (ECG/EKG)	$25, deductible applies	30%, deductible applies
Lab	No charge, deductible applies	30%, deductible applies
Value-Based Services		
Specified surgical procedures (spine surgery for pain, arthroscopies, shoulder surgery for osteoarthritis)	$400, deductible applies	30%, deductible applies
High-tech imaging services (CT scans, MRIs and PET scans)	$400, deductible applies	30%, deductible applies
Substance Use Disorder		
Office visits	$40, deductible applies	30%, deductible applies
Inpatient care (SHS facility)	$175/day, up to $875 maximum per stay, deductible applies	N/A
Inpatient care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Outpatient intensive services and programs (including partial hospitalization) for Substance Use Disorder	30%, deductible applies	Not covered
Residential programs	30%, deductible applies	30%, deductible applies
Mental health		
Office visits	$40, deductible applies	30%, deductible applies
Inpatient care (SHS facility)	$175/day, up to $875 maximum per stay, deductible applies	N/A
Inpatient care (non-SHS facility)	$300/day, up to $1,500 maximum per stay, deductible applies	30%, deductible applies
Partial hospitalization	30%, deductible applies	30%, deductible applies
Residential programs	30%, deductible applies	30%, deductible applies
Other Covered Services		
Physical therapy (SHS physical therapy providers)	$30, deductible applies	N/A
Physical therapy (non-SHS physical therapy providers)	$35, deductible applies	30%, deductible applies

Schedule of Benefits: Samaritan Choice HSA Eligible High-Deductible Plan

The table below summarizes the medical benefits for the Samaritan Choice HSA Eligible High-Deductible Plan. Please refer to other sections of this document for a detailed description of your benefits. This schedule does not replace your Summary of Benefits and Coverage (SBC) document. **Please note: You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a Provider for the difference between the Provider's charge and what your Plan pays (Balance Billing).**

Service	In-Network: Member pays	Out-of-Network: Member pays
All Copay costs shown in this chart are after your Deductible has been met, if a Deductible applies.		
Other Covered Services (continued)		
Occupational therapy	$35, deductible applies	30%, deductible applies
Speech therapy	$35, deductible applies	30%, deductible applies
Allergy injections (most) [3]	$15, deductible applies	30%, deductible applies
Injectables and other drugs administered in the office (other than oral medications) [3]	20%, deductible applies	20%, deductible applies
Ambulance, ground	30% after $100 copay, deductible applies	30% after $100 copay, deductible applies
Ambulance, air	30%, deductible applies	30%, deductible applies, plus, any balance billing
Durable Medical Equipment (DME), prosthetics, orthotics, and medical supplies	30%, deductible applies	50%, deductible applies
Continuous glucose monitors [4]	No charge, deductible applies	50%, deductible applies
Home health care	$30, deductible applies	30%, deductible applies
Hospice	No charge, deductible applies	30%, deductible applies
Hearing aids	Covered up to $1,000/year, deductible applies No limit for children ages 20 and under	Covered up to $1,000/year, deductible applies No limit for children ages 20 and under
Acupuncture	$35, deductible applies	35%, deductible applies
Chiropractic [5]	$25, deductible applies Covered up to $850/year	30%, deductible applies Covered up to $850/year
Panniculectomy [6]	50%, deductible applies	Not covered

[1] Primary care provider visit is defined as services provided by a pediatric, family medicine, and internal medicine or OB-GYN provider.

[2] Bariatric surgery is covered only at in-network/designated facilities and subject to its policies and surgical criteria.

[3] Contact Customer Service to determine your copay or coinsurance levels and applicable services. Please refer to the **Member Resources section** for contact information.

[4] Procedure codes that apply to the continuous glucose monitor benefit are as follows: A9276, A9277, A9278, K0553, and K0554.

[5] Chiropractic benefit only includes manipulations and exams. This benefit does not include x-rays, labs, radiology, or other services that are not considered to be a manipulation treatment.

[6] Panniculectomy services will only be covered when bariatric surgery has been performed at an in-network provider facility and will only be allowed after bariatric surgery has been authorized and performed by an in-network/designated facility.

Schedule of Benefits: Prescription Drug

The table below summarizes the pharmacy benefits for the Samaritan Choice Wellness and HSA Eligible High-Deductible Plans. Please refer to other sections of this document for a detailed description of your benefits.

Drug tiers	Samaritan Choice Wellness Plan Pharmacy Benefits	Samaritan Choice HSA Eligible High-Deductible Plan Pharmacy Benefits
Tier 1: Preventive	No charge, deductible does not apply	No charge, deductible does not apply
Tier 2: Low-cost therapeutic	No charge, deductible does not apply	No charge, deductible applies
Tier 3: Preferred	$7 or 20% (whichever is greater), deductible does not apply	$7 or 20% (whichever is greater), deductible applies
Tier 4: High-cost preferred	$25 or 25% (whichever is greater), deductible does not apply	$25 or 25% (whichever is greater), deductible applies
Tier 5: Non-preferred	50%, deductible does not apply	50%, deductible applies
Tier 6: High-cost specialty	15%, deductible does not apply	15%, deductible applies

Please refer to the Pharmacy Plan Benefits section of this document for additional information.

Tier 1: Preventive offers select preventive drugs.

Tier 2: Low-cost therapeutic offers select therapeutic drugs at a low cost.

Tier 3: Preferred provides the same high quality medicinal and therapeutic benefits without the high cost (mostly generics, some Brand Name Drugs).

Tier 4: High-cost preferred consists of medium cost Prescription Drugs that provide high quality, effective benefits to Samaritan Choice Plans' members and are less costly than other alternative drugs not included on the preferred drug list (both Brand Name and Generic Drugs).

Tier 5: Non-preferred are drugs that are non-preferred by the Plan (mostly Brand Name, some Generic Drugs). You may choose to receive non-preferred drugs rather than the therapeutic equivalent, which may be on a lower Cost Sharing tier. If your drug is categorized as a Tier 5 drug on the Formulary and does not have an equivalent preferred drug available, you may request a tier exception for your drug to be paid at Tier 4.

Tier 6: High-cost specialty includes high cost brand and generic specialty drugs, which may require special handling and/or close monitoring. You may be charged a high-cost specialty Coinsurance if the drug is received in another setting (for example, infusion).

Note: If a Generic Drug is released for a Brand Name Drug, the Plan automatically adds the generic equivalent to the Formulary and removes the Brand Name Drug. Drugs on the Formulary are subject to change throughout the year, upon review by the SCP Pharmacy and Therapeutics Committee.

This section replaces language in the Prior Authorization section on pages 16-18 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook.

2021 Prior Authorization list

Coverage of certain medical Services, procedures, supplies and equipment require Samaritan Choice Plans' (SCP) written authorization before being performed or supplied. Your Provider may request Prior Authorization by phone, fax, or mail. If for any reason your Provider will not, or does not, request Prior Authorization for you, you must contact SCP yourself. This requirement applies to both In-Network and Out-of-Network Providers. In some cases, SCP may require you to provide additional information or seek a second opinion before authorizing coverage.

Samaritan Choice Plans reserves the right to review or otherwise deny Services that are not found to be Medically Necessary[3]. Failure to obtain a Prior Authorization may result in your claim being denied, either in whole or in part. Prior Authorization is not a guarantee of payment.

Prior Authorization by Samaritan Choice Plans is required for the following medical services and surgical procedures:

- Bariatric surgery (benefit is for in-network/designated facilities only).
- Capsule/wireless endoscopies and motility monitoring studies.
- Chimeric antigen receptor (CAR) T-cell therapy.
- Durable Medical Equipment (DME), prosthetics, orthotics and medical supplies with billed amount greater than $1,000 for purchase. Rental items with rental fee greater than $1,000 per month or rental length greater than three months.
  - **Exception**: Diabetic and positive airway pressure (PAP) supplies.
- Elective coronary angioplasty.
- Genetic testing.
  - **Exception**: Standard prenatal testing.
- Hospitalization for dental procedures including Ambulatory Surgical Center (ASC).
- Hyaluronic acid or viscosupplementation, intra-articular injection (i.e. Orthovisc, Synvisc, etc.).
- Hyperbaric oxygen therapy.
- Infused/injected drugs (see attached list).
- Inpatient hospital care (including mental health and Substance Use Disorder).[1]
  - **Exception**: Labor & Delivery stays less than 96 hours.
  - **Exception**: Newborn stays less than 96 hours.
- Inpatient rehabilitation care.
- Panniculectomy.
- Parenteral and enteral nutrition (related supplies follow DME prior authorization requirements).
- Potentially cosmetic, experimental or reconstructive surgery and services, including new and emerging technologies and infused/injected drugs, and clinical trials.[2]
- Radiological services (for the following):
  - Magnetic Resonance Imaging (MRI).
  - Positron Emission Tomography (PET) scans.
  - Virtual colonoscopy.
- Residential services for mental health and Substance Use Disorder.
- Skilled Nursing Facility (SNF).
- Skin substitute—tissue engineered.
- Spinal injections for pain management (including in-office procedures).
  - **Exception**: Myelography.
  - **Exception**: Nerve blocks as part of covered surgery.
- Spinal surgeries.
- Transplants.
  - **Exception**: Corneal transplants.
- Urine drug tests (prior authorization required after 12 units per year).
- Uvulopalatopharyngoplasty.

[1] Emergency Services will not require Prior Authorization in accordance with Patient Protection and Affordability Care Act. We request notification of all emergency admissions and post-emergency observation stays that exceed 48 hours in order to ensure that all the member's care is appropriately coordinated.

[2] Potentially Cosmetic, Experimental or Reconstructive surgery and Services, including new and emerging technologies and infused/injected drugs, and clinical trials have the following requirements and considerations:

- Cosmetic and Experimental Services, which may include new and emerging technologies, often do not meet medical necessity and are generally not covered.
- Services which may be considered Reconstructive will require Prior Authorization to demonstrate medical necessity regardless of dollar amounts or codes billed.
- Prior Authorization for new and emerging technologies and infused/injected drugs is required to ensure that the Service meets current accepted standards of care.
- Potentially Experimental, new and emerging infused/injected drugs include those which are not approved by the Food and Drug Administration (FDA), or have been FDA approved within the last three years.

[3] **Medically Necessary**: Health care Services or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, Disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and
- Not primarily for the convenience of the patient, physician, or other health care Provider, and not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, or Disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Prior Authorization by Samaritan Choice Plans is required for the following drugs when paid under the medical plan. Any other brand name equivalents of the drugs below also require Prior Authorization:

- Alemtuzumab (Campath, Lemtrada).
- Belimumab (Benlysta).
- Bevacizumab (Avastin).
- Buprenorphine extended release injection (Sublocade).
- Certolizumab (Cimzia).
- Cetuximab (Erbitux).
- Daratumumab (Darzalex).
- Deflazacort (Emflaza).
- Denosumab (Prolia, Xgeva).
- Eculizumab (Soliris).
- Elotuzumab (Empliciti).
- Epoetin and Darbepoetin (Epogen, Procrit, Aranesp).
- Golimumab (Simponi, Simponi Aria).
- Infliximab (Remicade, Inflectra, Renflexis).
- Ipilimumab (Yervoy).
- Lanreotide (Somatuline).
- Laronidase (Aldurazyme).
- Mecasermin (Increlex).
- Mepolizumab (Nucala).
- Natalizumab (Tysabri).
- Nivolumab (Opdivo).
- Octreotide (Sandostatin).
- Ocrelizumab (Ocrevus).
- Omalizumab (Xolair).
- OnabotulinumtoxinA (Botox).
- Palivizumab (Synagis).
- Panitumumab (Vectibix).
- Pembrolizumab (Keytruda).
- Pemetrexed (Alimta).
- Pertuzumab (Perjeta).
- Ranibizumab (Lucentis).
- Ravulizumab-cwvz (Ultomiris).
- RimabotulinumtoxinB (Myobloc).
- Rituximab (Rituxan).
- Rituximab/hyaluronidase (Rituxan Hycela).
- Secukinumab (Cosentyx).
- Tocilizumab (Actemra).

Prior Authorization determination timeframes

Samaritan Choice Plans will decide and notify you of your authorization determination in accordance with reasonable timeframes, as required by Employee Retirement Income Security Act (ERISA).

Type of Claim	Authorization determination
Expedited requests	As your health status requires, but no later than 72 hours of request
Preservice requests	Within 15 days

The language in these benefits replaces the applicable language in the Medical Plan Benefits section on pages 9 and 13 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook.

Ambulance: Urgent and emergent Services of a state-certified ambulance are covered. Air transportation is also covered, but only to the nearest Hospital capable of treatment when ground transportation is inappropriate, and when Medically Necessary. The allowable for any medically appropriate air ambulance Service received from an Out-of-Network Provider will be reimbursed at up to 250% of the Medicare allowable. Please be aware that Services provided by any Out-of-Network Provider will cost more than those you would receive from an In-Network Provider, and your cost share may be higher. The Out-of-Network Provider may also choose to Balance Bill you for any amount not paid by this Plan. For the Wellness Plan, cost shares for air ambulance Services do not apply to the Out-of-Pocket Limit.

Mental health*: This Plan covers Medically Necessary crisis intervention, diagnosis, and short-term treatment subject to the following:

- Assessment and evaluation to diagnose a mental disorder or determine if a mental disorder exists.
- Treatment of mental Illness or disorders which are subject to significant improvement through evidence-based therapeutics.
- Treatment provided in health care facilities, residential programs or facilities.
- Treatment provided in day or Partial Hospitalization programs, or outpatient Services.

Please refer to the **Benefit Exclusions section** of this document for more information on Services not covered by this Plan.

Substance Use Disorder Services*: This Plan covers Medically Necessary crisis intervention, diagnosis, and short-term treatment, subject to the following:

- Assessment and evaluation to diagnose or determine if a Substance Use Disorder exists.
- Treatment of Substance Use Disorders which are subject to significant improvement through evidence-based therapeutics.
- Treatment provided in health care facilities, residential programs or facilities.
- Treatment provided in day or Partial Hospitalization programs, or outpatient Services.

Please refer to the **Benefit Exclusions section** of this document for more information on Services not covered by this Plan.

This section replaces the applicable language in the Benefits Exclusion section on page 22 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook.

This Plan does not cover the following Services:

- Any mental health Services unrelated to the treatment or diagnosis of a mental disorder.
- Educational programs, including court-ordered programs.
- Counseling in the absence of Illness.
- Long-term psychiatric care, which includes the following:
    - Applied Behavioral Analysis (ABA).
    - State Hospital care.
    - Secure Children's Inpatient (SCIP) care.
    - Secure Adolescent Inpatient (SAIP) care.

- Marital, family, career or personal growth counseling, unless it is part of an individual's treatment plan and billed specifically for the individual.
- Mental health treatment, advice or counseling, except as stated in the **Medical Plan Benefits section.**
- Mental or psychological evaluation for sexual dysfunction or inadequacy.
- Out-of-Network Outpatient Intensive Services and programs (including Partial Hospitalization) for Substance Use Disorder Services.
- Psychological testing that is not Medically Necessary.
- Treatment of dementia (such as Alzheimer's disease), including any organic psychotic manifestations.
- Treatment that is Experimental, investigational or unproven to treat a disorder.
- Treatment for intellectual disability, defined as below normal intellectual function with impaired learning, social adjustment and maturation.
- Treatment provided at a Joint Commission-accredited wilderness therapy program.

This Plan does not cover the following medical equipment and devices:

- Eyeglasses or contact lenses, vision therapy, orthoptics and visual appliances (colored lenses, prisms and special glasses) for reading, learning or behavioral disabilities, or dyslexia. These Services may be covered under your Samaritan Choice Vision Plan when enrolled and eligible.
- Hearing aid batteries.
- Implantable neurostimulators.
- Power-assisted Prosthetics.
- Routine supplies and equipment used for comfort, convenience, Cosmetic purposes or environmental control. This includes appliances like air conditioners, air filters, whirlpools, hot tubs, heat lamps or tanning lights. It also includes personal items like telephones, radios and televisions, or for guest meals and other personal items, maintenance supplies or equipment commonly used for purposes other than medical care.

This language replaces the applicable language in the 2020 Samaritan Choice Vision Plan Benefits section on page 2 in your Samaritan Choice Plans' 2020 Vision Benefits Member Handbook.

Covered Benefits

Eye examinations: One comprehensive eye exam (including eye refraction) per Calendar Year is covered 100% after a $25 Copay for In-Network vision Providers and 70% after a $25 Copay for Out-of-Network vision Providers. In addition, Visual Acuity Screening in children (ages 0-21 years) is covered and the Copay does not apply. The U.S. Preventive Services Task Force (USPTF) recommends Screening to detect amblyopia, strabismus, and defects in visual acuity in children in accordance with Bright Futures. Frequency per benefit period is covered in compliance with Bright Futures recommendations.

Vision hardware and/or lenses: The following hardware and/or lenses are covered on a Calendar Year basis at a **combined benefit maximum limit of $300 per Calendar Year**:

- Lenses are covered when eyeglasses are first acquired or when acquired by a change in prescription.
- Prescription lenses.
- Contact lenses.
- Frames.

Limitations

The vision benefit will only pay for the items listed above, up to the Allowed Amount per individual per Calendar Year.

Exclusions

The following are not covered benefits under this Plan:

- Hardware repairs.
- Fitting fees for contact lenses or eyeglasses.
- Medical or surgical treatment of the eyes.
- Visual fields testing.
- Non-prescription lenses.
- Extra charges for fashion eyewear such as blended, coated, glass, oversize lenses or extra charges for special frames.
- Subnormal vision aids.
- Orthoptics or vision training.
- Any expense which is in excess of the maximum Plan allowance.
- An eye examination required as a condition of employment.
- Any expenses which result from an act of declared or undeclared war or armed aggression.
- Any expense paid in whole or in part by any other provision of the Group Health Insurance Plan provided by the policyholder.
- Services and supplies that are payable under a workers' compensation or occupational disease law.

This language replaces the applicable language in the General Provisions section on pages 33-37 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook and on pages 13-18 in your Samaritan Choice Plans' 2020 Vision Benefits Member Handbook.

Quality of medical care

The Plan is not responsible for the quality of medical care the Covered Person receives. The Plan cannot be held liable for any Claims or damages connected with injuries suffered by the Covered Person while receiving medical Services and supplies. The Covered Person has the right to choose his or her own Hospital or physician; however, selecting an In-Network Provider will maximize benefits while minimizing out-of-pocket expenses. Whenever the Covered Person receives Services of an Out-of-Network Provider, it will likely result in greater out-of-pocket expense in the form of higher Deductibles, Copayments, and/or additional Coinsurance. Payments to Out-of-Network Providers are based on Maximum Plan Allowable as determined by the Plan, which may be significantly less than the Out-of-Network Provider's actual billed amount. The Covered Person may be responsible for any difference between the Maximum Plan Allowable and the actual billed amount. We are here to help you maximize your benefits and encourage you to call or e-mail us, so we may help you find an In-Network Provider whenever possible.

Coordination of Benefits

1. Coordination of this group contract's benefits with other benefits

This Coordination of Benefits (COB) section applies when a Covered Person has health care coverage under more than one plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each plan will pay a Claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms, without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

2. Definitions relating to Coordination of Benefits

Plan: Plan means any of the following that provide benefits or Services for medical, pharmacy, or routine vision Services. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no Coordination of Benefits (COB) among those separate contracts.

> 2.1 **Plan includes:** Group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans, or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as Skilled Nursing Care; and Medicare or any other federal governmental plan, as permitted by law.

2.2 **Plan does not include:** Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; specified Disease or specified Accident coverage; school Accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under 2.1 and 2.2 above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

The Plan: The Plan means, as used in this COB section, the part of this contract to which this COB section applies, and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from the Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules listed in section 3 determines whether the Plan is a primary plan or secondary plan when a Covered Person has health care coverage under more than one plan.

When primary, Samaritan Choice Plans determines payment for its benefits first before those of any other plan, without considering any other plan's benefits. When secondary, Samaritan Choice Plans determines its benefits after those of another plan and may reduce the benefits Samaritan Choice Plans pays so that all plan benefits do not exceed 100% of the total allowable expense.

Allowable expense: A health care expense, including Deductibles, Coinsurance and Copayments, which are covered at least in part by any plan covering a Covered Person.

SCP members are expected to pay for their cost shares (Copays, Coinsurances, and Deductibles), and SCP will only pay for benefits after satisfaction of member Deductibles and other eligibility requirements, even when SCP is in the secondary position. When a plan provides benefits in the form of Services, the reasonable cash value of each Service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering a Covered Person is not an allowable expense. In addition, any expense that a Provider, by law or in accordance with a contractual agreement, is prohibited from charging a Covered Person is not an allowable expense.

The difference between the cost of a semi-private Hospital room and a private Hospital room is not an allowable expense unless, one of the plans provides coverage for private Hospital room expenses.

If you are covered by two or more plans that compute their benefit payments on the basis of Maximum Plan Allowable or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

Allowable expense regarding Medicare: When this Plan pays secondary to Medicare, the Medicare approved amount will be the allowable expense for this Plan, as long as the Provider accepts Medicare. When the Provider does not accept Medicare, the Medicare limiting charge (the most that the Provider can charge you for the Service when they do not accept Medicare), will be the allowable expense. The Medicare payment combined with the payment from this Plan will not exceed 100% of the total allowable expense.

If you are covered by two or more plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

If you are covered by one plan that calculates its benefits or Services on the basis of Maximum Plan Allowable or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or Services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or Service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

The amount of any benefit reduction by the primary plan because the Covered Person has failed to comply with the provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, pre-certification of admissions, and In-Network Provider arrangements.

Closed panel plan: A closed panel plan is a plan that provides health care benefits to Covered Persons, primarily in the form of Service through a panel of Providers that has contracted with or is employed by the plan, and that excludes coverage for Services provided by other Providers, except in case of emergency or referral by a panel member. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a Covered Person uses a non-panel Provider, except for Emergency Services or authorized referrals that are paid or provided by the primary plan.

Custodial parent: A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the dependent child resides more than one-half of the Calendar Year excluding any temporary visitation.

3. Order of benefit determination rules

When a Covered Person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage, and without regard to the benefits of any other plan.

B. Except as provided in paragraph (1) below, a plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both plans state that the complying plan is primary.

    1. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide Out-of-Network benefits.

C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

D. Each plan determines its order of benefits using the first of the following rules that apply. Rules are applied in a sequential order:

    1. **Non-dependent or dependent:** The plan that covers a member other than as a dependent, for example as an employee, subscriber or retiree, is the primary plan; and the plan that covers the member as a dependent is the secondary plan. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the member as an employee, subscriber or retiree is the secondary plan and the other plan is the primary plan.

    2. **Dependent child covered under more than one plan:** Unless there is a court decree stating otherwise, when a member is a dependent child and is covered by more than one plan, the order of benefits is determined as follows:

        a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

            i. The plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or

            ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule applies to plan years commencing after the plan is given notice of the court decree.
    ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits.
    iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or
    iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:
        - The plan covering the custodial parent, first.
        - The plan covering the spouse of the custodial parent, second.
        - The plan covering the non-custodial parent, third.
        - The plan covering the dependent spouse of the non-custodial parent, last.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the dependent child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the dependent child.

Active employee or retired or laid-off employee: The plan that covers a member as an active employee, that is, an employee who is neither laid-off nor retired, is the primary plan. The plan covering that same member as a retired or laid-off employee is the secondary plan. The same would hold true if a Covered Person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

COBRA or state continuation coverage: If a member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, subscriber, or retiree, or covering the member as a dependent of an employee, subscriber, or retiree is the primary plan, and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

Longer or shorter length of coverage: The plan that covered the member as an employee, subscriber, or retiree longer is the primary plan and the plan that covered the member the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, the Plan will not pay more than Samaritan Choice Plans would have paid had Samaritan Choice Plans been the primary plan.

4. Effect on the benefits of this Plan

When the Plan is secondary, Samaritan Choice Plans may reduce our benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any Claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the Claim do not exceed the total allowable expense for that Claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a Covered Person is enrolled in two or more closed panel plans and if, for any reason, including the provision of services by a non-panel Provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

5. Right to receive and release needed information

Certain facts about health care coverage and Services are needed to apply this COB section and to determine benefits payable under "The Plan" and other plans. Samaritan Choice Plans may get the facts we need from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under the Plan and other plans covering a member claiming benefits. Samaritan Choice Plans need not tell or get the consent of any person to do this. Each Covered Person claiming benefits under this Plan must give Samaritan Choice Plans any facts we need to apply this section and determine benefits payable.

6. Facility of payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Samaritan Choice Plans may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under the Plan. Samaritan Choice Plans will not have to pay that amount again. The term "payment made" includes providing benefits in the form of Services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of Services.

7. Right of recovery

If the amount of the payments made by Samaritan Choice Plans is more than we should have paid under this COB section, Samaritan Choice Plans may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or Services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of Services.

This language replaces the applicable language in the Member Grievance and Appeal process section on pages 38-42 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook and on pages 18-22 in your Samaritan Choice Plans' 2020 Vision Benefits Member Handbook.

Member Grievance and Appeal process

Authorized Representative

You or someone you name to act on your behalf (Authorized Representative) may file a written Grievance and/or Appeal with Samaritan Choice Plans (SCP). An expedited Appeal may be filed verbally or in writing.

Your Authorized Representative can be a relative, friend, advocate, attorney, doctor, or someone else who is already authorized under state law.

Please note: In order for SCP to process a request received from your Authorized Representative, we must have proof of such designation. Proof can include a signed representative form, other appropriate legal papers supporting an Authorized Representative's status, or Durable Power of Attorney document.

SCP has an Authorized Representative form that you can request by calling Customer Service. Please refer to the **Member Resources section** to contact Customer Service.

Filing a Grievance

Grievance means a written complaint regarding:

- Availability, delivery or quality of health care Services, including a complaint regarding an adverse determination based on the decision of the Plan through a Prior Authorization.
- Claims payment, handling or reimbursement for health care Services.
- Matters pertaining to the contractual relationship between the member and the Plan.

You or your Authorized Representative may file a written Grievance. Send the written Grievance to us at the following address:

Samaritan Choice Plans Grievance Team
PO Box 1310
Corvallis, OR 97339
Fax: 541-768-9765
Email: SHPOgrvcteam@samhealth.org

You have the **option** to file a Grievance (complaint) through Samaritan Choice Plans' Grievance Team or you may choose to move straight to the Appeal process without submitting a Grievance.

Upon receiving a Grievance, we will send you or your Authorized Representative an acknowledgement letter. If the Grievance cannot be resolved within five business days of receipt, we will notify you in writing that additional time is required. You or your Authorized Representative will then receive a written decision within 30 days from your initial call or letter.

If you remain dissatisfied with the outcome of your Grievance, you or your Authorized Representative may file a written Appeal within 180 days of the denial or other action giving rise to the Grievance.

Filing an internal Appeal

If you remain dissatisfied after the initial adverse benefit decision or Grievance decision, you or your Authorized Representative have the right to file an Appeal. The Appeal request must be: 1) In writing. 2) Signed. 3) Include the Appeal reason. 4) Received by us within 180 days of the denial or other action giving rise to the Grievance. You may submit your Appeal in writing with a brief explanation as to why you would like to Appeal. You or your Authorized Representative have the right to appear in-person to talk about your Appeal.

Within five business days of receiving the Appeal, we will send you or your Authorized Representative an acknowledgement letter.

The Internal Appeal decision will be determined by an appropriate health care professional not previously involved in your case.

During the internal review, we may require an extension for processing your preservice Appeal. If so, a letter will be sent to you explaining the circumstances requiring the extension and a description of any additional information needed from you or your Providers. In no event will this extension exceed the timeframes explained in the **Appeal Timelines section**. If you do not agree with our decision to extend the timeframe to process your Appeal, you may file a Grievance.

You or your Authorized Representative will receive a written decision within 30 days (preservice, plus extension if needed) or 60 days (post-service) of our receiving your Appeal request.

Please note: If you, your Authorized Representative, or your treating Provider believes that the request to Appeal is urgent; meaning, a review decision made within the standard timeframe of 30 days could seriously jeopardize your life or health, or your ability to regain maximum function, your Appeal will be processed in an expedited manner (three days after receipt of the request). Only preservice requests qualify for expedited processing.

Urgent is determined when the member's life or health would be in serious jeopardy, or the member's ability to regain maximum function would be impaired, or the member would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Appeal.

You, your Authorized Representative or your treating Provider may request a simultaneous expedited external review.

For more information, please refer to the **Expedited Appeals section**.

External review

If you are still dissatisfied with our final adverse determination, your Appeal may qualify for an external review (at no cost to you) if:

- The Plan does not adhere to the rules and guidelines of the process defined for the internal review; or
- The internal review has been completed; and, the reason for the adverse decision was:
  - based on medical necessity; or
  - for treatment determined to be Experimental or investigational; or
  - for the purpose of continuity of care; or
- You and the Plan have mutually agreed to waive the internal Appeal requirement.

Your request for an external review must be received in writing to us within 120 days of our final adverse determination. Within five business days of receiving your request for external review, we will send you or your Authorized Representative a confirmation letter that your request is eligible for external review. (If your request is not eligible for external review, the Plan will notify you or your Authorized Representative in writing and include the reasons for the ineligibility.)

To apply for an external review, you must send your written request or the Appeal Request form to us at the following address:

Samaritan Choice Plans Appeals Team
PO Box 1310
Corvallis, OR 97339
Fax: 541-768-9765
Email: SHPOappealsteam@samhealth.org

External review decisions are made by randomly assigned Independent Review Organizations (IRO) who are not associated with Samaritan Health Services.

Please note: When you request an external review, the Plan will send you or your Authorized Representative a waiver that allows the IRO access to your medical records pertaining to the internal Appeal adverse decision. It is important for you to know that the Plan can only continue to process your request if the signed waiver is returned.

The Plan, upon receiving notification of the assigned IRO, will forward your request within five business days. You will receive a letter from the IRO informing you that your request for external review has been received. You will have 10 business days to submit additional information directly to the IRO.

The IRO will return a written decision to you or your Authorized Representative and to the Plan within the following timeframes:

- **Expedited** external review: **Three days** after receipt of the request.
- **Standard** external review: **45 days** after receipt of the request.

IRO decisions are final and we are bound by their decisions. If you want more information regarding external review, please refer to the **Member Resources section** to contact Customer Service.

Expedited Appeals

Urgent is determined when the member's life or health would be in serious jeopardy, or the member's ability to regain maximum function would be impaired, or the member would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Appeal.

If you believe your Appeal is urgent, you, your Authorized Representative, or your treating Provider may request an expedited Appeal. If the Appeal request meets the definition of urgent; meaning, a decision made within the standard timeframe of 30 days could seriously jeopardize your life or health, or your ability to regain maximum function, the Appeal will be processed in an expedited manner (within three days after receipt of the request).

For urgent Appeals, your treating Provider may act as your Authorized Representative without a signed Authorized Representative form.

If the Appeal does not meet the definition of urgent, you will be notified immediately, and the Appeal will then be processed within the standard timeframe.

When applicable, you may **simultaneously** request an expedited external review, in addition to an expedited internal review.

An expedited external review may be filed verbally or in writing within 120 days of our initial or final adverse determination.

An expedited internal review may be filed verbally or in writing within 180 days after you receive notice of the initial adverse determination.

The expedited Appeal request must:

- Be based on a preservice adverse determination.
- State the reason for the Appeal request.
- State the reason an expedited decision is needed.
- Include supporting documentation necessary for the Plan to make a decision.

The internal expedited review decision will be determined by an appropriate health care professional not previously involved in your case. A verbal notice of the decision will be provided to you, your Authorized Representative, and your treating Provider as soon as possible, but no later than three days after receipt of the request. A written notice will be mailed within one working day following the verbal notification.

For an expedited external review, the randomly assigned IRO will have three days to make their decision from the time they receive the Appeal information from the Plan.

To apply for an internal or external expedited review, send your written request along with a completed Authorization to Release Health Plan Records for External Review form to:

Samaritan Choice Plans Appeals Team
PO Box 1310
Corvallis, OR 97339
Fax: 541-768-9765
Email: SHPOappealsteam@samhealth.org

Call Customer Service:

541-768-4550; toll free 800-832-4580 (TTY 800-735-2900).

Appeal timelines

Samaritan Choice Plans (SCP) adheres to the following timeframes for making decisions for an internal Appeal:

- Three days for urgent.
- 30 days for preservice.
- 60 days for post-service.

SCP may take an extension of up to 14 days for preservice Appeals. You will be notified in writing if an extension is necessary.

Forms:

You may obtain the following forms for your Appeal by contacting Customer Service at: 541-768-4550; toll free 800-832-4580 (TTY 800-735-2900), or online at **choice.samhealthplans.org**:

- Authorized Representative.
- Appeal Request.

Your Appeal rights

You have the right to:

- File a Grievance about and Appeal any decision we make regarding availability, delivery, or quality of health care Services, including a complaint regarding an adverse determination based on the decision of the Plan through a Prior Authorization; Claims payment, handling, or reimbursement for health care Services or matters pertaining to the contractual relationship between the member and the Plan.
- Contact us when you:
  - Do not understand the reason for the denial.
  - Do not understand why the health care Service or treatment was not fully covered.
  - Do not understand why a request for coverage of a health care Service or treatment was not approved.
  - Cannot find the applicable provision in your Plan document.
  - Want a copy (free of charge) of the guideline, criteria, or clinical rationale that we used to make our decision.
- A full and fair internal review of your Appeal by individuals associated with us, but who were not involved in the adverse decision.
- Provide us with additional information that relates to your Appeal.
- Appear in-person to talk about your internal Appeal.
- An internal review decision within 30 days for preservice Appeals, 60 days for post-service Appeals, and three days for an expedited Appeal.
- File an external review (at no cost to you), if applicable.
- An external review decision within 45 days of the IRO receiving your standard request and three days for an expedited request.
- Send additional information, in writing, directly to the IRO.
- An expedited review if you, your Authorized Representative, or your treating Provider believes that waiting the standard 30-day timeframe would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed. (**Urgent** is determined when the member's life or health would be in serious jeopardy, or the member's ability to regain maximum function would be impaired, or the member would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Appeal.)
- A simultaneous expedited internal and external review, if applicable.

For more information about our Grievance and Appeals processes, contact Customer Service:

By phone:

541-768-4550; toll free 800-832-4580 (TTY 800-735-2900).

In writing:

Samaritan Choice Plans Appeals Team
PO Box 1310
Corvallis, OR 97339
Fax: 541-768-9765
Email: SHPOappealsteam@samhealth.org

You also have the right to file a complaint and seek further assistance if you are unsatisfied with how your Appeal or Grievance was handled by Samaritan Health Plans or if you remain unsatisfied with the outcome of your Appeal or Grievance:

U.S. Department of Labor
Seattle District Office
300 Fifth Avenue, Ste. 1110
Seattle, WA 98104
Phone: 206-757-6781
Fax: 206-757-6662

These definitions were added to the Definitions section on pages 53-54 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook and on page 30 in your Samaritan Choice Plans' 2020 Vision Benefits Member Handbook.

Family Deductible: For the Wellness Plan, the Family Deductible is the amount shown in the Schedule of Benefits that applies when three or more family members are enrolled in this Plan and is the maximum Deductible that enrolled family members must pay. For the HSA Eligible High-Deductible Plan, the Family Deductible is the amount shown in the Schedule of Benefits that applies when two or more family members are enrolled in this Plan and is the maximum Deductible that enrolled family members must pay. All amounts paid by family members toward their Individual Deductibles apply toward the Family Deductible. When the Family Deductible is met, no further Individual Deductibles will need to be met by any enrolled family members.

Note: No member will ever pay more than an Individual Deductible before the Plan begins paying for Covered Services for that member.

Individual Deductible: An Individual Deductible is the amount shown in the Schedule of Benefits that must be paid by the member before the Plan provides benefits for Covered Services for that member.

Maximum Plan Allowable (MPA): The amount that we use to calculate what we pay for Covered Services and Medical Supplies provided by an Out-of-Network Provider. MPA may be less than the amount billed for those Covered Services and Medical Supplies. MPA is calculated as the lesser of the amount billed by the Out-of-Network Provider or the amount determined in the order set forth below. MPA is not the amount that we pay for a Covered Service or supply; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in your Copayment and Coinsurance schedule.

- The MPA for Out-of-Network emergency care will be the greatest of: (1) The amount negotiated with In-Network Providers for the Emergency Service provided, excluding any In-Network Copayment or Coinsurance. (2) The amount calculated using the same method we generally use to determine payments for Out-of-Network Provider, excluding any In-Network Copayment or Coinsurance. (3) The amount paid under Medicare Part A or B, excluding any In-Network Copayment or Coinsurance.
- The MPA for covered outpatient pharmaceuticals (including but not limited to injectable medications) dispensed and administered to the patient by an Out-of-Network Provider, in an outpatient setting, including, but not limited to, physician office, outpatient Hospital facilities, and Services in the patient's home, will be the lesser of billed charges or the "Average Wholesale Price" for the drug or medication. "Average Wholesale Price" is the amount listed in a national pharmaceutical pricing publication and accepted as the standard price for that drug by Samaritan Health Plans.
- The MPA for Covered Services and Medical Supplies, excluding Emergency Medical Care and outpatient pharmaceuticals, received from an Out-of-Network Provider is a percentage of what Medicare would pay (known as the Medicare allowable amount). Medicare pays 100% of the Medicare allowable amount.
- The MPA for facility Services, including but not limited to Hospital, Skilled Nursing Facility, and outpatient surgery, is determined by applying 165% of the Medicare allowable amount.
- The MPA for Physician and all other types of Services and supplies is the lesser of the billed charge or 165% of the Medicare allowable amount.
- In the event that the billed charges for Covered Services and Medical Supplies received from an Out-of-Network Provider are more than the MPA, you are responsible for any amounts charged in excess of the MPA, in addition to applicable Deductibles, Copayments or Coinsurance.

This language replaces the applicable language in the Definitions section on page 55 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook and on page 31 in your Samaritan Choice Plans' 2020 Vision Benefits Member Handbook.

Out-of-Network Provider: A Provider who does not have a contract with your health insurer or Plan to provide Services to you. You'll pay more to see an Out-of-Network Provider. Also called "Non-Preferred Provider," "Nonparticipating Provider" or "Non-Contracted Provider." When Services are performed by or received from an Out-of-Network Provider, your expenses include a Calendar Year Deductible (if any), fixed dollar amounts for certain Services, and the amount by which billed charges exceed the Maximum Plan Allowable (MPA) for other Services. The definition of MPA is set forth in the "Definitions" section of this document. The MPA for Covered Services and supplies may not be the same as what an Out-of-Network Provider bills.

The following definition was removed from the Definitions section on page 56 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook and on pages 31-31 in your Samaritan Choice Plans' 2020 Vision Benefits Member Handbook.

Usual, Customary and Reasonable (UCR) Charges: The UCR is a method the Plan will utilize to determine the Allowed Amount for a Service, product, or Claim for an Out-of-Network Provider or facility for a Covered Service. The UCR is determined solely at the discretion of the Plan by taking into consideration the following factors: what the Plan could expect to pay if the Service or product was received from an In-Network Provider or facility, the fee(s) which the Out-of-Network Provider or facility most frequently charges the majority of patients for the Service or supply, the cost to the Out-of-Network Provider or facility for providing the Services, the prevailing range of fees charged in the same geographic area by Out-of-Network Providers or facilities of similar training and experience for the Service or supply, and the Medicare reimbursement rates. The term "same geographic area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Out-of-Network Providers or facilities, persons or organizations rendering such treatment, Services, or supplies for which a specific charge is made. To be "Usual, Customary and Reasonable," charge(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "usual" refers to the amount of a charge made for medical Services, care or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "customary" refers to the form and substance of a Service, supply or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age, and who receive such Services or supplies within the same geographic locale.

UCR charges may, at the Plan's discretion, alternatively be determined and established by the Plan using normative data including Medicare cost-to-charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

This language replaces the applicable language in the Plan Disclosures section on pages 43-50 in your Samaritan Choice Plans' 2020 Medical and Pharmacy Benefits Member Handbook and on pages 23-27 in your Samaritan Choice Plans' 2020 Vision Benefits Member Handbook.

Samaritan Choice Plans disclosures

The following are Federal laws and Plan notices that apply to your health benefits coverage and are found in appropriate sections of this document. You may access your Plan documents online at **choice.samhealthplans.org**.

Family and Medical Leave Act of 1993 (FMLA)

Employees are eligible for leave if they have at least 12-months of service and have worked at least 1,250 hours during the previous 12-month period. Eligible employees are entitled to request FMLA leave for up to a maximum of 12 workweeks within a 12-month period for the following reasons:

- To care for a child following a birth or placement of a child with the employee for adoption or foster care.
- To bond with a child (leave must be taken within one year of the child's birth or placement).
- To care for the spouse, child, or parent of the employee who has a serious health condition, or the employee is unable to perform the essential functions of his or her own job because of the employee's own serious health condition.
- For any qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status.
- An eligible employee may also take up to 26 workweeks of leave during a "single 12-month period" to care for a covered service member with a serious Injury or Illness when the employee is the spouse, son, daughter, parent or next of kin of the service member.

If both parents work for the Employer, they are entitled to a total of 12 weeks of leave for the birth of a newborn or the placement of an adopted or foster child, and they may decide how to divide the leave. An entitled family and medical leave (FMLA) is NOT considered a COBRA qualifying event unless coverage is reinstated at the end of the leave (please refer to the Continuation Coverage section).

If the employee chooses to continue coverage while on an approved FMLA leave, he or she may do so by paying any required contribution rates that would have been paid by payroll deduction if they had been working. All contributions are due the first of each month and if the employee fails to pay any required contribution, coverage will terminate on the last day of the month that contributions were paid.

If the employee returns to active employment after an entitled FMLA leave, group coverage will be reinstated. Waiting periods satisfied prior to an employee's approved leave would be reinstated when an employee returns to work. This is true even if coverage was terminated due to lapse of contribution payments on the employee's part. Benefits will be restored to the benefits equivalent to those the employee would have had if leave had not been taken and contribution payments had not been missed.

If the employee chooses not to participate while on a FMLA leave but subsequently returns to active working status on or before the expiration of the leave, the employee and all eligible dependents will immediately become covered under the Plan without being required to give evidence of insurability.

If the employee fails to return from leave (except because of your own or a relative's serious health condition, or another circumstance beyond your control), SHS has the right to recover contributions it paid during the leave. If the employee does not return from a FMLA leave, health coverage will cease, and a COBRA qualifying event will occur on the earlier of the:

- End of the leave period, or
- Day the Employer learns the employee does not plan to return.

Also, Oregon has a family leave law that has been revised to substantially parallel the federal FMLA law. However, there are a few provisions that differ between the Oregon Leave law and FMLA. Please contact the Human Resources office for details on the policies and procedures of these laws, and to obtain the required leave request forms.

Oregon Family Leave Act (OFLA)

An OFLA covered Employer (25 or more employees) that provides a group health plan must continue to offer an employee the same coverage under the same terms as if they had continued to work while on OFLA. If family member coverage is provided to the employee, family member coverage must be maintained during the period of family leave. The employee must continue to make any normal contributions to the cost of the Health Insurance Premiums. House Bill 2600 aligns OFLA with FMLA's continuation of group Health Insurance coverage. Please contact the Human Resources office for details on the policies and procedures of these laws, and to obtain the required leave request forms.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Coverage will terminate if you are called to active duty by any of the armed forces of the United States of America. However, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if you request to continue coverage and pay any required contributions toward the cost of the coverage during the leave. If the leave is less than 30 days, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If you do not elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day you return to active employment with the group if you are released under honorable conditions, but only if you return to active employment:

- On the first full business day following completion of your military service for a leave of 30 days or less.
- Within 14 days of completing your military service for a leave of 31 to 180 days; or
- Within 90 days of completing your military service for a leave of more than 180 days.

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an Illness or Injury, determined by the Veteran's Administration (VA) to be service connected, will be allowed.

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this Plan. There will be no additional Deductible owed for the year as if you had been continuously covered under this Plan from your original effective date. (This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your Employer.)

Leave of absence: If you are granted an approved non-FMLA or USERRA leave of absence, you can arrange to continue coverage for yourself and your family for up to three months. You must continue any Premium contribution payments you were making prior to the leave.

Strike or lockout

If you are covered by a collective bargaining agreement and are involved in a strike or lockout, coverage for you and your family may be able to be continued. You must pay the full cost of coverage directly to the union or organization that represents you.

Enforcement

The U.S. Department of Labor Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 866-4-USA-DOL or visit its website at **www.dol.gov/vets**. An interactive online USERRA advisor can be viewed at **www.dol.gov/elaws/userra.htm**.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation.
- You may also bypass the VETS process and bring a civil action against an Employer for violations of USERRA.

Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

MHPAEA, as amended by the Patient Protection and Affordable Care Act (ACA), generally requires that group health plans and Health Insurance issuers offering group or individual Health Insurance coverage ensure that the financial requirements and treatment limitations on mental health or Substance Use Disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans and group and individual Health Insurance issuers that provide coverage for mental health or Substance Use Disorder and benefits in addition to medical/surgical benefits.

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your Employer, your state may have a Premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these Premium assistance programs, but you may be able to buy individual coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Oregon, contact your State Medicaid or CHIP office to find out if Premium assistance is available. For more information, visit **healthcare.oregon.gov/pages/index.aspx** or call: 800-699-9075.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 877-KIDS NOW or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the Premiums for an Employer-sponsored plan.

If you or your dependents are eligible for Premium assistance under Medicaid or CHIP, as well as eligible under your Employer Plan, your Employer must allow you to enroll in your Employer Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for Premium assistance. If you have questions about enrolling in your Employer Plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 866-444-EBSA (3272).

Genetic Information Nondiscrimination Act of 2008 (GINA) (H.R. 493 (110th))

GINA expands the genetic information nondiscrimination protections included in Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under GINA, group health plans cannot base Premiums for a plan or a group of similarly situated individuals on genetic information. GINA generally prohibits plans from requesting or requiring an individual to undergo genetic tests and prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes.

GINA applies generally to group health plans. Unlike the provision under Title I of HIPAA, there is no exception for very small health plans with less than two Participants who are current employees.

Samaritan Choice Plans' coverage and benefit provisions will comply with the Genetic Information Nondiscrimination Act of 2008; therefore, Samaritan Choice Plans' members will not be discriminated against based on genetic information.

WHCRA full annual notice

The Women's Health and Cancer Rights Act of 1998 provides protections for individuals who elect breast reconstruction after a Mastectomy. Under WHCRA, group health plans offering Mastectomy coverage must provide coverage for certain Services relating to the Mastectomy, in a manner determined in consultation with the attending physician and patient.

The required coverage includes:

- All stages of reconstruction of the breast on which the Mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the Mastectomy, including lymphedema.

Under WHCRA, Mastectomy benefits may be subject to an annual Deductible and Coinsurance consistent with those established for other benefits under the Plan or coverage. Please refer to the **Schedule of Benefits** for details.

Keep this notice for your records and call your Plan Administrator, Samaritan Choice Plans, for more information.

The Newborn's and Mothers' Health Protection Act of 1996

Group health plans and Health Insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of opportunity to enroll in connection with extension of dependent coverage to age 26 (Section 2714, Patient Protection and Affordable Care Act of 2010 (PPACA))

Individuals whose coverage ended or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26, are eligible to enroll with Samaritan Choice Plans. Individuals may request enrollment for such children for 30 days from the date of notice. For more information, please refer to the **Member Resources section** to contact Customer Service.

Lifetime limit no longer applies and enrollment opportunity notice (PPACA, 2010)

The lifetime limit on the dollar value of benefits under Samaritan Choice Plans no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan are eligible to enroll in the Plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, please refer to the **Member Resources section** to contact Customer Service.

Patient protections notice (PPACA, 2010)

Samaritan Choice Plans generally allows the designation of a Primary Care Provider*. You have the right to designate any Primary Care Provider who participates in our Network and who is available to accept you or your family members. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, please refer to the **Member Resources section** to contact Customer Service.

For children, you may designate a pediatrician as the Primary Care Provider.

You do not need Prior Authorization from Samaritan Choice Plans or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our Network, who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain Services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please refer to the **Member Resources section** to contact Customer Service.

* Primary Care Provider is defined under Samaritan Choice Plans' provisions as a pediatric, family medicine, and internal medicine or OB-GYN Provider.

Statement of ERISA rights

As a Participant in Samaritan Choice Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive information about your Plan and benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. Copies must be furnished no later than 30 days after a written request. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue group health plan coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or Health Insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases -- if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage, if applicable.

Prudent actions by Plan fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce your rights

If your Claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance with your questions

This document provides only essential guidance as required by Federal Guidelines and may not include all rules and requirements. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Certificate of creditable coverage

A Covered Person who ceases to be covered under the Plan will be provided a certificate that evidences the Covered Person's creditable coverage and the period of that creditable coverage. The time as of which the certificate will be provided, and the contents of the certificate are explained below.

Rights to receive certificates

A certificate of creditable coverage will automatically be provided to a Covered Person upon the occurrence of certain events. In certain cases, a Covered Person, or someone on behalf of the Covered Person, may also request a certificate.

Automatic provision of certificate

A Covered Person whose coverage under the Plan is to end (or which would end but for the right to elect COBRA Continuation Coverage) will automatically be provided a creditable coverage certificate. In that event, the certificate will be provided at the time the Covered Person will lose coverage under the Plan or within a reasonable time after such date.

In the case of a Covered Person who has elected COBRA Continuation Coverage, a certificate of creditable coverage will be provided upon request.

A certificate automatically provided to a Covered Person will disclose the last period of the Covered Person's continuous coverage under the Plan.

Provision of certificate upon request

A Covered Person, or someone on behalf of a Covered Person, may request a certificate of creditable coverage at any time within 24 months of the date that coverage under the Plan ended. A request for a certificate can be made even if a certificate was previously provided, including upon a prior request.

A certificate, provided upon request, will disclose each period of continuous coverage that ceased during the 24-month period ending on the date of the request, or which was continuing on the date of the request. A separate certificate may be provided for each period of continuous coverage.

Specification of benefits

A group health plan or issuer may request, on behalf of a Covered Person who was previously provided a certificate of creditable coverage, for specific information regarding categories of benefits that had been provided under the Plan to the Covered Person. The Claims Administrator may charge the requesting plan or issuer for the reasonable cost of providing such benefit information. Subject to the payment of such costs, the Claims Administrator will promptly provide to the requesting entity all requested information that is reasonably available to the Claims Administrator.

Nondiscrimination notice

Discrimination is against the law

Samaritan Health Plans (SHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Samaritan Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Samaritan Health Plans:

- Provides free aids and Services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language Services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these Services, contact the SHP Compliance Officer.

If you believe that Samaritan Health Plans has failed to provide these Services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a Grievance with:

SHP Compliance Officer
PO Box 1310
Corvallis, OR 97339

Phone: 541-768-4550, toll free 800-832-4580 (TTY 800-735-2900)
Fax: 541-768-9791
Email: SHPOCompliance@samhealth.org

You can file a Grievance in-person or by mail, fax, or email. If you need help filing a Grievance, the SHP Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, DC 20201
800-368-1019; 800-537-7697 (TDD)

Complaint forms are available at **hhs.gov/ocr/office/file**.

Important notice from Samaritan Health Services about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current Prescription Drug Coverage with Samaritan Choice Plans and about your options under Medicare's Prescription Drug Coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug Coverage in your area. Information about where you can get help to make decisions about your Prescription Drug Coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's Prescription Drug Coverage:

1. **Medicare Prescription Drug Coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug Coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly Premium.**
2. **Samaritan Health Services has determined that the Prescription Drug Coverage offered by Samaritan Choice Plans is, on average for all Plan Participants, expected to pay out as much as standard Medicare Prescription Drug Coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher Premium (a penalty) if you later decide to join a Medicare drug plan.**

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare, and each year from Oct. 15 through Dec. 7.

However, if you lose your current creditable Prescription Drug Coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current Coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current Samaritan Choice Plans coverage may be affected.

Samaritan Choice Plans' Prescription Drug Coverage includes the following:

1. **Samaritan Choice Wellness Pharmacy Plan**

   Tier 1: Preventive with no charge, Deductible does not apply. Tier 2: Low-cost therapeutic with no charge, Deductible does not apply. Tier 3: Preferred with $7 Copay or 20% Coinsurance (whichever is greater), Deductible does not apply. Tier 4: High-cost preferred with $25 Copay or 25% Coinsurance (whichever is greater), Deductible does not apply. Tier 5: Non-preferred with 50% Coinsurance, Deductible does not apply. Tier 6: High-cost specialty with 15% Coinsurance, Deductible does not apply.

2. **Samaritan Choice HSA Eligible High-Deductible Pharmacy Plan**

   Tier 1: Preventive with no charge, Deductible does not apply. Tier 2: Low-cost therapeutic with no charge, Deductible applies. Tier 3: Preferred with $7 Copay or 20% Coinsurance (whichever is greater), Deductible applies. Tier 4: High-cost preferred with $25 Copay or 25% Coinsurance (whichever is greater), Deductible applies. Tier 5: Non-preferred with 50% Coinsurance, Deductible applies. Tier 6: High-cost specialty with 15% Coinsurance, Deductible applies.

In addition to Prescription Drugs, your current coverage pays for other health expenses. You will still be eligible to receive all of your current health and Prescription Drug benefits if you choose to enroll in a Medicare Prescription Drug plan.

If you do decide to join a Medicare drug plan and drop your current Samaritan Choice Plans coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher Premium (Penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Samaritan Choice Plans and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher Premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable Prescription Drug Coverage, your monthly Premium may go up by at least 1% of the Medicare base beneficiary Premium per month, for every month that you did not have coverage. For example, if you go 19 months without creditable coverage, your Premium may consistently be at least 19% higher than the Medicare base beneficiary Premium. You may have to pay this higher Premium (a penalty), as long as you have Medicare Prescription Drug Coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current Prescription Drug Coverage

Please call Samaritan Choice Plans at 541-768-4550, toll free 800-832-4580 (TTY 800-735-2900). **NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Samaritan Choice Plans changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer Prescription Drug Coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription Drug Coverage:

- Visit **Medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY 877-486-2048.

If you have limited income and resources, extra help paying for Medicare Prescription Drug Coverage is available. For information about this extra help, visit Social Security on the web at **socialsecurity.gov**, or call 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher Premium (a penalty).

Plan administration

Other authorities and responsibilities

Samaritan Health Services has the discretionary authority to interpret the Plan, in order to make eligibility and benefit determinations, as it may determine in its sole discretion. Samaritan Health Services also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Samaritan Health Services, as the Plan Administrator, may give other decision-makers the authority to interpret the Plan, to resolve and interpret any ambiguities that exist, and to make factual determinations on behalf of Samaritan Choice Plans.

The Plan is administered by Samaritan Health Plans, a division of Samaritan Health Services, the Plan Administrator, and the named fiduciary for all purposes except deciding benefit Claims. The Human Resources Vice President of Samaritan Health Services is the person who acts on behalf of the Plan Administrator. Samaritan Health Services has agreed to indemnify the Human Resources Vice President for any liability that he or she Incurs as a result of acting on behalf of the Plan Administrator, unless such liability is due to his or her gross negligence or misconduct. Samaritan Health Services and Samaritan Health Plans share a responsibility for administering the Plan as discussed in this document.

Compliance with state and federal mandates

To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in this document, including the Employee Retirement Income Security Act of 1974 (ERISA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), and the Women's Health and Cancer Rights Act of 1998 (WHCRA).

These laws have been amended from time to time. In the event of any conflict between these provisions and the current provisions of the law, the current provisions of the law shall govern.

Wellness program disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us and we will work with you, (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits Employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.