Samaritan Health Plans

Samaritan Health Plans

Group Certificate of Medical, Surgical, Pharmacy and Hospital Insurance

Samaritan Health Plans, Inc.
2300 NW Walnut Blvd
Corvallis, Oregon

Bruce Butler
Chief Executive Officer

DRAFTER'S NOTE: Employer name and Effective date of coverage will populate based on group name and effective date. Plan name will populate based on group's selection. Group's Group Number will be populated based on number assigned in SHP system. Month and Year will populate with effective Month and Year of Group. Policyholder Name will be populated based on information from the group application. 'Coverage for' will populate based on **who the group chooses to offer coverage.**

[Plan Administrator: Name of Plan Administrator]

[Plan Sponsor: Name of Plan Sponsor]

[Participating] Employer name: [Name of Employer]

Effective date of coverage: [Effective date]

Plan name: [Samaritan Everyday Choices Option 1, Samaritan Everyday Choices Option 2, Samaritan Everyday Choices Option Basic, Samaritan Everyday Choices HDHP [Deductible amount]][Samaritan Momentum [Deductible] [Coinsurance]]

Group Number: [Group Number]

Coverage for: [Employee only. Any reference to Dependents is not applicable.] [Employee and children only. Any reference to Spouse/domestic partner is not applicable.] [Employee, Spouse/domestic partner, and children.]

THIS AGREEMENT made and entered into this 1st day of [Month & Year] and between Samaritan Health Plans, Inc., an Oregon not-for-profit corporation, and [Policyholder Name] (herein called "Policyholder").

In this Group Certificate, Samaritan Health Plans is referred to as "we", "us" or "our". Members enrolled in this Plan are referred to as "you" or "your".

In consideration of the Policyholder's payment of monthly premium in the amounts and at the time required, Samaritan Health Plans will insure each enrolled person in accordance with the provisions and subject to the conditions of this Group Policy.

This document and any endorsements, riders, amendments, applications or attached papers, if any, describes the benefit coverage for Medical, Surgical, Pharmacy, and Hospital benefits for eligible Participants issued by Samaritan Health Plans to the Policyholder. Samaritan Health Plans guarantees coverage based on Eligibility and provisions of this document, not based on health status, race, creed, disability, or sexual orientation.

The Group Policy becomes effective at 12:01 a.m. on the date written above and continues in effect for a period of 12 months, provided premiums are paid when due and in the required amounts. The Group Policy is automatically renewed from month to month thereafter unless modified or terminated.

Every effort has been made to make these explanations as accurate as possible in accordance with the Life and Health Insurance Policy Language Simplification Act, the Affordable Care Act (ACA) and any applicable Oregon Revised Statutes.

For more information, contact Samaritan Health Plans at:

Samaritan Health Plans
2300 NW Walnut Blvd.
Corvallis, OR 97330

Customer Service Department
Monday through Friday, 8 a.m. to 8 p.m.
541-768-4550 / 800-832-4580
TTY 800-735-2900
samhealthplans.org

To Our Members

Dear Samaritan Health Plans Member:

Welcome to Samaritan Health Plans. We are proud to serve our neighbors of Oregon and contribute to the health and well-being of our communities!

Please read this document and your Schedule of Benefits carefully. It provides you with the details regarding your benefits and any limitations.

You also have 24/7 access to this document and all member forms online at samhealthplans.org.

For questions about your benefits, our Customer Service Department is available to assist you, **Monday through Friday:**

- **By Phone**
  8 a.m. to 8 p.m., at 541-768-4550 or toll-free at 800-832-4580 (TTY 800-735-2900)
- **By Email**
  8 a.m. to 5 p.m., at HealthPlanResponse@samhealth.org
- **In Person**
  8 a.m. to 5 p.m., at 2300 NW Walnut Boulevard, Corvallis Oregon 97330

We will mail you an ID card, separate from this document. If you need health care Services before you receive your ID card, please contact our Customer Service Department for assistance.

We look forward to serving you!

Sincerely,

Samaritan Health Plans

Discrimination is Against the Law

Samaritan Health Plans 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 Denise Severson at 541-768-4550, TTY: 800-735-2900.

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:

Denise Severson, Compliance Manager/Officer
P.O. Box 1310 Corvallis OR 97339
541-768-4550, TTY: 800-735-2900, Fax: 541-768-9791
dseverson@samhealth.org

You can file a Grievance in person or by mail, fax, or email. If you need help filing a Grievance, Denise Severson, the Compliance Manager/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 https://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 http://www.hhs.gov/ocr/office/file/index.html.

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Resource Guide

The Samaritan Health Plans home office in Corvallis is maintained to meet your servicing needs.

Come see us:

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

Contact us:

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

- **By Phone**
  8 a.m. to 8 p.m., at 541-768-4550 or toll-free at 800-832-4580 (TTY 800-735-2900)
- **By Email**
  8 a.m. to 5 p.m., at HealthPlanResponse@samhealth.org

Member Portal:

myhealthplan.samhealth.org/portal/Login.aspx

Website:

samhealthplans.org

Drug Formulary:

samhealthplan.org/groupbenefits

Provider Directory:

samhealthplans.org/groupfindcare

Becoming a Samaritan Member

When you become a Member of Samaritan Health Plans, you will receive new Member materials from your Employer. The materials include important information about your benefits and coverage, including your appeal rights. You can, at any time, request these materials from your Employer. When requested, you will receive the documents within 30 days of your request.

Please Keep These Materials for Future Reference:

- Welcome Letter
- Schedule of Benefits
- Glossary of Health Coverage and Medical Terms
- Group Certificate (this document)
- Group Certificates for additional Plans or Coverage Riders (if purchased)
- Prior Authorization List
- Summary of Benefits & Coverage

Your Health Plan ID Card

The subscriber will receive an ID card(s) once you have been enrolled. This card must be presented when Services are received. The card provides information that is needed for the provider to bill for Services. If an ID card is misplaced or personal information changes, or you need to add new Members, please contact our Customer Service Department. Refer to the Resource Guide on page 1 for contact information.

Provider Directory

You can find information about In-Network providers:

- On the Samaritan Health Plans' website at samhealthplans.org/groupfindcare.
- By contacting our Customer Service Department. You can also request a copy of the provider directory, which we will provide at no cost to you.

Interpreter Services

If you need an interpreter at your medical appointment, please contact our Customer Service Department to make those arrangements. To make sure that an interpreter will be at your appointment, please have this information ready when you call:

- The name of the person or persons the appointment is for
- The Member's ID number
- A home phone number
- The date and the time of the appointment

- The name of the health care provider
- The full address of the provider's office
- The phone number of the provider's office
- The reason for the appointment

Please refer to the Resource Guide on page 1 to contact Customer Service with all of the necessary information at least 72 hours before your appointment.

Member Portal

Your Member portal at myhealthplan.samhealth.org/portal/Login.aspx provides you with secure, 24/7 access to:

- Claims processed by your health plan; and
- Details about your Eligibility with the Plan, including the amount you have met toward your Deductibles and your coverage limits.

For questions about your Member portal and technical support if needed, please refer to the Resource Guide on page 1.

Federal and State Continuation Coverage

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

Under federal and state laws, you [and your Dependents] may have the right to continue this Plan's coverage for a specified time.

The following sections describe your rights to continuation under federal and state laws, and the requirements you must meet to enroll in continuation coverage.

Federal COBRA Continuation

If your Employer has 20 or more employees, you [and/or eligible Dependents] may be eligible to continue your health care coverage under the Plan on a self-pay basis under certain qualifying events. This continuation coverage is made available pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. The following describes your rights to continuation under COBRA, and the requirements you must meet to enroll in continuation coverage. If you have questions about your COBRA continuation coverage, you should contact your Employer.

DRAFTERS NOTE: Language will populate for groups who choose to extend independent COBRA rights to domestic partners.

[A domestic partner who was covered at the time of the qualifying event may elect COBRA continuation coverage. Domestic partners have the same COBRA rights as a Spouse. Where this section refers to divorce or legal separation, dissolution of domestic partnership applies.]

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

You [and your Dependents] may only continue the health coverage that was in effect when the qualifying event took place. The coverage will be the same as that provided under the Plan for active employees.

[A child who is born to or adopted by you while you are receiving continuation coverage is also entitled to continuation coverage. Written notice of a child born to or adopted by you while you are receiving continuation coverage must also be provided to the Employer within 60 days of that event.]

Individuals entitled to COBRA continuation coverage have the same rights afforded similarly-situated plan Members who are not enrolled in COBRA. [COBRA Participants may add newborns, a new Spouse, [a new Qualified Domestic Partner,] and adopted children (or

children placed for adoption) as covered Dependents in accordance with the Plan's Eligibility and enrollment rules, including the Plan's special enrollment rules.]

Qualifying Events

A "qualifying event" is an event that causes your regular coverage under the Plan to end and makes you eligible for continuation coverage. If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

DRAFTERS NOTE: Language will populate for employee/Dependent coverage.

[Your Spouse [or Qualified Domestic Partner] will become a qualified beneficiary if they lose coverage under the Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than for gross misconduct; or
- You become divorced or legally separated [, or dissolve your domestic partnership].

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Your covered eligible children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than for gross misconduct;
- You become divorced or legally separated from your Spouse [, or dissolve your domestic partnership]; or
- Your child is no longer eligible for coverage under the Plan.]

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Notification of Qualifying Event – Your Responsibility

In the event of your divorce or legal separation of the employee and Spouse, [termination of domestic partnership,] or an eligible child's losing Eligibility for coverage as an eligible child, you must notify your Employer within 60 days after the qualifying event occurs. Your notice must include the nature and date of the qualifying event, the name of the person losing coverage, and a mailing address for that person. The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Employer has been timely notified that a qualifying event has occurred.]

Length of COBRA Continuation Coverage

DRAFTERS NOTE: Language will populate for groups who choose to extend independent COBRA rights to domestic partners.

COBRA continuation coverage is a temporary continuation of coverage. When the following qualifying events happen, the law [and the Plan] allows coverage for the lengths of time below:

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, Spouse [or domestic partner], and children may continue for up to 18 months[1]
Employee's divorce or legal separation[, or termination of domestic partnership]	Spouse [or domestic partner] and children may continue for up to 36 months[2]
Employee's Eligibility for Medicare benefits if it causes a loss of coverage	Spouse [or domestic partner] and children may continue for up to 36 months[2]
Employee's death	Spouse [or domestic partner] and children may continue for up to 36 months[2]
Child no longer qualifies as a Dependent	Child may continue for up to 36 months[2]

[1] If the employee or covered Dependent is determined disabled by the Social Security Administration within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.

[2] The total maximum continuation period is 36 months, even if there is a second qualifying event. A second qualifying event might be a divorce, separation [, domestic partnership termination], death, or child no longer qualifying as a Dependent after the employee's termination or reduction in hours.

When the qualifying event is the death of the employee, divorce or legal separation, [dissolution of domestic partnership,] or an eligible child's losing Eligibility as an eligible child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which their employment terminates, COBRA continuation coverage for the employee's Spouse [or Qualified Domestic Partner] and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended, which are detailed below.

Disability Extension of 18-month Period of Continuation Coverage

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

If you [or anyone in your family covered under the Plan is][are] determined by the Social Security Administration (SSA) to be disabled and you notify the Employer in a timely fashion, you [and your entire family] may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

In order to be eligible for this extended continuation coverage period, the disabled individual (or someone on the individual's behalf) must notify the Employer of the SSA disability determination within 60 days of the issuance of the determination by the SSA (or, if later, within 60 days of the end of the month in which the employee terminates employment or transfers to part-time status) and before the end of the otherwise applicable 18-month continuation period, whichever period ends first. The notice must include a copy of the SSA determination. If the notice of the SSA determination is not provided to the Employer within this time period, then the 11-month extension of coverage will not be available.

If the SSA later makes a final determination that the individual is no longer disabled, the individual must notify the Employer within 30 days of the final determination by the SSA.

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage. Qualified Domestic Partner will populate when a group chooses to extend COBRA rights to Qualified Domestic Partners.

[Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse or Qualified Domestic Partner and eligible children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse or Qualified Domestic Partner and any eligible children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, [or has a domestic partnership termination,]or if the eligible child stops being eligible under the Plan as an eligible child, but only if the qualifying event would have caused the Spouse's Qualified Domestic Partner or eligible child to lose coverage under the Plan had the first qualifying event not occurred.

In all cases, you must make sure that the Employer is notified of the second qualifying event within 60 days of the second qualifying event. Your notice must include the nature and date of the second qualifying event, the name of the person losing coverage, and a mailing address for that person.]

Once Notification Is Given

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

When the Employer is notified that one of the above events has occurred, you will receive notice that you [or your covered Dependents] have the right to elect continuation coverage. Under this provision, the COBRA-eligible person must elect continuation coverage within 60 days from the date coverage would otherwise be lost because of one of the events described above or 60 days from the date of notification of your COBRA rights, whichever is later. Failure to elect continuation coverage within that period will cause coverage under the Plan to end as it normally would under the terms of the Plan.

Cost of COBRA Continuation Coverage

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

You [or your covered Dependents] are responsible for the full cost of continuation coverage and any administrative fee assessed. Payment for continuation coverage for any month is due on the first day of the month, or as of such later day established by your Employer. The only exception is the premium payment for continuation coverage during the period preceding the election, which must be made within 45 days of the date of election or a later date allowed by the Employer. Premium rates may change annually.

When COBRA Continuation Coverage Ends

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage. Qualified Domestic Partner will populate when a group chooses to extend COBRA rights to Qualified Domestic Partners.

COBRA continuation coverage will end for a person (i.e., you, your Spouse, Qualified Domestic Partner, or Dependents, as applicable) if one of the following events occurs:

- Failure to timely pay the full required continuation premium;
- The Employer no longer offers group health coverage;
- The person later becomes covered under any other group health plan. However, coverage under another plan will not cause continuation to end if the other plan excludes or limits coverage for a pre-existing condition of the person;
- The person later becomes entitled to Medicare benefits under Part A, Part B, or both;
- In the case of a person who qualified for an extra 11 months continuation coverage based on the disability and persons receiving continuation coverage by reference to such disabled person, the date of a final determination by the Social Security Administration that the person is no longer disabled;
- The applicable period of continuation ends; or
- Coverage is terminated for cause (e.g., a Member submits a fraudulent Claim).

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of an employee [or Dependents] not receiving continuation coverage. Once COBRA continuation coverage ends, it cannot be reinstated.

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

State Continuation

[Continuation for Spouses or Qualified Domestic Partners over Age 55

Subject to the general provision of the Plan, if you die, become divorced, or legally separated, or terminate your domestic partnership, and your covered Spouse or Qualified Domestic Partner is age 55 or over, your Spouse or Qualified Domestic Partnerand any other covered Dependents may continue medical coverage under the Plan on a self-pay basis until the earliest to occur of the following events:

- Failure to pay premiums when due;
- Termination of the Group Policy, unless another group health plan is made available by the Employer to its employees;
- Your legally separated, divorced or surviving Spouse or Qualified Domestic Partner becomes covered under another group health plan or becomes eligible for Medicare; or
- Covered Dependents no longer meet the Eligibility requirements of the Plan.

In order to be eligible for continued coverage, your Spouse or Qualified Domestic Partner, or Dependents must give written notice of the legal separation, termination of marriage or domestic partnership, or death of the employee to the Employer within:

- Thirty days of the date of the employee's death;
- Sixty days of the date of legal separation [or dissolution of domestic partnership]; or
- Sixty days of the date of entry of the divorce decree.]

USERRA Continuation

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

If you take a leave of absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA). You [and your enrolled Dependents] can continue this Plan's coverage if you, the employee, no longer qualify for coverage under the Plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your Eligibility for USERRA continuation

coverage will end. Premium for continuation coverage is your responsibility. The following requirements apply to USERRA continuation:

- [Family members who were not enrolled in the group Plan cannot take continuation. The only exceptions are newborn babies and newly acquired Dependents not covered by another group health plan;]
- To apply for continuation, you must submit a completed continuation election form to your Employer within 30 days after the last day of coverage under the group Plan;
- You must pay continuation premium to your Employer by the first of each month, or such later date as allowed by your Employer. Your Employer will include your continuation premium in the group's regular monthly payment. Samaritan Health Plans cannot accept the premium directly from you; and
- Your Employer must still be insured by Samaritan Health Plans. If this Plan is discontinued by your Employer or otherwise terminated, you will no longer qualify for continuation through Samaritan Health Plans.

Continuation After Injury or Illness Covered by Workers' Compensation

If you have an Injury or Illness covered by workers' compensation, you may continue your coverage under this Plan by self-paying the health plan premium until the earliest of the following dates:

- You take full-time employment with another Employer; or
- Six months from the date you first pay your health insurance premium under this provision.

Continuation under this provision will be concurrent with COBRA continuation for the period that you are also eligible for COBRA continuation.

Work Stoppage

If you are a union member, you have certain continuation rights in the event of a labor strike or lockout. Your Employer is responsible for collecting your premium and can answer questions about coverage during the strike.

Eligibility and Enrollment

Employees

Your Employer decides the minimum number of hours that employees must regularly work each week in order to be eligible for health insurance coverage under the Plan. Your Employer can also require new employees to satisfy a Waiting Period (not to exceed 90 days) before they are eligible for enrollment. All employees who meet these requirements are eligible to enroll in the Plan. Eligibility is not based on any health status-related factors.

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Family Members

If you are enrolled in the Plan, the following family members are also eligible for enrollment as your Dependent:

- [Your legal Spouse or Qualified Domestic Partner;]
- [Your children until they attain the age of 26, regardless of the child's place of residence, marital status, or financial dependence on you. For purposes of Eligibility for enrollment in the Plan, the term "child" means:
    - a biological child of you or your Spouse;
    - an adopted child of you or your Spouse;
    - a child placed with you while adoption proceedings are pending;
    - a child for whom you are required to provide insurance coverage under a Qualified Medical Child Support Order (QMCSO);
    - a child for whom you are the legal guardian; and
    - a child of a Qualified Domestic Partner.]
- [Your siblings, nieces, nephews, or grandchildren under the age of 26 who are unmarried, not in a domestic partnership, registered or otherwise, and for whom you are the court appointed legal custodian or guardian with the expectation that the child will live in your household for at least a year;]
- [Your, your Spouse's or your Qualified Domestic Partner's Dependent children age 26 or over who are mentally or physically disabled. To qualify as a Dependent, the child must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. We require documentation of the disability from the child's physician and will review the case before determining Eligibility for coverage.]

[To be eligible for coverage as a Dependent, a Dependent child of divorced parents does not have to qualify as a Dependent for Internal Revenue Service tax exemption purposes.]

[Family or household members other than those listed above are not eligible to be enrolled under your coverage. Dependent parents, foster children, and any other relatives who are not described above are not eligible for coverage under the Plan. Grandchildren are eligible to be enrolled only if they have been adopted or placed with you for adoption, or for whom you have legal guardianship.]

DRAFTERS NOTE: Default to exclude. Variables will be determined by Group or participating Employer.

[Retirees

A retiree is eligible to enroll and remain in the Plan only if he or she:

- Is not Medicare eligible, and;
- [Is a retired employee of the [Group] [participating Employer] who has retired from service, and;]
- [Is eligible to receive retirement benefits under the Public Employees Retirement System (PERS), and;]
- [Has worked for the [Group] [participating Employer] at least [1-20] continuous years immediately before retirement, and;]
- [Meets the retiree Eligibility rules as required by the [Group] [participating Employer] and approved by Samaritan Health Plans]

A retiree may enroll [or add Dependents] upon retirement by submitting a Member Enrollment/Termination/Change of Status/Waiver application within 30 days of retirement. Coverage will be effective the first day of the following month. At the time of retirement or any day thereafter, if a retiree declines or terminates coverage for the retiree [and/or Dependents], that decision is irrevocable. Retirees may opt-out [or remove Dependents] from the Plan at any time and for any reason, but the option for coverage cannot be reinstated.]

How and When to Enroll

When You First Become Eligible

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

The initial coverage eligibility date for you [and your enrolling family members] is in accordance with the Eligibility rules established by your Employer. Coverage will only begin if we receive your Member Enrollment/Termination/Change of Status/Waiver application with your Employer's premium payment for that month. In order to become enrolled as of that initial coverage eligibility date, you must enroll within the 30-day period following the initial coverage eligibility date, this is known as the initial enrollment period.

If you do not enroll within this initial enrollment period, you must wait until the next Open Enrollment Period to enroll, unless you incur a special enrollment event discussed below.

To enroll, you must complete and sign a Member Enrollment/Termination/Change of Status/Waiver application, which is available from your Employer. The application must include complete information on you [and your enrolling family members]. Return the application to your Employer, and your Employer will send it to Samaritan Health Plans.

Open Enrollment

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

The Open Enrollment Period is the only time, other than initial Eligibility or a special enrollment period, during which you [and/or your eligible Dependents] may enroll in the Plan. You must submit to your Employer a Member Enrollment/Termination/Change of Status/Waiver application [on behalf of all individuals you want enrolled]. If you do not enroll within this Open Enrollment Period, you must wait until the next Open Enrollment Period to enroll, unless you incur a special enrollment event discussed below.

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Mid-Year Special Enrollment – Newborns

A newborn baby of you, your Spouse, or your Qualified Domestic Partner is eligible for enrollment under the Plan during the 30-day period after birth. To add the child to your coverage, you must submit a Member Enrollment/Termination/Change of Status/Waiver application listing the child as your Dependent. A Claim for maternity care is not considered notification for the purpose of enrolling a newborn child. You may be required to submit a copy of the newborn's birth certificate to complete enrollment.

If an additional premium for coverage is required, then the baby's Eligibility for enrollment will end 30 days after birth if Samaritan Health Plans has not received a Member Enrollment/Termination/Change of Status/Waiver application and the correct premium. The premium is charged from the date of birth and prorated for the first month.

If no additional premium is required, then the baby's Eligibility continues as long as you are covered. However, Samaritan Health Plans cannot enroll the child and pay benefits until we receive a Member Enrollment/Termination/Change of Status/Waiver application listing the child as your Dependent.]

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Mid-Year Special Enrollment – Adopted Children

When a child is placed in your home for adoption, the child is eligible for enrollment during the 30-day initial enrollment period after placement for adoption. "Placement for adoption" means the assumption and retention by you, your Spouse, or your Qualified Domestic Partner

of a legal obligation for full or partial support and care of the child in anticipation of adoption of the child. To add the child to your coverage, you must complete and submit a Member Enrollment/Termination/Change of Status/Waiver application listing the child as your Dependent. You can be required to submit a copy of the certificate of adoption or other legal documentation from a court or a child placement agency to complete enrollment.

If an additional premium is required, then the child's Eligibility for enrollment will end 30 days after placement if Samaritan Health Plans has not received a Member Enrollment/Termination/Change of Status/Waiver application and the correct premium. The premium is charged from the date of placement and prorated for the first month.

If no additional premium is required, then the child's Eligibility continues as long as you are covered. However, Samaritan Health Plans cannot enroll the child and pay benefits until we receive a Member Enrollment/Termination/Change of Status/Waiver application listing the child as your Dependent.]

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Mid-Year Special Enrollment – Family Members Acquired by Marriage

If you marry, you can enroll yourself in the Plan (if you are not already enrolled) or you can add [your new Spouse and] any newly eligible Dependent children to your coverage. The enrollment must be made during the 30-day period from the date of the marriage. Samaritan Health Plans must receive your Member Enrollment/Termination/Change of Status/Waiver application and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the date of marriage. You may be required to submit a copy of your marriage certificate to complete enrollment.]

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Mid-Year Special Enrollment – Family Members Acquired by Domestic Partnership

If you are enrolled in the Plan, you may enroll a new Qualified Domestic Partner and any eligible Dependent children of the Qualified Domestic Partner. The enrollment must be made during the 30-day period from the date of the domestic partnership. Samaritan Health Plans must receive your Member Enrollment/Termination/Change of Status/Waiver application and additional premium during the initial enrollment period. Coverage for your new Qualified Domestic Partner and any eligible Dependent children of the Qualified Domestic Partner will then begin on the first day of the month after the beginning of the partnership. You may be required to submit information requested by the Employer evidencing the qualification of the domestic partnership to complete enrollment.]

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Mid-Year Special Enrollment – Family Members Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible sibling, niece, nephew, or grandchild, you can add that family member to your coverage. To be eligible for coverage, the family member must be:

- Not in a domestic partnership, qualified or otherwise
- Under the age of 26
- Expected to live in your household for at least a year, unless otherwise ordered by court

Samaritan Health Plans must receive your Member Enrollment/Termination/Change of Status/Waiver application and additional premium during the 30-day initial enrollment period beginning on the date of the court appointment. Coverage will then begin on the first day of the month following the date of the court order. You may be required to submit a copy of the court order to complete enrollment.]

DRAFTERS NOTE: The language will not be standard. The language will be inserted for those groups who require this language for their processes. Language around family members will populate for employee/dependent or employee/child coverage.

[Returning to Work After a Layoff

If you are laid off and then rehired by your Employer within nine months, you will not have to satisfy another Waiting Period.

Your health coverage will resume coinciding with the date of return to work from layoff and again meet your Employer's minimum hour requirement. If your Dependents were covered before your layoff, they can resume coverage at that time as well.

[You must re-enroll your Dependents by submitting a Member Enrollment/Termination/Change of Status/Waiver application to Samaritan Health Plans within the 30-day initial enrollment period following your return to work. Failure to submit the application within the 30-day initial enrollment period to Samaritan Health Plans will cause you to be considered a late enrollee and coverage will be deferred until the next open enrollment date.]

Returning to Work After a Leave of Absence (LOA)

If you return to work after an employer-approved leave of absence of nine months or less, you will not have to satisfy another probationary Waiting Period.

Your health coverage will resume coinciding with the date of return from LOA and again meet your Employer's minimum hour requirement. [If your family members were covered before your layoff, they can resume coverage at that time as well.]

[You must re-enroll your family members by submitting a Member Enrollment/Termination/Change of Status/Waiver application to Samaritan Health Plans within the 30-day initial enrollment period following your return to work. Failure to submit

the application within the 30-day initial enrollment period to Samaritan Health Plans will cause you to be considered a late enrollee and coverage will be deferred until the next open enrollment date.]]

Other Special Enrollment Events

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

Your Employer may have an agreement with Samaritan Health Plans allowing employees with other health coverage to waive enrollment in the Plan. In that case, the employee [and Dependents] can decline coverage during the initial enrollment period. If the employee is eligible to decline coverage and wishes to do so, the employee must submit a Member Enrollment/Termination/Change of Status/Waiver application to the Employer. The employee [and Dependents] can enroll in this Plan later if the employee qualifies under rules discussed below.

If the agreement between Samaritan Health Plans and the Employer requires Eligible Employees to participate in this Plan, the employee must enroll during the initial enrollment period. [However, the employee's Dependents can decline coverage, and they can enroll in the Plan later if they qualify under rules discussed below.]

If you waive coverage under the Plan for a year, you must wait until the next Open Enrollment Period to elect coverage under the Plan, unless you experience a special enrollment event, as outlined in this section.

Special Enrollment – Loss of Eligibility for Other Coverage

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

If the employee declined enrollment for themselves [or Dependents] because of other health insurance coverage, the employee [or Dependents] can enroll in the Plan later if the other coverage ends involuntarily. [Dependents may enroll, as long as the employee enrolls in coverage.] "Involuntarily" means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below an Employer's minimum requirement, the other insurance plan was discontinued, the other employer's premium contributions toward the other insurance plan ended, or because of death of a Spouse or domestic partner, divorce, or legal separation. To do so, the employee must request enrollment within 30 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverage ends, if the other coverage is through Medicaid or a state Children's Health Insurance Program (CHIP)). Coverage on this Plan will begin on the first day of the month after the other coverage ends.

Special Enrollment – Premium Assistance Subsidy

DRAFTERS NOTE: Language will populate based on 'Coverage for' selection.

If the employee [or the employee's Dependents] become[s] eligible for a premium assistance subsidy or Medicaid coverage under Medicaid or a state CHIP, the employee can enroll themselves [and/or Dependents] at that time. To do so, the employee must request enrollment within 60 days of the date the employee [and/or Dependents] become[s] eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Qualified Medical Child Support Orders (QMCSO)

Samaritan Health Plans will comply with the terms of any QMCSO. A QMCSO is a child support order, judgment or decree (including a court-ordered marital settlement agreement) requiring a group health plan to allow you to enroll the child for medical coverage. An order must meet certain legal requirements to be a QMCSO. Samaritan Health Plans has the sole authority to determine whether those legal requirements have been met. If these requirements have been met, the Plan must provide the coverage required by the order. However, you will be required to make the same contributions for the coverage of the child that is otherwise payable for the coverage of a Dependent. You will be notified if your Employer receives a QMCSO relating to you.]

Termination of Coverage

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

If you leave your job for any reason or your work hours are reduced below your Employer's minimum requirement, coverage for you [and your enrolled Dependents] will end. Coverage ends as of the end of the period in which you worked full time and for which a premium was paid. You can, however, be eligible to continue coverage for a limited time. Refer to Federal and State Continuation Coverage for more information.

[Subject to restrictions imposed by Internal Revenue Code Section 125 and your Employer, you can voluntarily discontinue coverage for your enrolled Dependents at any time by completing a Member Enrollment/Termination/Change of Status/Waiver application and submitting it to your Employer. Keep in mind that once coverage is discontinued, your Dependents may not be able to re-enroll in the Plan until the next enrollment period.]

[Divorced Spouses or Legal Separation

DRAFTERS NOTE: Language will populate for employee/Dependent coverage.

If you divorce, coverage for your Spouse will end on the last day of the month in which the divorce decree or legal separation is final. You must notify your Employer within 30 days of the divorce or legal separation. Continuation coverage may be available for your Spouse. Refer to Federal and State Continuation Coverage for more information.]

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Dissolution of Domestic Partnership

If you dissolve your qualified domestic partnership, coverage for your [domestic partner and their] children not related to you by birth or adoption will end on the last day of the month in which the dissolution of the domestic partnership is final. You must notify your Employer of the dissolution of the domestic partnership. Continuation coverage may be available for your domestic partner and their covered children. Refer to Federal and State Continuation Coverage for more information.]

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[Dependent Children

When your enrolled child no longer qualifies as a Dependent, coverage will end on the last day of the month in which the Dependent attains the age of 26 or otherwise ceases to qualify as an eligible Dependent. Refer to "Eligibility and Enrollment" for information on when your Dependent child is eligible beyond age 25. Refer to Federal and State Continuation Coverage where you can find more information on other coverage options for those who no longer qualify for coverage.]

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[If You Die

Coverage for you and your Dependents will end on the last day of the month in which your death occurs. However, your Dependents may extend their coverage on a self-pay basis. Refer to Federal and State Continuation Coverage for details on the extended coverage.]

Service Area and Provider Network

Please call Samaritan Health Plans for details on your provider network.

Samaritan Health Plans contracts directly with providers throughout the State of Oregon. In addition, Samarian Health Plans uses the First Choice Health Network to supplement its provider panel in Oregon. For contracted provider coverage in the remainder of the United States, Samaritan Health Plans uses First Choice Health Network and First Health Network.

DRAFTERS NOTE: The bracketed language will be inserted for groups who have purchased Alternative Care Rider.

[Samaritan Health Plans also contracts with Complimentary Healthcare Plans (The CHP Group) to utilize the network for chiropractic, licensed massage, and acupuncture Services.]

Not all providers in our Service Area are considered In-Network providers. Please refer to the Resource Guide on page 1 to verify the network status of your provider before getting Services.

Coverage Outside of the United States

Samaritan Health Plans covers all urgent and emergent Services received outside of the country at the In-Network provider benefit level. Any other Services besides urgent and emergent Services provided out of the country will not be covered.

Members may need to pay for Services out-of-pocket at the time of service. Please fill out and submit a Member Reimbursement Claim form. Provide all receipts and pertinent documentation of the covered health care expenditures to the Plan for evaluation and reimbursement. All member reimbursement requests must be submitted to Samaritan Health Plans within 365 days of the date Services were obtained.

When submitting a reimbursement request for a foreign Claim please include the following information:

- Charged amount by Service received
- Currency type submitted on bill and conversion rates for that particular time. If this is not provided, Samaritan Health Plans will convert currency as of the date of processing
- Date of service
- Diagnosis
- Member name
- Member ID number
- Procedure code
- Provider name
- Services rendered
- Total charge on bill
- Units received for each Service
- Where you received Services

PLEASE NOTE:

Not all providers or pharmacies in our Service Area are considered In-Network providers. Not all providers or pharmacies outside our Service Area are considered Out-of-Network Providers.
Please refer to the Resource Guide on page 1 to verify the network status of your provider or Pharmacy before obtaining Services.

Plan Benefits

This Plan provides benefits for the following Services and Supplies as outlined in your Schedule of Benefits. These Services and Supplies may require you to satisfy a Deductible, make a Copayment and/or Coinsurance, and can be subject to additional limitations or maximum dollar limits (maximum dollar limits do not apply to Essential Health Benefits). However, all Services and Supplies must be Medically Necessary to be covered under this Plan. For a medical expense to be eligible for coverage, the Member must be covered under this Plan on the date the expense is incurred.

Please be aware that just because a treatment is prescribed by a health care provider, it does not mean it is Medically Necessary or that it will be covered under this Plan. Samaritan Health Plans reserves the right to review or otherwise deny Services that are not found to be Medically Necessary. In addition, some Medically Necessary Services and Supplies may be excluded from coverage under this Plan.

Please refer to your Schedule of Benefits and the Benefit Exclusions section for more information.

Covered Benefits

**May require Prior Authorization*

Acupuncture – Covered with purchase of Alternative Care Rider. See the Alternative Care Rider for benefit information.

Allergy Injections – Covered Services are paid according to the plan and may be provided by your Primary Care Provider or a Specialist Provider in an office setting.

Alternative Care – Covered with purchase of Alternative Care Rider. See the Alternative Care Rider for benefit information.

Ambulance Air – Certified air transportation is covered to the nearest Hospital or facility capable of treatment, when ground transportation is not medically appropriate, and when Medically Necessary.

Ambulance Ground – Services of a state-certified ambulance are provided when Medically Necessary. The cost of ground transportation is covered to the nearest facility capable of providing the necessary care, or to a facility specified by us.

DRAFTERS NOTE: Covered for In-Network only. Benefit coverage and Cost Share will be determined by negotiation with each group. Benefit and Cost Share will be listed on Schedule of Benefits if offered by group.

[Bariatric Surgery* – Refer to your Schedule of Benefits for more information. May be covered only when the following criteria are met:

1. BMI greater than or equal to 40 kg/m2

   OR

   BMI greater than or equal to 35 kg/m2 with one of the following co-morbid conditions, which are expected to be improved with surgery:
   a. Hypertension
   b. Diabetes
   c. Hyperlipidemia
   d. Sleep apnea
   e. Coronary artery disease
   f. Documented weight loss of greater than 5% after entering bariatric program;

2. Psychological evaluation by psychologist or psychiatrist, approved by the Bariatric Surgery Program documenting absence of psychopathology that would interfere with understanding or compliance with surgical program. Examples: personality disorder, uncontrolled Substance Use Disorder, uncontrolled major mood or thought disorder

   OR

   Same evaluation demonstrates presence of psychological issues that are controlled and will not compromise surgical outcome. Note: medical insurance will pay for evaluation only. Mental Health treatment is covered under Mental Health benefit, whether or not it is related to obesity;

3. Documentation of previous compliance with medical care and willingness to comply with preoperative and postoperative treatment plans;

4. No medical condition that would make the surgery unusually risky;

5. Age 18 or older; and

6. Covered only at Good Samaritan Regional Medical Center through the Bariatric Surgery Program, and subject to its policies and surgical criteria.]

Bilateral Cochlear Implants* – Covered, including the cost of repair and replacement parts when medically appropriate for the treatment of hearing loss. The cost of the implant is reimbursed under the DME, Prosthetics, Orthotics, and Medical Supplies benefit.

Blood Transfusions – Covered Services, including the cost of blood or blood plasma and storage, are paid based on place of service, provider type, and provider billing. Refer to your Schedule of Benefits for Cost Share information.

Cardiac Rehabilitation* – For patients who have coronary artery disease, angina, congestive heart failure, have had cardiac surgery, angioplasty or stent, heart transplant or heart attack and who meet the following criteria:

1. Have a heart condition where exercise is standard treatment

2. Need medical monitoring and supervision during exercise for safety
3. The exercise program is ordered by a physician, physician assistant (PA) or a nurse practitioner (NP)

The benefit is as follows:

- Phase I (inpatient) Covered Services are paid according to the plan.
- Phase II (short-term outpatient) Covered Services are paid according to the plan.
- Phase III (long-term outpatient) Services are not covered.

Cardiac Rehabilitation is not covered for risk reduction in patients without heart disease, or patients who can exercise independently.

Chemotherapy* – Covered Services are paid based on the type of chemotherapy you receive and where Services are rendered. There may be cost sharing for drugs used. We provide coverage for oral anticancer medications on the basis no less favorable than intravenously or injected drugs that are covered as medical benefits. When Services are rendered at a Pharmacy, refer to the Prescription Drug Benefits section.

Chiropractic – Covered with purchase of Alternative Care Rider. See your Alternative Care Rider for benefit information.

Circumcision* – Covered Services are paid based on place of service, provider type, and provider billing. Refer to your Schedule of Benefits for Cost Share information.

Clinical Trial* – The Plan covers the costs of the care of Members who are qualified individuals, and who are enrolled in and participating in an approved clinical trial, and will not exclude, limit or impose additional conditions on the coverage of such routine costs. The Experimental portion of clinical trials are typically not covered. The coverage is subject to other provisions of the Plan, including Copayments, Deductibles and Coinsurance. However, Services that are normally covered under the Plan will be covered under the applicable benefit and in accordance to the provisions outlined by the Services billed by the provider and will follow all provisions of this Plan.

A "qualified individual" is an individual who is eligible to participate in an approved clinical trial and either the individual's doctor has concluded that the participation is appropriate or scientific information established that their participation is appropriate.

An "approved clinical trial" is defined below as a Phase I, II, III, or IV clinical trial for the prevention, detection, or treatment of cancer or other life-threatening condition or Disease. An "approved clinical trial" means a clinical trial that is:

- Funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;
- Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare

Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;
- Conducted as an Investigational new drug application, an Investigational device exemption or a biologics license application subject to approval by the United States Food and Drug Administration; and
- Exempt by federal law from the requirement to submit an Investigational new drug application to the United States Food and Drug Administration.

"Routine costs" means all Medically Necessary conventional care, items, or Services consistent with the coverage provided by the Plan if typically provided to a patient who is not enrolled in a clinical trial.

If an In-Network provider is participating in an approved clinical trial, the Plan can require the individual to participate in the trial through that In-Network provider if the provider will accept the individual as a Participant in the trial.

Cochlear Implants* – Covered, including the cost of repair and replacement parts when medically appropriate for the treatment of hearing loss. The cost of the implant is reimbursed under the DME, Prosthetics, Orthotics, and Medical Supplies benefit.

Colonoscopy (Non-Preventive) * – Covered Services are paid based on place of service, provider type, and provider billing. A non-preventive colonoscopy is done when you have a predetermined diagnosis or are presenting with an applicable health problem.

Craniofacial Anomalies* – The Plan covers dental and orthodontic Services for the treatment of Craniofacial Anomalies if the Services are Medically Necessary to restore function. Covered Services are paid based on place of service, provider type, and provider billing.

Dental Hospitalization* – Covered Services are paid based on place of service, provider type, and provider billing, and must be Medically Necessary. Refer to your Schedule of Benefits for Cost Share information.

Dental Services* – Covered Services provided by a dentist or physician, to treat an Injury of the jaw or natural teeth are paid under the Plan as a medical benefit.

Refer to your Schedule of Benefits for Cost Share information. Covered Services are paid based on place of service, provider type, and provider billing.

Only the following major dental procedures are eligible for reimbursement:

- Multiple extractions
- Removal of impacted teeth
- Tumors, benign & malignant
- Leukoplakia & premalignant lesions
- Trauma to jaw, acute damage to teeth, jaw fracture
- Lacerations in mouth
- Infection beyond tooth or gum
- Facial cellulitis
- Infection beyond tonsillar pillar
- Systemic disease manifestation in mouth – Lichen planus, Sjögren's syndrome, etc.
- When the patient has another serious medical condition that can complicate the dental procedure
- When the Service is found to be related to an Accident or reconstructive procedure

Developmental and Learning Disabilities – Covered Services are paid according to the plan for developmental and/or learning disabilities. We cover Services which are Medically Necessary, meet the provisions of the Plan, or are required by law. We also cover Services for Members who have been diagnosed with a Pervasive Developmental Disorder. Services are paid based on place of service, provider type, and provider billing. Refer to Benefit Exclusions for more information. (Limits do not apply for Mental Health and Substance Use Disorder Services.)

Diabetes Education – Covered Services of a Certified Diabetes Educator (CDE) for diabetes self-management education programs are covered. This means outpatient instruction for diabetics about the Disease and its control, taught by a CDE.

Diabetes Management for Pregnant Women – Covered Services, drugs, and Supplies that are Medically Necessary for a woman to manage her diabetes during each pregnancy, beginning with conception and ending six weeks postpartum, are covered. Covered Services are paid based on place of service, provider type, and provider billing.

Diabetic Supplies – Eligible Supplies defined as continuous glucose monitors, gauzes, syringes, needles, lancets, alcohol and alcohol swabs, and betadine swabs. Some items can be purchased at a Pharmacy. When diabetic supplies are purchased at a Pharmacy, refer to the Prescription Drug Benefits section.

Dialysis – Covered Services are paid based on place of service, provider type, and provider billing.

Durable Medical Equipment (DME), Prosthetics, Orthotics and Medical Supplies* – Purchase or rental of Durable Medical Equipment including crutches, wheelchairs, orthopedic braces, prosthetics, glucometers, and equipment for administering oxygen are covered. Durable Medical Equipment must be prescribed in writing by a licensed provider. Refer to the Benefit Exclusions section for additional information.

Artificial Limbs and Eyes – Items that are not power assisted are covered. Repairs to existing Prosthetics (even if acquired before the Member's coverage under the Plan) are also covered, up to the cost of replacement.

Bras – Following a Mastectomy, bras are eligible covered items without a limit to the number of bras allowed per year. Swimwear is not covered for any reason under the Plan.

Breast Prosthesis – Both internal and external breast prosthesis, as a result of a Mastectomy are covered, regardless where the original service took place. Removal or replacement of Breast Prosthesis is covered only when Medically Necessary. The Women's Health and Cancer Rights Act (WHCRA) requires the Plan to cover Services that support rehabilitation and reconstruction in the instance that a Member receives these Services due to cancer and related treatment. All stages of reconstruction are covered with a single determination of Prior Authorization.

Breast Pumps and Breast Pump Supplies – Refer to the Preventive Care Services section for more information.

Diabetic Equipment – Eligible equipment is covered. The following are considered diabetic equipment: diabetic pumps, glucose monitors, test strips, diabetic shoes and inserts, and diabetic shoe fitting. Diabetic Supplies are considered a separate benefit from diabetic equipment. Refer to the Diabetic Supplies benefit in this section for more information.

Maxillofacial Prosthetic Services – Services are only covered when the damage results from Disease, trauma, birth or developmental deformities. The treatment must be necessary to control or eliminate infection or pain. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Repairs to existing Prosthetics (even if acquired before the Member's coverage under the Plan) are also covered, up to the cost of replacement.

Medical Supplies – Eligible Supplies are covered when Medically Necessary and ordered by a provider for the treatment or diagnosis of an Illness, Injury, or Disease. Examples include chem strips, needles, ostomy Supplies, syringes, and medical foods. Refer to Medical Foods for more information.

Orthotics – Eligible devices are covered if Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. This can include custom made or fitted foot Orthotics. A licensed provider, within the scope of their license, must prescribe the device. Coverage is determined by Medicare standards of care.

Prosthetics – Eligible devices are covered if Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. Power-assisted Prosthetics are not covered. Repairs to existing Prosthetics (even if acquired before the Member's coverage under the Plan) are also covered, up to the cost of replacement. Coverage is determined by Medicare standards of care.

Vision Hardware – Eligible items after cataract surgery or due to medical needs are covered. Hardware needed after cataract surgery is a one-time per eye benefit.

Emergency Services – Services for emergency conditions are covered. See Definitions for information about emergencies. **Emergency Room Care for any reason does not require Prior Authorization.**

Eating Disorders – Covered as a Mental Health benefit. Covered Services are paid based on place of service, provider type, and provider billing.

Essential Health Benefits – The Plan covers the ten categories of benefits defined by the Secretary of U.S. Department of Health and Human Services as Essential Health Benefits. See Definitions. Please note that pediatric dental is not covered by the Plan.

Genetic Testing* – Covered Services are paid according to the plan. Standard prenatal testing does not require Prior Authorization.

Hearing Aids and/or Hearing Assistive Technology Systems* – Covered only in accordance with the requirements of state and federal law, and must be Medically Necessary and prescribed, fitted, and dispensed by a licensed audiologist or hearing aid Specialist. Services include those required and defined by ORS 743A.141. Examples of this may include:

- One hearing aid per hearing impaired ear
- Ear molds and replacement ear molds
- One box of replacement batteries per year for each hearing aid
- Necessary diagnostic and treatment services
- Bone conduction sound processors, if necessary for appropriate amplification of the hearing loss
- Hearing assistive technology systems, if necessary for appropriate amplification of the hearing loss

This will be reimbursed under the DME, Prosthetics, Orthotics, and Medical Supplies benefit. Contact our Customer Service Department for specific coverage requirements.

High-Tech Imaging* – Imaging Services such as MRI, CT scans, PET scans and/or SPECT scans are considered high-tech imaging. Refer to your Schedule of Benefits for Cost Share information.

Home Health – Covered Services are paid according to the plan. Refer to your Schedule of Benefits for Cost Share information. Services provided during your home health visit may apply to other benefits and have other Cost Shares. For example, physical therapy done in your home will be paid under the physical therapy benefit.

Hospice – Covered Services are paid according to the plan.

Infusion* – Covered Services are paid according to the plan and reimbursed under the outpatient Services benefit. You may have additional costs for the drugs used during your infusion Services. Refer to the Prescription Drug Benefits section for more information and your Schedule of Benefits for Cost Share information.

Injections* – Covered Services are paid according to the plan based on place of service, provider type, and provider billing. When an injectable drug is purchased at a Pharmacy, pharmacy cost sharing may apply. Refer to the Prescription Drug Benefits section.

Inpatient Hospital* – Covered Services are paid according to the plan. Only emergency admissions are covered without Prior Authorization. Samaritan Health Plans must be notified of an emergency admit within 48 hours, or as soon as reasonably possible. Professional Services (for example, doctors) may be billed separately from the facility charges. Covered Services are paid according to the plan based on place of service, provider type, and provider billing.

Charges for a semi-private Hospital room are covered. Charges for a private room are covered, if the attending physician orders Hospitalization in an intensive care unit, coronary care unit, or private room for septicemic-caused isolation. Covered inpatient Hospital Services can include (but are not limited to):

- Anesthesia and post-anesthesia recovery
- Blood and/or blood products
- Cardiac care unit
- Delivery, post-partum, newborn care
- Dressings, equipment, and other necessary Supplies
- Inpatient drugs
- Laboratory and radiology Services
- Operating room
- Respiratory care
- Semi-private room

Charges for rental of telephones, radios or televisions, or for guest meals or other personal items, are not covered. We cover Services by any approved Hospital that is owned and operated by the State of Oregon and any state approved community Mental Health and developmental disabilities program.

Inpatient Habilitative Services* – Covered Services are paid according to the plan to help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. Services must be consistent with the condition being treated and must be part of a prescribed formal written treatment program. These Services are covered for a maximum of 30 days per Calendar Year. (Limits do not apply for Mental Health and Substance Use Disorder Services.)

Inpatient Rehabilitative Services* – Covered Services are paid according to the plan to restore and improve lost body functions after Illness or Injury. Services must be consistent with the condition being treated and must be part of a prescribed formal written treatment program. These Services are covered for a maximum of 30 days per Calendar Year. (Limits do not apply for Mental Health and Substance Use Disorder Services.)

Laboratory Services* – Covered Services are paid according to the plan when provided by or prescribed by a provider. Services are paid based on place of service, provider type, and provider billing. Refer to your Schedule of Benefits for Cost Share information.

Mammogram (Non-Preventive) – Covered Services are paid according to the plan for diagnosis in symptomatic or high-risk women. Services are reimbursed under the Radiology benefit. Refer to your Schedule of Benefits for Cost Share information. (For routine preventive mammogram, refer to the Women's Preventive Care Services section.)

Massage Therapy Services – Covered with purchase of Alternative Care Rider. See your Alternative Care Rider for benefit information.

Maternity Care* – Covered Services of a physician or certified nurse midwife are covered. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for Illness. We cover care necessary to support a healthy pregnancy and labor and delivery. We cover Members whose mothers have taken medication containing diethylstilbestrol (DES) prior to the insured's birth.

Inpatient Hospitalization admissions for childbirth do not require a Prior Authorization in accordance with the Newborns' and Mothers' Health Protection Act. Services do not require Prior Authorization unless the Hospital stay exceeds 48 hours for a vaginal delivery, or 96 hours for a cesarean section.

Medical Foods* – Covered Services are paid according to the plan under the DME, Prosthetics, Orthotics, and Medical Supplies benefit. Services for a non-prescription elemental enteral formula for home use is covered if:

- The formula is Medically Necessary for the treatment of severe intestinal malabsorption;
- A provider has issued a written order for the formula; and
- The formula comprises the sole source, or an essential source, of nutrition.

If non-prescription elemental enteral formula is ordered by a provider, the provider must write a prescription for the item and the Member will need to submit a Medical Reimbursement Claim form.

Inborn Errors of Metabolism – Covered Services are paid according to the plan to treat inborn errors of metabolism involving amino acid, carbohydrate, and fat metabolism when medically standard methods of diagnosis, treatment, and monitoring exist.

Nutritional Supplies and medical assessment equipment necessary to diagnose, monitor and control disorders of inborn metabolic disorders are covered.

Medically Necessary PKU formulas (nonprescription elemental enteral formula) for home use when ordered by your provider are covered:

- If the formula is Medically Necessary for the treatment of severe intestinal mal-absorption, inborn errors of metabolism that involve amino acids, carbohydrates and fat metabolisms;
- A provider has issued a written order for the formula; and
- If the formula comprises the sole source, or an essential source, of nutrition.

Mental Health and Substance Use Disorder: Inpatient* – Services are considered inpatient when you are admitted to a facility. Refer to your Schedule of Benefits for Cost Share information. Professional Services (for example, doctors) may be billed separately from the facility charges. Covered Services are paid according to the plan based on place of service, provider type, and provider billing.

Mental Health and Substance Use Disorder: Outpatient – Covered Services are paid according to the plan based on place of service, provider type, and provider billing. Refer to your Schedule of Benefits for Cost Share information.

DRAFTERS NOTE: Default will be to include the language.

Mental Health and Substance Use Disorder Services* – The Plan covers Medically Necessary treatment of Mental Health conditions and Substance Use Disorders. Refer to the Benefit Exclusions section for more information on Services not covered by this Plan.

This Plan covers, but is not limited to, the following Services:

- Assessment and evaluation in order to diagnose or determine if a Mental Health condition or Substance Use Disorder exists;
- Treatment of Mental Health conditions or Substance Use Disorders which are subject to significant improvement through evidence-based therapeutics;
- Treatment [, other than for Substance Use Disorder,] provided in healthcare facilities, Residential programs or facilities, day or Partial Hospitalization programs, or Intensive Outpatient Services [Outpatient intensive Services and programs, including Partial Hospitalization, for Substance Use Disorder is covered In-Network only];
- Treatment provided at a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited wilderness therapy program that has been licensed by the State of Oregon as Residential treatment for Mental Health and addiction Services.

Samaritan Health Plans covers Services and treatment for those Mental Health and Substance Use Disorder diagnoses covered under the Mental Health and Addiction Equity Act of 2008. Samaritan Health Plans is compliant with state and federal Mental Health parity.

Multidisciplinary Programs* – Include, but are not limited to, pain management, and child development and rehabilitation center (CDRC) programs. Services usually consist of a team of providers coordinating and working for the benefit of one Member. These programs do not require an authorization; however, some Services done as a result of treatment can require Prior Authorization.

Specific Services that are a part of the Member's treatment plan can require authorization; for example, MRIs, Hospitalizations, or genetic testing, and any other Services on the Prior Authorization list. Refer to the Prior Authorization section for more information. Covered Services are paid according to the plan based on place of service, provider type, and provider billing.

Nursery Care* – Routine nursery care of eligible newborns, while the mother is hospitalized and eligible for maternity benefits under the Plan, are covered. Newborn stays less than 5 days do not require Prior Authorization.

Nutritional Therapy and/or Counseling – Covered Services of a registered and licensed dietician for the treatment of celiac sprue, hyperlipidemia, eating disorders, obesity, or otherwise stated as Medically Necessary by a provider are covered and paid based on place of service, provider type, and provider billing. Registered and licensed dieticians are considered Specialists.

Occupational Therapy* – Covered Services are paid according to the plan. Services must be prescribed by a Professional Provider. The written prescription must include site, modality, duration, and frequency of treatment. These Services can be provided in both inpatient and outpatient settings and are referred to as Rehabilitative and Habilitative Services. Refer to your Schedule of Benefits for Cost Share information.

Osteopathic Manipulation – Covered Services are paid according to the plan only for the treatment of disorders of the musculoskeletal system. Services are covered and paid based on place of Service, provider type (performing Services within the scope of their license), and provider billing. Any accumulators or limits will apply.

Outpatient Drugs* – Drugs that are administered on an outpatient basis in a Hospital, alternate facility, physician's office, or in the Member's home. Benefits under this section are provided only for outpatient drugs which, due to their characteristics (as determined by the Plan), must typically be administered or directly supervised by a qualified, licensed/certified health professional. Benefits under this section do not include drugs that are typically available by Prescription Order or refill at a Pharmacy. Covered Services are paid according to the plan based on place of service, provider type, and provider billing.

Outpatient Habilitative Services – Covered Services that assist with learning or improving new skills or functions. An example of Habilitative Services is Speech Therapy for a child who is not talking at the expected age.

Outpatient Rehabilitative Services – Covered Services are paid according to the plan for the purpose of restoring certain functional losses due to Illness or Injury.

Outpatient Services* – Covered Services for approved, Medically Necessary procedures, that can be performed safely on an outpatient basis are covered. Outpatient settings include Hospital outpatient departments, Ambulatory Surgical Centers and clinics. Outpatient Services may be subject to professional, and facility fees or Copays.

Pain Management* – Covered Services provided as part of a pain management treatment plan or done within a pain management clinic are covered. Covered Services are paid according to the plan based on place of service, provider type, and provider billing.

Physical Therapy* – Covered Services of a licensed physical therapist, are paid according to the plan. Services do not require a physician referral; Members can self-refer. We cover Medically Necessary therapy and Services for the treatment of traumatic brain injury. These Services can be

provided in both inpatient and outpatient settings and are referred to as Rehabilitative and Habilitative Services. Refer to your Schedule of Benefits for Cost Share information.

Primary Care Provider (PCP) – Covered Services provided by a PCP are paid according to the plan.

Professional Provider – Services of a Professional Provider are covered for diagnosis or Medically Necessary treatment of Illness or Injury, and for covered Preventive Services. Services that can be considered professional include, but are not limited to, PCP office visits, Specialist visits, care management Services, education Services, radiology and laboratory readings, and professional surgeon Services. Covered Services are paid according to the plan based on place of service, provider type, and provider billing. Refer to your Schedule of Benefits for Cost Share information.

Professional Provider Visits in the Hospital* – Eligible Expenses include Professional Provider visits to you during a covered Hospital or Skilled Nursing Facility stay. We do not cover separately, visits relating to surgery performed during a Hospital stay because these visits are ordinarily included in the surgeon's fee. Eligible Expenses also include physician consultations with written reports during each Hospital stay. We do not cover staff consultations required by Hospital rules. These benefits apply only if you are eligible for Hospital or Skilled Nursing Facility benefits.

Radiology – Covered Services provided by or prescribed by a provider are paid according to the plan. Covered Services include, but are not limited to, diagnostic and therapeutic Services, fluoroscopy, and electrocardiograms. Refer to high-tech imaging and Preventive Care Services within this section for additional information. Refer to your Schedule of Benefits for Cost Share information.

Reconstructive Services/Surgery* – Covered Services are paid according to the plan**,** under the following circumstances, when Medically Necessary:

- Reconstructive surgery to primarily correct a functional disorder;
- Breast reconstruction following Medically Necessary Mastectomy, including reconstruction of the opposite breast to achieve Cosmetic symmetry (all stages of Reconstructive surgery are covered under one authorization determination);
- Reconstructive surgery necessitated by an accidental Injury;
- Surgery to correct a facial scar or defect resulting from Medically Necessary surgery that was covered, or would have been covered, under this Plan;
- Surgery to correct a scar or defect resulting from surgery for cancer;
- Surgery to correct a congenital defect; or
- Treatment for Gender Dysphoria.

Additional Reconstructive surgery that is Medically Necessary to correct a functional disorder resulting from the initial Injury or surgery will be covered.

Routine Foot Care – Unless the Member has diabetes mellitus, treatment for corns and calluses, toenail conditions, hypertrophy or hyperplasia of the skin and nails is not covered. Covered

Services are paid according to the plan based on place of service, provider type, and provider billing.

Skilled Nursing Facility (SNF)* – Covered Services of a Skilled Nursing Facility are covered for up to 60 days per Calendar Year of extended care. Custodial Care is not a covered benefit.

Sleep Lab – Covered Services are paid according to the plan, when performed in a home or Hospital setting, based on place of service, provider type, and provider billing.

Speech Therapy* – Covered Services of a certified speech therapist are paid according to the plan. Services for Speech Therapy will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological Disease or Injury. Speech and/or cognitive therapy for acute Illnesses and Injuries are covered up to one-year post injury when the Services do not duplicate those provided by other eligible providers, including occupational therapists or neuropsychologists. Medically Necessary therapeutic Services for the treatment and care for brain trauma or stroke are covered.

Surgery* – Covered Services are paid according to the plan. This includes operative and cutting procedures, treatment of fractures, dislocations and burns. Surgical Supplies are covered and paid based on place of service, provider type, and provider billing.

Telemedical Services – The Plan covers Telemedical Services, including Services for diabetes. It covers Telemedical Services via two-way electronic communication. These Services are covered to allow health professionals to interact with a patient, parent or guardian of a patient or another health professional on a patient's behalf, who is at an originating site, in connection with a Medically Necessary diagnosis.

Tobacco Use Cessation – Covered Services include ways to help you stop using tobacco. If your provider feels that you need a prescription to help you quit tobacco, the Plan will pay for Nicotine Replacement Therapy (NRT) at no cost to you. Refer to the Prescription Drug Benefits section.

Services may include medical and behavioral interventions (counseling, telephone counseling and self-help materials) and drug treatments. Services are reimbursed under the Preventive Care benefit. Refer to your Schedule of Benefits for Cost Share information.

Transplant Services* – Covered Services including organ and tissue Transplants are covered. Corneal Transplants do not require Prior Authorization.

This Plan covers the following Medically Necessary organ and tissue Transplants:

- Bone marrow and peripheral blood stem cell
- Bone marrow for aplastic anemia
- Corneal (no Prior Authorization required)
- Heart
- Heart-Lung
- Kidney
- Kidney-Pancreas (under certain conditions)

- Leukemia
- Liver
- Lung
- Lymphoma
- Pancreas
- Pediatric bowel
- Severe combined immune-delivery disease or Wiskott-Aldrich Syndrome

This Plan only covers Transplants of human body organs and tissues. Transplants of artificial or animal organs and tissues are not covered. Immunosuppressive drugs associated with covered Transplants are covered. There are no exclusion periods for Transplants.

For detailed Transplant information, please contact our Customer Service Department.

> **Transplants, In-Network** – If a Transplant is performed at an In-Network provider facility, covered charges are paid in full less applicable Copays, Coinsurance and Deductibles.
>
> **Transplants, Out-of-Network** – If Transplant Services are available through a contractual agreement with an In-Network facility but are performed at an out-of-network facility, this Plan pays the lesser of 50% of the billed amount or $100,000. Allowed charges are paid in full less applicable Copays, Coinsurance and Deductibles. The balance is your responsibility and does not accumulate toward this Plan's Out-of-Pocket Maximum. Services provided by Out-of-Network Providers are paid according to the Cost Shares in the Schedule of Benefits for Out-of-Network Providers.

Traumatic Brain Injury Services* – Covered Services includes therapy and Services for the treatment of a traumatic brain injury. Services are covered and paid based on place of service, provider type, and provider billing.

Tubal Ligation and Vasectomy Procedures – Covered Services are paid according to the plan based on place of service, provider type, and provider billing. Refer to your Schedule of Benefits for Cost Share information.

Urgent Care Services – Covered Services are paid according to the plan. See Definitions for a description of Urgent Care Services. Refer to your Schedule of Benefits for Cost Share information.

Wellness Benefits – Your Plan includes the following wellness benefits. This benefit is available to subscribers and spouses/domestic partners.

- **Individual Wellness Assessment** – Interactive, online questionnaire that evaluates lifestyle and its impact on good health.
- **Health Risk Screening** – Blood test that identifies risks and health indicators for certain Diseases and medical conditions.
- **Personal Health Coach** – A trained certified professional provides confidential, one-on-one sessions to assist Members in reaching their health and wellness goals.
- **Health Risk Score and Report** – Provides a snapshot of the Member's current health and recommends appropriate action items. Requires completion of individual wellness assessment and health risk screening.

Wigs* – One synthetic wig following chemotherapy or radiation therapy is covered per Calendar Year.

X-Rays – Covered Services provided by or prescribed by a provider are paid according to the plan. Covered Services include X-rays and professional readings. Refer to your Schedule of Benefits for Cost Share information.

Preventive Care Services

Preventive Care Services and chronic Disease management do not require Copays or cost sharing when received by an In-Network provider. Out-of-network Services will have cost sharing applied. Refer to your Schedule of Benefits for Cost Share information. Health care reform preventive services requirements are developed through the guidelines provided by the US Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices of the Centers for Disease Control, and Health Resources and Services Administration (HRSA). Prior Authorizations are not required for preventive benefits.

If you have questions as to whether a Service is preventive, please refer to the Resource Guide on page 1 to contact our Customer Service Department.

A and B list for Preventive Services:

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Women's Preventive Services:

http://www.hrsa.gov/womensguidelines/

The schedules provided for the preventive benefits below are only recommendations and do not represent a full list.

PKU Testing – We cover PKU testing to detect the presence of Phenylketonuria (PKU). This is recommended testing for newborns. If the test detects the presence of PKU, we cover the formulas determined to be Medically Necessary for the treatment of PKU. We cover necessary formulas for treatment under the DME, Prosthetics, Orthotics, and Medical Supplies benefit of this Plan.

Colorectal Screenings – We cover Services for colorectal cancer screening that have been assigned either a grade A or grade B by the United States Preventive Services Task Force (USPSTF) for any individual at high risk, and as a part of the individual's routine Preventive Care. Screenings are provided at zero Cost Share to the Member for preventive screenings.

The USPSTF recommends screening for adults age 50 and older using:

- Fecal occult blood testing
- Colonoscopies, including removal of polyps
- Sigmoidoscopy
- Double contrast barium enemas

We cover preventive colorectal screenings for individuals who are younger than 50 or require a screening any time prior to a 10-year interval and have been diagnosed by their provider as high risk for colorectal cancer. An individual is considered high risk if the individual has:

- A family history of colorectal cancer
- A prior occurrence of cancer or precursor neoplastic polyps
- A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease
- Crohn's disease or ulcerative colitis
- Other predisposing factors

Immunizations – We cover immunizations recommended by the Centers for Disease Control and Prevention, as Medically Necessary. Covered expenses do not include immunizations for the sole purpose of travel, school, work/ occupation, or residence in a foreign country. Human papilloma virus (HPV) vaccine is covered for beneficiaries of this Plan who are at least 11 years of age but no older than 26 years of age. See Benefit Exclusions.

Prostate Screening Exams – Each Calendar Year for men age 50 and over or for those considered high risk.

Routine Physical Exams – Routine physical exams can include related laboratory and radiology Services, and bone density screening for patients considered at risk per Medicare guidelines.

DRAFTERS NOTE: Language will populate for employee/child and employee/Dependent coverage.

[Well Child Care – Covered Services are paid according to the plan. Recommendations are for 12 well baby exams in the first 36 months of life, then annually after that.

> **Well Baby Care** – Well baby care covers physical examinations provided by a Professional Provider, including the standard in-hospital examination at birth, diagnostic X-rays, and laboratory Services for an enrolled baby up to age 24 months.
>
> **Well Child Care** – We cover routine periodic health appraisals, routine physical examinations, and physical examinations required for school and/or to participate in athletics. Handling fees are not covered.
>
> We cover physical examinations and any related laboratory tests and X-ray examinations up to the following amounts:
>
> - Age 2-6, one examination every Calendar Year.
> - Age 7-17, one examination every two Calendar Years.]

Women's Preventive Care Services

We cover Women's Preventive Care Services. This includes annual women's exams, although it is recognized that several visits can be needed to obtain all necessary recommended Preventive

Services, depending on a woman's health status, health needs, and other risk factors. Women's exams include the following:

- **Clinical Breast Exam** – An annual breast exam for women 18 years of age or older or at any time when the women's healthcare provider recommends for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer.
- **Routine Gynecological Exams** – Routine pelvic exams and Pap smears are covered. The USPSTF recommends screening for cervical cancer in women ages 18 to 64 years with cytology (Pap smear) every 3 years or when the women's health care provider recommends an exam. HRSA recommends HPV DNA testing for women age 30 and older with normal cytology to occur no more frequently than every 3 years.
- **Routine Preventive Mammograms** – An annual mammogram for the purpose of early detection for a woman 40 years of age or older is covered.

We also cover screening and appropriate counseling or interventions for:

- Breastfeeding comprehensive support, counseling and Supplies; and
- Breast cancer chemoprevention counseling.

Women's Preventive Care Services do not require Copays or cost sharing when received by an In-Network provider. Out-of-network Services will have cost sharing applied unless:

- There is no In-Network provider to furnish the Service, drug, device, product or procedure that is geographically accessible or accessible in a reasonable amount of time as defined by the Department of Consumer and Business Services by rule; or
- An In-Network provider is unable or unwilling to provide the service in a timely manner.

Refer to your Schedule of Benefits for Cost Share information.

Women's Preventive Services requirements are developed through the guidelines provided by the Health Resources and Services Administration (HRSA) and the Women's Preventive Services Initiative (WPSI). Prior Authorizations are not required for Women's Preventive Care benefits.

If you have questions as to whether a women's care Service is preventive, please refer to the Resource Guide on page 1 to contact our Customer Service Department.

Women's Preventive Services:

http://www.hrsa.gov/womensguidelines/

Women's Preventive Service Initiative Report, published December 2016 and available at:

http://dfr.oregon.gov/business/insurance-industry/health-insregulation/Pages/regulatory-guid.aspx

Reproductive Health Care Services

We cover Reproductive Health Care Services as required under the Oregon Insurance Code. Reproductive health Services do not require Copays or cost sharing when received by an In-Network provider. Out-of-network Services will have cost sharing applied. Refer to your Schedule of Benefits for Cost Share information.

If you have questions as to whether a Service is a reproductive health care service, please refer to the Resource Guide on page 1 to contact our Customer Service Department.

The schedules provided for the Reproductive Health Care Services benefits below are only recommendations and do not represent a full list.

Contraceptives – We cover at no cost to the Member all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for Members with reproductive capacity, as prescribed by a provider.

Contraceptives are covered for:

- A three-month period for the first dispensing
- A twelve-month period for subsequent dispensing of the same contraceptive regardless if the Member was enrolled in the Plan at the time of the first dispensing

We also cover:

- Hormonal contraceptives, including injectable, oral, patches and rings, prescribed by a provider or Pharmacist; and
- Pharmacy Claims for over-the-counter contraceptives that are FDA approved.

DRAFTER'S NOTE: Default to include language. Language will be removed for religious groups who opt out of covering this benefit.

[**Abortions** – Abortions are covered as required by state law.]

Counseling – We cover counseling for sexually transmitted infections including, but not limited to, human immunodeficiency virus and acquired immune deficiency syndrome.

Screening and Counseling – We cover screening for chlamydia, gonorrhea, Hepatitis B, Hepatitis C, human immunodeficiency virus and acquired immune deficiency syndrome, human papillomavirus, syphilis, anemia, urinary tract infection, pregnancy, Rh incompatibility, gestational diabetes, osteoporosis, breast cancer and cervical cancer.

We also cover:

- Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indicated; and
- Screening and appropriate counseling or interventions for:
    - Tobacco Use; and

- Domestic and interpersonal violence.

Prescription Drug Benefits

The level of Prescription Drug Coverage is determined through a five-tier system. To find out which tier a specific drug is covered in or if there are any specific limits or authorization requirements, see the Formulary at samhealthplans.org/groupbenefits. Refer to the Resource Guide on page 1 where you and your physician can find out more about additional requirements or limits on covered drugs.

- **Tier 1: Low Cost Therapeutic** – Drugs that provide the same high quality medicinal and therapeutic benefit found in Brand Name Drugs without the Brand Name Drug cost. These drugs help reduce your out-of-pocket costs.
- **Tier 2: Preferred** – In most cases preferred drugs (or Brand Name Drugs), provide high quality, effective and affordable prescription benefits to our Members. Preferred drugs are either more effective or equally effective, but less costly than other alternative drugs not included on the preferred drug list. They are often the preferred agent in a class of drugs that has many alternatives and will treat most health conditions.
- **Tier 3: High Cost Preferred** – This tier consists of medium-cost prescription drugs that provide high quality effective benefits to Plan members and are less costly than other alternative drugs not included on the preferred drug list.
- **Tier 4: Non-preferred** – This tier is generally next highest in Copayment and cost and are non-preferred by the Plan. Drugs in this tier often require utilization management requirements to be met.
- **Tier 5: High Cost Specialty** – Drugs in this tier include high cost brand and generic specialty drugs, which may require special handling and/or close monitoring. Drugs in this tier often require utilization management requirements to be met.

Drugs in the Formulary are subject to change throughout the year, upon review by the Pharmacy & Therapeutics Committee. You may be charged a Coinsurance or Cost Share if the drug is received in another setting (for example, infusion).

Preventive Drugs have coverage at a $0 Copayment when health care reform requirements are met.

Prescription Eye Drops – The Plan will provide coverage for one early refill of Prescription Eye Drops to treat glaucoma if all of the following criteria are met:

1. The refill is requested by a Member less than 30 days after the later of:
    a. The date the original prescription was dispensed to the insured; or
    b. The date that the last refill of the prescription was dispensed to the insured;

2. The prescriber indicates on the original prescription that a specific number of refills will be needed;
3. The refill does not exceed the number of refills that the prescriber indicated in number 2 above; and
4. The prescription has not been refilled more than once during the 30-day period prior to the request for an early refill.

Benefit Exclusions

The following is a list of benefit exclusions. Refer to the specific benefit category in the Plan Benefits section for additional information.

Least Costly Setting for Services

Covered Services must be performed in the least costly setting where they can be provided safely. For example, if a procedure that can be done safely on an outpatient basis is done in a Hospital inpatient setting, this Plan will only pay what it would have paid for the procedure on an outpatient basis. This determination will be made by Samaritan Health Plans.

Excluded Services

This Plan covers only the Services and conditions identified in this Group Policy. Unless a Service or condition is specifically covered, it is excluded.

This Plan Does Not Cover the Following Surgeries and Procedures:

- Any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for Injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or Mental Health condition);
- Panniculectomies;
- Cosmetic Services and surgery, except those Services and surgery that fall under the "reconstructive Services/surgery" benefit;
- Abdominoplasty;
- Treatment for infertility, including artificial insemination, in vitro fertilization, or Gamete Intrafallopian Transfer (GIFT) procedures;
- Surgery to reverse voluntary sterilization;
- Routine foot care such as treatment for corns and calluses, toenail conditions, hypertrophy or hyperplasia of the skin and nails unless the patient has diabetes mellitus;
- Surgical procedures that alter the refractive character of the eye, unless Medically Necessary;
- Treatment to augment or reduce the upper or lower jaw, except when Medically Necessary;
- Temporomandibular joint (TMJ) or myofascial pain treatment, advice, or appliances;
- Services for dental implants, or improving placement of dentures;

- Sex transformations are excluded when not Medically Necessary or when not related to a Mental Health condition;
- Sexual dysfunction is excluded when not Medically Necessary or when not related to a Mental Health condition;
- Eye surgeries to improve vision, such as Lasik, unless Medically Necessary;
- Myeloablative high dose chemotherapy, except when the related Transplant is covered;
- Services, Supplies, testing or treatment for sterility, infertility, impotency, frigidity, or sexual inadequacy, unless Medically Necessary or when not related to a Mental Health condition; and
- Custodial Care, including routine nursing care, and rest cures, and Hospitalization for environmental change.

This Plan Does Not Cover the Following Drugs and Medications:

- Prescription Drugs used primarily for weight control or obesity.
- Non-prescription drugs, except for:
    - Insulin;
    - Certain over-the-counter (OTC) drugs when required by law.
- Immunizations or Services in anticipation of exposure through travel, school or work;
- Vitamins, except those which by law require a Prescription Order, or which are required by law to be covered by the Plan;
- Drugs with no proven therapeutic indication;
- Drugs for which Claims are submitted 12 months or more after the date of purchase;
- Drugs or devices used for infertility;
- Drugs or devices used for impotence and sexual dysfunction (e.g., Viagra, Medicated Urethral System for Erection (MUSE), Yohimbine, Osphena, etc.), unless Medically Necessary or as a result of a Mental Health diagnosis;
- Drugs or devices used for Cosmetic reasons (e.g., Rogaine, Propecia, Botox, Renova, etc.), unless Medically Necessary; and
- Drugs used for other than Medically Necessary indications.

This Plan Does Not Cover the Following Medical Equipment and Devices:

- Eyeglasses or contact lenses, eyeglass or contact lens fitting fees, vision therapy, orthoptics and visual appliances (colored lenses, prisms and special glasses) for reading, learning or behavioral disabilities or dyslexia; and
- 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 and televisions, and maintenance Supplies or equipment commonly used for purposes other than medical care.

This Plan Does Not Cover the Following Mental Health and Substance Use Disorder Services, Unless Medically Necessary Within the Scope of the Provider or as Ordered by the Court:

- Marital, family, career, or personal growth counseling, unless it is a part of a Member's treatment plan and billed specifically for the Member;
- Educational programs, including some court-ordered programs that do not require coverage by the state of Oregon;
- Voluntary mutual support groups like Alcoholics Anonymous, unless court ordered;
- Counseling in the absence of Illness;
- Psychological testing that is not Medically Necessary; and
- Any Mental Health Services unrelated to the treatment or diagnosis of a mental disorder.

This Plan Does Not Cover the Following Health Related Conditions, Services, or Supplies, Unless Medically Necessary and Within the Scope of the Provider's License:

DRAFTERS NOTE: Language will populate for groups who have NOT purchased Samaritan Health Plan's Alternative Care Rider.

- [Alternative Care Services, including Acupuncture, Chiropractic, and Massage;]
- Homeopathic treatment;
- Biofeedback, for diagnosis other than Mental Health and Substance Use Disorder, migraine headaches and incontinence;
- Hypnosis; and
- Experimental or Investigational.

Other Services, Supplies, and Treatments this Plan Does Not Cover:

- Any charge over the Usual and Customary or Reasonable Charge for Services or Supplies;
- Hospital, Skilled Nursing Facility or other facility Services that began before the covered person's coverage began, including Services and Supplies;
- Treatment incurred prior to enrollment and coverage under the Plan or after coverage terminates. The only exception is that if this Group Policy is replaced by a group health policy while you are hospitalized, Samaritan Health Plans will continue paying covered Hospital expenses until you are released, or your benefits are exhausted, whichever occurs first;
- Services or Supplies otherwise available (such Services or Supplies will be covered if otherwise required by law);
- Services provided by an immediate family member, including parents, grandparents, Spouse or domestic partner, siblings, children and grandchildren;
- Services or Supplies for which no charge is made, or for which no charge is normally made in the absence of insurance;
- Services or Supplies for which the covered person is not charged or cannot be held liable because of an agreement between the provider rendering the service and another third-party payer that has already paid for the service;

- Services or Supplies with no charge, or which your Employer would have paid for if you had applied;
- The Plan does not cover Services for the sole purpose of travel, school, work or occupation (for example, immunizations, routine physicals, or laboratory Services);
- Charges for Services or Supplies if you are not willing to release medical information to Samaritan Health Plans in order to determine eligibility for payment;
- Charges for travel or work-related expenses, telephone consultations, missed appointments, get acquainted visits, completion of Claim forms or completion of reports requested by the Claims Administrator in order to process Claims;
- Care designed mainly to help with daily activities such as walking, getting out of bed, bathing, dressing, eating, and preparing meals;
- Services and Supplies not specifically described as benefits under this Plan;
- Charges that are the responsibility of a third party, such as, Personal Injury Protection (PIP) insurance, motor vehicle liability insurance, or uninsured or underinsured motorists; and
- Treatment incurred as a result of an Injury/Illness payable under any automobile medical, Personal Injury Protection (PIP), automobile no-fault, underinsured or uninsured motorist coverage, homeowners' medical payments coverage, commercial premises coverage or similar contract or insurance. This applies when the contract or insurance is either issued to or makes benefits available to the Member whether or not the Member makes a Claim under such coverage. Further, the Member is responsible for any cost-sharing required by the other coverage, unless state laws require otherwise. Once benefits under such contract or insurance are exhausted or expired or considered to no longer be Injury related under the no-fault provisions of the contract, benefits will be provided according to this Plan.

Prior Authorization

This Prior Authorization section describes requirements for receiving medical benefits. Refer to the Prescription Drug Benefits section for authorization requirements for Pharmacy benefits.

Coverage of certain Services, procedures, Supplies and equipment require written Prior Authorization by Samaritan Health Plans before being performed or supplied. Your provider can 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 Samaritan Health Plans yourself. In some cases, additional information or a second opinion can be required before authorizing coverage. For a full list of medical benefits that require Prior Authorization, visit our website at samhealthplans.org/employergroup**.**

Emergency Services will not require Prior Authorization. We request notification of any emergency admissions and observation stays which exceed 48 hours in order to ensure that all of the Member's care is appropriately coordinated.

Prior Authorization Determination Timeframes

Samaritan Health Plans will decide and notify you of your authorization determination in accordance with reasonable timeframes, as required by the State of Oregon.

Type of Claim	Authorization Determination
Pre-Service requests	Within 2 business days

Claims Involving Prior Authorization (Pre-Service Claims)

For Services that do not involve urgent medical conditions – Samaritan Health Plans will notify your provider or you of its decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Samaritan Health Plans will notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Samaritan Health Plans will complete its review and notify your provider or you of its decision. If the information is not received within 45 days, we will make a decision based on the information we have within 15 days following the 45-day period.

For Services that involve urgent medical conditions – Samaritan Health Plans will notify your provider or you of its decision within 72 hours after the Prior Authorization request is received. If Samaritan Health Plans needs additional information to complete its review, it will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Samaritan Health Plans will complete its review and notify the requesting provider or you of its decision by the earlier of:

- 48 hours after the additional information is received; or
- If no additional information is provided, 48 hours after the additional information was due.

Notification of Determination

Notification of Samaritan Health Plan's benefit determination will be communicated by letter, fax, or electronic transmission to the Hospital, the provider, and the Member. If time is a factor, notification will be made by telephone and followed up in writing.

Length of Time Determinations are Valid

A Prior Authorization determination relating to benefit coverage and medical necessity, of a medical or Mental Health Service to be provided to a Member, is valid for 30 calendar days. A Prior Authorization determination relating to the Member's Eligibility for coverage under the Plan is valid for five business days, unless Samaritan Health Plans has specific knowledge that the Member's coverage is ending sooner than five business days and Samaritan Health Plans specifies the termination date in the authorization. These specified times are not binding on Samaritan Health Plans if there was misrepresentation on the part of the policyholder, Member, or provider that was relevant to the Prior Authorization request, or the request is incomplete. The Prior Authorization is limited to the specific provider requesting the authorization or to Services of a designated group of In-Network providers.

Other Services

Care Coordination Services

Samaritan Health Plans offers care coordination Services to Members who have been diagnosed with chronic medical conditions or who are experiencing complex medical events. Care coordination staff help Members navigate and participate in their individual plan of care and support communication between providers across different healthcare settings. Care coordination Services can include health coaching, case management, and care management by the involved provider team.

Health Coaching

Samaritan Health Plans offers one-on-one Services designed to assist Members in reaching health and wellness goals. The program will help you:

- Identify what is motivating you to make lifestyle changes;
- Set specific, measurable, attainable, realistic and time-limited goals;
- Identify barriers and create steps to overcome the barriers; and
- Build skills to find reliable health information and wellness resources specific to your needs.

Primary Care Home

The Primary Care Home (PCH) practice provides relationship-based, primary health care that focuses on the health needs of the whole person. The PCH is responsible for meeting the large majority of each patient's physical and Mental Health care needs, including prevention and wellness, acute care, and chronic care. They coordinate care across all elements of the broader health care system, including Specialty Care, Hospitals, Home Health Care, and community Services.

Claims Information

When a Claim is submitted for payment every attempt will be made to process it promptly and accurately. Claims must be submitted within one year (365 days) of the time the covered person receives the service or supply to be eligible for payment. We reserve the right to examine, at our own expense, the insured when and as often as it can reasonably require when a Claim is pending.

Within 30 days of receipt of a clean Claim, Samaritan Health Plans will process your Claim. We will report this information to you on a form called an Explanation of Benefits (EOB). The Plan can pay Claims, deny them, or accumulate them toward satisfying the Deductible (if applicable). If Samaritan Health Plans denies all or part of a Claim, the reason or reasons for the action will be stated in the EOB. The explanation will also contain the following items:

- Reference to the relevant Plan provisions
- A description of any additional information that is needed and why such information is needed
- A statement of whether you must provide any additional information and why that information is necessary
- A statement that you can obtain, upon request, copies of information and documents relevant to your Claim

If a Member receives payment for a benefit that he or she is not eligible to receive, the Plan has the right to recover the payment from the Member (including by reducing future Claim payments for the Member) or anyone else who benefits from it. The Member has the right to appeal Claims decisions that they do not agree with. Refer to Member Grievance and Appeals Review.

All Claims should be submitted to Samaritan Health Plans at the following address:

Samaritan Large Group Plans
Samaritan Health Plans
PO Box 887
Corvallis, OR 97339

Member Claim Reimbursements

Payee of Claims

We have the sole right to decide whether to pay benefits to you, to the provider of Services, or to you and the provider jointly. If a person entitled to receive payment under the Plan has died, is a minor or is incompetent, we can pay the benefits (up to $1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment. A payment made

in good faith under this provision will fully discharge Samaritan Health Plans' obligations under the Plan.

When the Hospital Bills You

DRAFTERS NOTE: Language will populate for employee/child or employee/Dependent coverage.

You can be billed for inpatient care you [or a Dependent] receives in an out-of-network Hospital, and for outpatient care you receive in any Hospital outside our network that can be paid by the provisions of this Plan. In order to claim your benefits for these charges, send a copy of the bill to us, and be sure it includes all of the following:

- The name of the covered person who was treated
- Your name and your group and identification numbers
- A description of the symptoms that were observed or a diagnosis
- A description of the Services and the dates on which they were given

If you have already paid for the Services or Supplies, please note that fact boldly on the form and include a receipt. Refer to the Resource Guide on page 1 for reimbursement forms.

The same procedure should be followed with bills for Hospital or physician care you received outside the United States, for Emergency Services ONLY. Reimbursement will be made at the rate of exchange at the time the Claims are processed.

Notice of Claim

Written notice of Claim must be given to Samaritan Health Plans within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member to Samaritan Health Plans at PO Box 887 Corvallis, OR 97339, with information sufficient to identify the Member, shall be deemed notice to the insurer.

Physicians' Charges

Your physician can bill charges directly to us. Payment will be made directly to the provider. If your physician does not bill us directly, you can send physician bills to us yourself. Be sure the physician uses his or her billing form and includes on the bill:

- the patient's name and the group and identification number
- the date treatment was given
- the diagnosis
- an itemized description of the Services given and the charges for them

If you have already paid for the Services and Supplies, please note that fact boldly on the form and include a receipt.

If the treatment is for an accidental Injury, include a statement explaining the dates, time, place, and circumstances of the Accident when you send us the physician's bill.

Physician Reimbursement

You are entitled to ask if Samaritan Health Plans has special financial arrangements with our physicians that can affect the use of Services. To get this information, contact our Customer Service Department and request information about our physician payment arrangements.

Other Health Care Charges

As we explained previously in the description of benefits, the Plan will pay for certain other health care expenses. Bills should be forwarded to us as you receive them. You can also send them to us at regular intervals, for example, once a month. Again, if you have already paid for the Services and Supplies, please note that fact boldly on the form and include a copy of your receipt.

Prescription Drug Rebates

Samaritan Health Plans participates in arrangements with drug manufacturer's, which allows us to receive rebates based on volume of certain Prescription Drugs purchased on behalf of covered individuals.

Any rebates that we receive from drug manufacturers will be used to help minimize future covered health care expenses for individual Members and the health plan.

Appliances

By this term, we mean things such as artificial limbs, crutches, and wheelchairs. Bills for any of these items should include a complete description of the appliance and the reason it is needed. If your doctor wrote a prescription for the appliance, this should also be included with your Claim. Always include your group and identification numbers and the patient's name.

Ambulance Service

Bills for ambulance Service must show where the patient was picked up and where the patient was taken. They should also show the date of service, the patient's name, group, and member ID numbers. We will send our payment for covered expenses directly to the ambulance Service provider.

Claim Determinations

Within 30 days of our receipt of a clean Claim, we will notify you of the action we have taken on it, adverse or not. However, this 30-day period can be extended by an additional 30 days in the following situations:

- When we cannot take action on the Claim due to circumstances beyond our control, we will notify you within the initial 30-day period that the extension is necessary, including an explanation of why the extension is necessary and when we expect to act on the Claim.
- When we cannot take action on the Claim due to lack of information, we will notify you within the initial 30-day period that the extension is necessary, including a specific description of the additional information needed and an explanation of why it is needed.
- You must provide us with the requested information within 30 days of receiving the request for additional information. If we do not receive the requested information to process the Claim within the 60 days we have allowed, we will deny the Claim.

Time Frames for Processing Claims

If Samaritan Health Plans denies your Claim, we will send an Explanation of Benefits ("EOB") to you with an explanation of the denial within 30 days after we receive your Claim. If we need additional time to process your Claim for reasons beyond our control, we will send a notice of delay to you explaining those reasons within 30 days after we receive your Claim. We will then complete our processing and send an EOB to you within 45 days after we receive your Claim. If we need additional information from you to complete our processing of your Claim, we will send you a separate request for information and you will have 45 days to submit the additional information. Once we receive the additional information from you we will complete our processing of the Claim within 30 days.

Timely Submission of Claims

Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Division of Financial Regulation's administrative rule setting standards for prompt payment.

Please send all claims to:
Samaritan Health Plans
P.O. Box 887
Corvallis, OR 97339

Claims Involving Concurrent Care Decisions

If an ongoing course of treatment for you has been approved by Samaritan Health Plans and it then determines through its medical cost management procedures to reduce or terminate that course of treatment, you will be provided with advance notice of that decision. You may request a reconsideration of that decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Samaritan Health Plans will then notify you of its reconsideration decision within 24 hours after your request is received.

Motor Vehicle Coverage

In addition to liability insurance, most motor vehicle insurance policies are required by law to provide primary medical payments insurance and uncovered motorist insurance. Many motor vehicle policies also provide underinsurance coverage. Benefits for health care expenses are excluded under this policy to the extent that you are able to or are entitled to recover from any type of motor vehicle insurance coverage.

Here are Some Rules, Which Apply with Regard to Motor Vehicle Insurance Coverage:

- If a Claim for health care expenses arising out of a motor vehicle accident is filed with us and motor vehicle insurance has not yet paid, we may advance benefits as long as you agree in writing:
    - to give information about any motor vehicle insurance coverage which can be available to you; and
    - to hold the proceeds of any recovery from motor vehicle insurance in trust for us and reimburse us as provided in the following paragraphs;
- If we have paid benefits before motor vehicle insurance has paid, we are entitled to have the amount of the benefit we have paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of you, is held in trust for us. This is true whether such recovery or payment is from primary medical payments coverage, uninsured motorist coverage or underinsured motorist coverage;
- If you Incur health care expenses for treatment of an Illness or Injury arising out of a motor vehicle accident after receiving a recovery from uninsured or underinsured motor vehicle coverage, we will exclude benefits for otherwise Eligible Charges until the total amount of health care expenses incurred after the recovery exceed the Net Recovery Amount (as defined in the "Third Party Liability" provision); and
- You, if involved in a motor vehicle accident, can have rights both under motor vehicle insurance coverage and against a third party who can be responsible for the Accident. In that case, both this provision and the "Third Party Liability" provision apply.

Third-Party Liability and Right of Subrogation

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

Subject to the requirements of Oregon law, this provision applies when you Incur health care expenses in connection with an Illness or Injury for which one or more third parties can be responsible, including surrogacy. In that situation, benefits for such expenses are excluded under this Plan to the extent you [or your covered Dependent] receive[s] a recovery from or on behalf of the responsible third party.

Here are Some Rules, Which Apply in These Third-Party Liability Situations:

- If a Claim for health care cost is filed with us and you have not yet received recovery from the responsible person, we can advance benefits for covered expenses if you [or your covered Dependent] agree[s] to hold, or direct[s] your attorney or other representative to hold, the recovery against the other party in trust for us up to the amount of benefits we paid in connection with the Illness or Injury.
- If we pay benefits, we will be entitled to have the amount of the benefits we have paid separated from the proceeds of any recovery you receive from or on behalf of the third party and held in trust for payment to us.
- We are entitled to the amount of benefits we have paid in connection with the Illness or Injury, regardless of whether you [or your covered Dependent] have been made whole, from the proceeds of any settlement, arbitration award, or judgment that results in a recovery for you [or your covered Dependent], the third party's insurer, or any other insurance recovery. This is so regardless of whether: the third party or the third party's insurer admits liability; the health care expenses are itemized or expressly excluded in the third-party recovery; or the recovery includes any amount (in whole or in part) for Services, Supplies, or accommodations covered under the policy. The amount to be in trust shall be calculated based upon Claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.
- If you make a recovery and fail to hold in trust for us the amount of paid benefits and to pay us that amount as required by this Third-Party Liability (TPL) provision, we can limit future treatment or future medical benefits for any care up to the amount of benefits we paid for the Illness or Injury caused by the third party. Not all TPL Claims will go to subrogation. Samaritan Health Plans follows rules on Third Party Liability and subrogation to the full intent of the law.
- We expect full reimbursement before any amounts are deducted from the Plan, proceeds, award, judgement, settlement or other arrangement. This obligation to reimburse the Plan shall be equally binding upon you regardless of whether or not the third party or its insurer has admitted liability, or the medical charges are itemized in the third-party payment.
- If you or your Dependent Incur health care expenses for treatment of the Illness or Injury after recovery, we will exclude benefits for otherwise Eligible Charges until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount.

The Term "Net Recovery Amount" is Calculated as Follows:

The amount of recovery; plus

the amount you recovered from any other source such as other insurance as a result of the Illness or Injury;

Minus

the difference between the total amount of third-party related health expenses incurred prior to the recovery and the benefits we paid before the recovery toward such cost;

Minus

the amount you reimbursed to us out of the recovery for benefits we paid before the recovery;

Minus

the total expenses paid by you when getting the recovery such as reasonable attorney fees and court expenses;

shall equal the "net recovery amount."

Workers' Compensation

We do not cover any work-related Illness, Injury, or Disease that is caused by any for-profit activity, whether through employment or self-employment. The only exceptions are if:

- You are the owner, officer, or partner of the Employer group, are injured in the course of employment with the covered Employer group, and are otherwise exempt from the applicable state or federal workers' compensation insurance program;
- The appropriate state or federal workers' compensation insurance program has determined that coverage is not available for your Injury; or
- If you are employed by an Oregon domiciled group, have timely filed an application for coverage with the State Accident Insurance Fund or other Workers' Compensation carrier, and are waiting for determination of coverage from that entity.

If you are not an owner, officer, or partner of the Employer group, then we may pay your medical Claims if a workers' compensation Claim has been filed and is not yet accepted or has been denied and is under appeal, according to the provisions of this certificate.

We will not cover any Claims that are resolved related to a disputed Claim settlement. We do not cover any Services or Supplies received for work-related injuries or illnesses when you have an accepted condition, even when the Service or Supply is not a covered benefit under your Workers' Compensation coverage.

This provision applies if you have made or are entitled to make a Claim for workers' compensation. Benefits for treatment of an Illness or Injury arising out of or in the course of employment or self-employment for wages or profit are subject to review for proper adjudication. Services can be subject to additional recovery. The only exception would be if you are exempt from state or federal workers' compensation.

Here are Some Rules, Which Apply in Situations Where a Workers' Compensation Claim Has Been Filed:

- You must notify us in writing within 5 days of filing a workers' compensation Claim; and
- If the entity providing workers' compensation coverage denies your Claims and you have filed an appeal, we can advance benefits if you agree in writing to hold any recovery you obtain from the entity providing workers' compensation coverage in trust for us according to the Third-Party Liability provision.

Medicare

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

In certain situations, this Plan is primary to Medicare. When you are covered by Medicare and this Plan at the same time and if this Plan is primary, the Plan pays benefits for Eligible Charges first and Medicare pays second in specific situations. Those situations are:

- When you [or your Spouse] [are] [is] age 65 or over and by law Medicare is secondary to the Plan;
- When you [or your covered Dependent] Incur[s] Eligible Charges for kidney Transplant or kidney dialysis and by law Medicare is secondary to the Plan; and
- When you [or your covered Dependent] [are] [is] entitled to benefits under section 226(b) of the Social Security Act (Medicare disability) and by law Medicare is secondary to the Plan.

For additional information on how this Plan coordinates with Medicare, please see www.medicare.gov.

Coordination of Benefits

Coordination of this Group Contract's Benefits with Other Benefits

This Coordination of Benefits (COB) section applies when a Member 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 plan terms without regard to the possibility that another plan can cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan can reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable Charges.

Definitions Relating to Coordination of Benefits

The following are definitions that apply to this Coordination of Benefits section.

Plan – Plan means any of the following that provides benefits or Services for medical care or treatment. 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 COB among those separate contracts.

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.

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 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.

Coordination – When this Plan is primary, we determine payment for our benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, we determine our benefits after those of another plan and can reduce the benefits we pay so that all plan benefits do not exceed 100% of the total Allowable Charges.

Allowable Charges – A health care cost, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any plan covering a Member. When a plan provides benefits in the form of Services, the reasonable cash value of each Service will be considered an Allowable Charge and a benefit paid. A charge that is not covered by any plan covering a Member is not an allowable expense. In addition, any charges that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Charge.

The Following are Examples of Expenses that are NOT Allowable Charges:

- The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Charge, 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 usual and customary fees 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 Charge.
- 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 Charge.

- If you are covered by one plan that calculates its benefits or Services on the basis of usual and customary fees 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 Charge 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 Charge used by the secondary plan to determine its benefits.
- The amount of any benefit reduction by the primary plan because you have failed to comply with the Plan provisions is not an Allowable Charge. Examples of these types of Plan provisions include second surgical opinions, Prior Authorization of admissions, and In-Network provider arrangements.

Closed Panel Plan

A closed panel plan is a plan that provides health care benefits to Members primarily in the form of Services 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 cases of emergency or referral by a contracted provider. This Plan is not a closed panel provider plan.

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[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.]

Order of Benefit Determination Rules

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

- The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan. Except as provided in the bullet 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.
- 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 coverage that are superimposed over base plan Hospital and surgical benefits, and insurance type coverage that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

Each Plan Determines its Order of Benefits Using the First of the Following Rules that Apply:

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.

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

[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 are 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 subparagraph does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
   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 paragraph (A) of this subsection determines 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 paragraph (A) of this subsection determines the order of benefits

iv. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

I. The plan covering the custodial parent
II. The plan covering the custodial parent's Spouse
III. The plan covering the non-custodial parent
IV. The plan covering the non-custodial parent's Spouse

(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 Member 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 order of benefit determination rules 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 order of benefit determination rules 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 Charge shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than we would have paid had we been the primary plan.

Effect on the Benefits of this Plan

When this Plan is secondary, we can 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 expense. 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 can 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 Charge 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 Member 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.

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 this Plan and other plans. We can 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 this Plan and other plans covering a Member claiming benefits. We need not tell, or get the consent of, any person to do this. Each Member claiming benefits under this Plan must give us any facts we need to apply this section and determine benefits payable.

Facility of Payment

A payment made under another plan can include an amount that should have been paid under this Plan. If it does, we can pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We 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.

Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB section, we can 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 can be responsible for the benefits or Services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of Services.

Other Claims Recoveries

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

If we mistakenly make a payment for you [or your covered Dependent] to which you [or your covered Dependent] [are] [is] not entitled, or if we pay a person who is not eligible for payments at all, we have the right to recover the payment from the person we paid or anyone else who benefits from it, including a provider of Services. Our right to recovery includes the right to deduct the amount paid by mistake from future benefits we would provide for you [or any of your covered Dependents] even if the mistaken payment was not made on that person's behalf.

We regularly engage in activities to identify and recover Claims payments, which should not have been paid (for example, Claims which are the responsibility of another, duplicates, errors, fraudulent Claims, etc.). We will credit to your group's experience or the experience of the pool under which your group is rated all amounts that we recover, less our reasonable expenses in getting the recoveries. At our own expense, have the right and opportunity to examine you [or the covered Dependent] when and as often as it can reasonably require while a Claim is pending.

If you have questions, please refer to the Resource Guide on page 1.

Member Grievance and Appeals Review

Complaints, Grievances and Appeals

If you have questions or concerns about your benefits, the quality of care you receive, or how quickly and informally the Claims Administrators reached a decision or handled a Claim, please contact our Customer Service Department. We may be able to resolve an issue quickly and informally.

Filing a Grievance

You or your Authorized Representative can file your Grievance verbally or, in writing. Within five (5) business days of receiving a Grievance, we will send you or your Authorized Representative an acknowledgment letter. If the Grievance cannot be resolved within five business days, 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.

You may receive information about our Grievance and appeal processes by contacting our Customer Service Department. Refer to the Resource Guide on page 1 for more information.

Filing a Level 1 Appeal

You or your Authorized Representative may submit an appeal of an Adverse Benefit Determination. The appeal request must be:

1. in writing;
2. signed;
3. include the appeal reason; and
4. received by us within 180 days of the denial or other action giving rise to the appeal.

You can use an Appeal Request Form available from Customer Service to provide this information.

Within five (5) business days of receiving the appeal, we will send you or your Authorized Representative an acknowledgment letter. You or your Authorized Representative has the right to appear in person to talk about your appeal. The Level 1 appeal decision will be determined by a healthcare professional not previously involved in your initial Adverse Benefit Determination. You or your Authorized Representative will receive a written decision within 30 days 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. For urgent appeals, your treating provider can act as your Authorized Representative.

If your request for appeal meets the definition of urgent, you or your Authorized Representative can request a simultaneous expedited External Review. For more information, please refer to Expedited Appeal Process below.

External Review

External Review decisions are made by Independent Review Organizations (IRO) that is not associated with Samaritan Health Plans. Your external review appeal will be randomly assigned to an IRO by the Oregon Division of Financial Regulation.

Your appeal can 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
- The Level 1 appeal has been completed; and, the reason for the Level 1 adverse decision was:
    - based on medical necessity
    - for treatment determined to be Experimental or Investigational
    - for the purpose of continuity of care (no interruption of an active course of treatment); or
- You and the Plan have mutually agreed to waive the internal appeals requirement

We must receive your written request for an external review within 180 days of the Level 1 adverse decision.

Please note: When you send a request for external review, you or your Authorized Representative must submit a signed waiver granting the IRO access to your medical records pertaining to the adverse decision. You can request the waiver form from the Plan.

If your request meets the definition of urgent as defined by law, you or your Authorized Representative can request an expedited External Review. For more information, please refer to Expedited Appeal Process.

To apply for an External Review, you must send your written request or the Appeal Request Form to us. Refer to the Resource Guide on page 1 for more information.

Once Samaritan Health Plans has been notified of the assigned IRO, we will submit your external review request to the IRO within 5 business days. When you are notified by the IRO that your request for external review has been received, you will have 5 business days to submit additional information about your appeal.

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

- Expedited External Review – 3 days after receipt of the request
- Standard External Review – 30 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 Resource Guide on page 1.

Expedited Review Process

If you believe your appeal is urgent, you, your Authorized Representative or your treating provider, can request an expedited review. If the appeal request meets the definition of urgent under the law; which means, 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 3 days of our receiving the appeal request). 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.

The expedited review request must:

- be filed verbally or in writing within 180 days after you receive notice of the initial written pre-service denial;
- state the reason for the appeal request;
- state the reason an expedited decision is needed; and
- include supporting documentation necessary to make a decision

When applicable, if you are simultaneously requesting an expedited external review in addition to an expedited internal review, a signed waiver granting the IRO access to your medical records pertaining to the adverse decision must be included.

The internal expedited review decision will be determined by a healthcare 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 3 days of our receiving the appeal. A written notice will be mailed within one working day following the verbal notification.

If you have requested a simultaneous expedited external review, Samaritan Health Plans will also forward your appeal to the IRO. Once the IRO has made a decision, Samaritan Health Plans is obligated to follow and honor the decision that was made by the IRO, regardless of the decision or opinions made by Samaritan Health Plans. If Samaritan Health Plans does not honor the decision made by the IRO, you or your Authorized Representative has the right to sue.

To apply for an Expedited Review, you must send your written request or the Appeal Request Form to us. Refer to the Resource Guide on page 1 for more information.

Appeal Timeframes

Samaritan Health Plans has the following timeframes for making internal review decisions on appeals:

- 3 days for urgent appeals
- 30 days for pre-service appeals
- 30 days for post-service appeals

To obtain an Appeal Request Form or a waiver granting IRO access to your medical records, refer to the Resource Guide on page 1 for more information.

Plan Administration

Governing Law

The interpretation and validity of this contract will be governed by the laws of the State of Oregon without regard to its conflict of law rules, and by applicable Federal Law. If there is conflict between the provisions of this Plan and Oregon State or Federal Laws, Oregon State or Federal Laws will take precedence over the provisions of this Plan.

Compliance with State and Federal Mandates

The Plan will provide benefits in accordance with the requirements of all applicable state and federal laws. These laws may be amended from time to time. In the event of any conflict between the provisions of the Plan and the current provisions of the law, the current provisions of the law will govern.

Other Authorities and Responsibilities

Samaritan Health Plans is not the named fiduciary, Plan Sponsor, or Plan Administrator of the Plan. Samaritan Health Plans does not have discretionary authority with regards to administration of the Plan and does not make Member Eligibility determinations.

Samaritan Health Plans may make factual determinations relating to benefits provided under the Plan. Samaritan Health Plans may delegate this discretionary authority to other persons or entities that may provide administrative services for the Plan, such as Claims processing. The identity of the service providers and the nature of their Services may be changed from time to time.

A Member cannot assign any benefit or money due under this Plan to any other person, medical Service or Supply provider, corporation, or any other organization. Any attempted assignment will be void and of no effect. For purposes of this provision, an "assignment" refers to the transfer of your rights to the benefits described in this Plan, to any other person, corporation, or other organization or entity.

Changing this Certificate

The Plan as described in this certificate explains the benefits available to you under a Group Policy contract entered into by and between Samaritan Health Plans and your Employer (the policyholder). The contract between Samaritan Health Plans and your Employer contains additional information regarding Eligibility and benefits available under the Plan. No prior inducements, either orally or in writing, are of any force or effect unless they are included in this document or the contract between Samaritan Health Plans and your Employer. Your

Employer is responsible for setting Eligibility and enrollment requirements and Samaritan Health Plans is responsible for the payment of Claims under the Plan. Please contact your Employer for additional information on the contract between Samaritan Health Plans and your Employer.

No change in this Group Policy shall be valid until approved by an executive officer of Samaritan Health Plans and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions.

Group Contract Renewal and Termination

The Group Policy governing will renew automatically from year to year unless terminated by the Employer as otherwise provided in the group contract. Samaritan Health Plans will only terminate the Group Policy in the event of nonpayment of premiums, fraud, violation of participation or contribution rules, termination of the Plan, the Employer moves outside the Service Area, or membership in an association cease. Termination of the Employer under the contract will completely end all obligations of Samaritan Health Plans to provide the Members with benefits after the date of termination (except where required by ORS 743B.341 which provides coverage for Hospital or medical Services or expenses under the provisions of a policy for those who have been hospitalized on the date of termination if the policy is terminated and immediately replaced by a group health insurance policy issued by another insurer).

If the Employer terminates the Group Policy, the Employer must provide Samaritan Health Plans with written notice of termination. Samaritan Health Plans must receive the notice at least 30 days in advance of the proposed termination date. The Employer must provide in writing whether Samaritan Health Plans is being replaced by another Group Policy. The Employer shall continue to be liable for plan premiums for all Members enrolled in plan through the end of the first full month requested and agreed upon termination date.

Rescinding Coverage

Coverage can be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the Group Policy. We will provide at least 30 days advance written notice to each covered employee who would be affected prior to rescinding coverage. Rescissions are defined as any retroactive cancellations of coverage, except for those attributable to failure to pay premiums or contributions. These requirements do not apply to prospective cancellations.

Samaritan Health Plans may not rescind the Plan unless:

(a) The Employer:
    A. Performs an act, practice or omission that constitutes fraud
    B. Makes an intentional misrepresentation of a material fact as prohibited by the terms of the Plan;

(b) Samaritan Health Plans provides at least 30 days' advance written notice, in the form and manner prescribed by the Oregon Division of Financial Regulation, to each Member who would be affected by the rescission of coverage; and
(c) Samaritan Health Plans provides notice of the rescission to the Oregon Division of Financial Regulation in the form, manner and time frame prescribed by the Oregon Division of Financial Regulation by rule.

Legal Action

No action at law or in equity shall be brought to recover on this Plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

We acknowledge that misstatements, misrepresentations, omissions, or concealments on the part of the Employer are not fraudulent unless they are made with intent to knowingly defraud. In order for Samaritan Health Plans to deny a Claim on the basis of misstatements, misrepresentations, omissions or concealments on the part of the Employer, we must show that the misinformation is material to the content of this contract, that we relied upon the misinformation and that the information was either material to the risk assumed by us or that the misinformation was provided fraudulently.

No Claim for loss incurred or disability, as defined in the certificate, commencing after two years from the date of issue of this certificate shall be reduced or denied on the ground that a Disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of the Group Policy.

Relationship to Samaritan Health Services

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

The Employer on behalf of itself and its covered employees [and their Dependents] hereby expressly acknowledges its understanding that this Plan constitutes a plan solely between the Employer group and Samaritan Health Plans. Neither Samaritan Health Plans, nor Samaritan Health Services is acting as the Plan Administrator or Plan Sponsor under ERISA. The Employer on behalf of itself and its covered Participants further acknowledges and agrees that it has not entered into this Plan based upon representations by any person or entity other than Samaritan Health Plans and that no person or entity other than Samaritan Health Plans shall be held accountable or liable to the Employer or the Members for any of our obligations to the Employer or the Members created under this Plan. This paragraph shall not create any additional obligations whatsoever on the part of Samaritan Health Plans other than those obligations created under other provisions of this Plan.

Inmates and Juveniles in Detention Centers

We will not deny reimbursement for any Service or Supply covered by the Plan or cancel the coverage of a Member under the Plan on the basis that:

- The insured is in the custody of a local supervisory authority, if the insured is in custody pending the disposition of charges
- The insured receives publicly funded medical care while in the custody of a local supervisory authority
- The care was provided to the insured by an employee or contractor of a county or a local supervisory authority, if the employee or contractor meets the credentialing criteria of the health benefit plan

Confidential Communication

A Member has the right to have protected health information sent directly to the Member instead of the person who pays for your health insurance plan. A Member can request that they be contacted:

- At a different email address
- By email
- By telephone

To make this request, submit the Oregon Request for Confidential Communication standardized form to:

Samaritan Health Plans
P.O. Box 1310
Corvallis, OR 97339

Your health plan must acknowledge the receipt of the request form and respond to your confidential communications request. If you have any questions, please refer to the Resource Guide on page 1.

Important Notices

Notice of Special Enrollment

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

Under federal law, upon the incurrence of a "special enrollment" event, you have the right to enroll [a Dependent in the group health plan, and possibly yourself,] during the middle of the year, without regard to the Plan's normal annual Open Enrollment Period rules. These special enrollment events are discussed below.

Loss of Coverage. If you are declining enrollment for yourself [or your Dependents] (including your Spouse)] because of other health insurance or group health plan coverage, you may be able to enroll yourself [and your Dependents] in this Plan if you [or your Dependents] lose Eligibility for that other coverage (or if the Employer stops contributing towards your [or your Dependents'] other coverage). However, you must request enrollment within 30 days after your [or your Dependents'] other coverage ends (or after the Employer stops contributing toward the other coverage).

[**New Dependent.** If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.]

Medicaid or CHIP coverage. If you [or your Dependents] lose coverage under either a Medicaid plan or under a state Child Health Insurance Plan (CHIP) due to a loss of Eligibility for that program's coverage, you may be able to enroll yourself [and your Dependents] in this Plan. You may also be able to enroll yourself [and your Dependents] in this Plan if you [or your Dependents] become eligible for premium assistance for this Plan through either a Medicaid plan or a state Child Health Insurance Plan (CHIP). For these two special enrollment options only, you must request enrollment within 60 days after the loss of Eligibility or becoming eligible for premium assistance, as applicable. To request special enrollment or obtain more information, please contact your Employer.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) of 1998 requires Samaritan Health Plans to notify you of your rights related to benefits provided through the Plan in connection with a Mastectomy. You as a Participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

- 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; and
- Prostheses and treatment of physical complications of the Mastectomy including lymphedema.

All stages of reconstruction are covered with a single determination of Prior Authorization.

These benefits are subject to the Plan's regular Deductible and Copays/Coinsurance. Refer to your Schedule of Benefits for details.

Protection of Genetic Information

Genetic Information about you [or your family members] may not be used or disclosed for activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, or for any other underwriting purpose.

Your Rights and Responsibilities

In accordance with Oregon law, the following Disclosure Statement includes questions and answers to fully inform you about the benefits and policies of this health insurance Plan.

Your Rights as a Member

- A right to receive information about the organization, its Services, its practitioners and providers and Member rights and responsibilities;
- A right to be treated with respect and recognition of your dignity and right to privacy;
- A right to participate with your healthcare provider in making decisions regarding your care;
- A right to a candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage;
- You have a right to the confidential protection of your medical information and records;
- A right to voice complaints or appeals about the organization or the care it provides;
- A right to make recommendations regarding the organization's Member rights and responsibilities policy; and
- You have the right to continue care from an individual provider for a limited period of time after the medical Services contract terminates.

Your Responsibilities as a Member

- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care;
- A responsibility to follow plans and instructions for care that you have agreed to with your practitioners;
- A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible;
- A responsibility for payment of Copays at the time of service and to be on time for that service; and
- A responsibility for reading and understanding all materials about your health plan benefits and for making sure that family members covered under this Plan also understand them.

How do I access care in the event of an emergency?

If you experience an emergency situation, you should obtain care from the nearest appropriate facility, or dial 911 for help.

If there is any doubt about whether you require emergency treatment, you can always call your Primary Care Provider for advice. The Primary Care Provider is able to assist you in coordinating medical care and is an excellent resource to direct you to the appropriate care since he or she is familiar with your medical history.

How will I know if my benefits change or are terminated?

Samaritan Health Plans will notify you of changes or termination of coverage 30 days prior to the effective date of change or termination. We have the right to make changes that are in the best interest of its Members and/or its independent contractors.

What happens if I am receiving care and my doctor is no longer a contracted provider?

When a Professional Provider's contract with us ends for any reason, we will give notice to those covered that we know are under the care of the provider of their rights to receive continued care (called "continuity of care"). We will send this notice no later than 10 days after the provider's termination date or 10 days after the date we learn the identity of an affected covered individual, whichever is later. The exception to our sending the notice is when the Professional Provider is part of a group of providers and we have agreed to allow the provider group to provide continuity of care notification to those covered.

When Continuity of Care Applies

If you are undergoing an active course of treatment by an In-Network Professional Provider and benefits for that provider would be denied (or paid at a level below the benefits for an Out-of-Network Provider) if the provider's In-Network contract with us is terminated or the provider is no longer participating in our In-Network provider network, we will continue to pay Plan benefits for Services and Supplies provided by the Professional Provider as long as:

- You and the Professional Provider agree that continuity of care is desirable, and you request continuity of care from us;
- The care is Medically Necessary and otherwise covered under the Plan;
- You remain eligible for benefits and covered under the Plan; and
- The Plan has not terminated.

Continuity of care does not apply if the contractual relationship between the Professional Provider and us ends in accordance with quality of care provisions of the contract between the provider and us or because the Professional Provider:

- Retires;
- Dies;
- No longer holds an active license;
- Has relocated outside of our Service Area;
- Has gone on sabbatical; or
- Is prevented from continuing to care for patients because of other circumstances.

How Long Continuity of Care Lasts

Except as follows for pregnancy care, we will provide continuity of care until the earlier of the following dates:

- The day following the date on which the active course of treatment entitling you to continuity of care is completed; or the 120th day after notification of continuity of care.

If you become eligible for continuity of care after the second trimester of pregnancy, we will provide continuity of care for that pregnancy until the earliest of the following dates:

- The 45th day after the birth;
- The day following the date on which the active course of care treatment entitling you to continuity of care is completed; or
- The 120th day after notification of continuity of care

The notification of continuity of care will be the earliest of the date we or, if applicable, the provider group notifies you of your right to continuity of care, or the date we receive or approve the request for continuity of care.

Medical Necessity of Continuing Care

If questions arise about the medical necessity of continued care for treatment or Services, the Plan can ask the attending physician to provide evidence supporting the need for this care. The Plan can discontinue payment of benefits if the medical information from your physician does not clearly indicate that continued care for treatment or Services is Medically Necessary.

Quality of Medical Care

The covered person always has the right to choose his or her own Hospital or physician. The Plan is not responsible for the quality of medical care the covered person receives. The Plan cannot be held liable for any Claims for damages connected with injuries suffered by the covered person while receiving medical Services and Supplies.

Complaint and Appeals:

If I am not satisfied with my health plan or provider what can I do to file a complaint or get outside assistance?

To voice a complaint with us, simply follow the process outlined under Member Grievances and Appeals, including, if applicable, information about filing an appeal to be reviewed by an independent physician without charge to you.

> You also have the right to file a complaint and seek assistance from the Division of Financial Regulation.
>
> **By calling** 503-947-7984 or the toll-free message line at 888-877-4894

By electronic mail at: DFR.InsuranceHelp@oregon.gov

By writing Oregon Division of Financial Regulation
Consumer Advocacy Unit at:
PO Box 14480; Salem, OR 97309-0405

Consumer Advocacy website: https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

What is your Prior Authorization and utilization review criteria?

Prior Authorization is the process we use to determine the medical necessity of a Service before it is rendered. Contact our Customer Service Department at the phone number on the back of your identification card and also review the Prior Authorization list. Many types of treatment can be available for certain conditions. The Prior Authorization process helps the provider work together with you, other providers, and us to determine the treatment that best meets your medical needs and to avoid duplication of Services.

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for you. And, Prior Authorization is your assurance that medical Services will not be denied because they are not Medically Necessary.

Utilization review is a process in which we examine Services you receive to ensure that they are Medically Necessary—with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of Medically Necessary under Definitions.

Let us know if you would like a written summary of information that we can consider in our utilization review of a particular condition or Disease. Refer to the Resource Guide on page 1 to contact our Customer Service Department.

How are important documents (such as my medical records) kept confidential?

We have a written plan to protect the confidentiality of health information. Only employees who need to know in order to do their jobs can access your personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing you coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from you or your Authorized Representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance, or peer review.

My neighbor has a question about the Plan that he has with you and doesn't speak English very well. Can you help?

Yes. Simply have your neighbor call our Customer Service Department at the number on his or her identification card. One of our representatives will coordinate the Services of an interpreter over the phone. We can help with sign language as well as spoken languages.

What additional information can I get from you upon request?

The following documents are available by calling our Customer Service Department:

- Rules related to our medication Formulary, including information on whether a particular medication is included or excluded from the Formulary and information on what medications require Prior Authorization from Samaritan Health Plans;
- Provisions for behavioral health Services, and Hospital Services, and how you can obtain the care or Services;
- A copy of our annual report on complaints and appeals;
- A description of our risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the Health Care Financing Administration;
- A description of our efforts to monitor and improve the quality of health Services;
- Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for your care; and
- Information about our Prior Authorization and utilization review procedures.

What other source can I turn to for more information about your company?

The following information regarding the health benefit plans of Samaritan Health Plans is available from the Division of Financial Regulation:

- The results of all publicly available accreditation surveys;
- A summary of our health promotion and Disease prevention activities;
- Samples of the written summaries delivered to Plan holders;
- An annual summary of Grievances and appeals;
- An annual summary of utilization review policies;
- An annual summary of quality assessment activities; and
- An annual summary of scope of network and accessibility of Services.

To obtain the mentioned information, contact the Oregon Division of Financial Regulation:

By calling 503-947-7984 or the toll-free message line at 888-877-4894

By electronic mail at DFR.InsuranceHelp@oregon.gov

By writing Oregon Division of Financial Regulation
Consumer Advocacy Unit at:

PO Box 14480
Salem, OR 97309-0405

Consumer Advocacy website https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

Definitions

Definitions pertaining to Prescription Drugs are in the Prescription Drug Benefits section of this Group Certificate.

Accident – An unforeseen or unexpected event causing Injury that requires medical attention.

Adverse Benefit Determination – The Claims Administrator's denial, reduction or termination of a health care item or service, or the failure or refusal of the Claims Administrator to provide or to make a payment in whole or in part for a health care item or service, that is based on a:

- Denial of Eligibility for or termination of enrollment in the Plan;
- Rescission or cancellation of a policy or certificate;
- Imposition of a preexisting condition exclusion, source-of injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or Services;
- Determination that a health care item or service is Experimental, Investigational or not Medically Necessary, effective or appropriate; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Allowed Amount – The maximum amount that is payable to the provider of service for Medically Necessary Covered Services. For an In-Network provider, the Allowed Amount is the amount that the provider has agreed to accept for a particular service. For an Out-of-Network Provider, the Allowed Amount is the amount that Samaritan Health Plans has determined to be the Usual, Customary and Reasonable Charge for the particular service. For questions regarding the basis for the determination of the Allowed Amount, please contact our Customer Service Department.

Ambulatory Surgical Center – A facility or that portion of a facility licensed by the state in which it is located, that operates exclusively for the purpose of providing surgical Services to patients who do not require Hospitalization and for whom the expected duration of Services does not exceed 24 hours following admission.

Authorized Representative – An individual who by law or by the consent of a person can act on behalf of the person. The authorization must be made by the completion of an Authorized Representative form that is available online. Refer to Resource Guide on page 1.

Authorized Services – Services or Supplies that have been approved by the Claims Administrator.

Behavioral Health Assessment – An evaluation by a Behavioral Health Clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

Behavioral Health Clinician – Includes the following types of providers:

- Licensed psychiatrist;

- Licensed psychologist;
- Certified nurse practitioner with a specialty in psychiatric Mental Health;
- Licensed clinical social worker;
- Licensed professional counselor or licensed marriage and family therapist;
- Certified clinical social work associate;
- Intern or resident who is working under a board-approved supervisory contract in a clinical Mental Health field; and
- Any other clinician whose authorized scope of practice includes Mental Health diagnosis and treatment.

Behavioral Health Crisis – A disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a Hospital to prevent a serious deterioration in the individual's mental or physical health.

Benefit Year – The Benefit Year for coverage under this Group Certificate begins on the Effective Date of coverage set forth in the front of this Group Certificate, and on each anniversary of that Effective Date.

Calendar Year – The 12-month period starting on each January 1st and ending on December 31st of the same year.

Claim – A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider in accordance with the terms of the Plan for items or Services you think are covered.

Claims Administrator – Samaritan Health Plans serves as the Claims Administrator with respect to Claims made under this Plan.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA is a Federal law that provides rights to temporary continuation of group health plan coverage for certain employees, retirees, and family members at group rates when coverage is lost due to certain qualifying events.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the Allowed Amount for the service. You generally pay Coinsurance plus any Deductibles you owe. For example, if the Plan's Allowed Amount for an office visit is $100 and you've met your Deductible, your Coinsurance of 20% would be $20. The Plan pays the rest of the Allowed Amount. Coinsurance is not applied toward the Deductible.

Complications of Pregnancy – Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus.

Coordination of Benefits (COB) – A method for determining the amount that each plan should pay, when a covered person is covered under two or more health care plans. It determines

which plan is primary, and which plan is secondary, thus "coordinating" benefits between the two plans.

Copayment (Copay) – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health service. A Copayment, or Copay, is a flat fee in place of or before the application of Coinsurance. Copayments are not applied toward the Deductible. You are responsible for payment of Copays at the time of service.

Cosmetic – Services and Supplies that are applied to normal structures of the body primarily for the purposes of improving or changing appearance or enhancing self-esteem without improving function.

Cost Share – Your share of costs for Services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost shares are Copayments, Deductibles, and Coinsurance. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan does not cover, usually are not considered cost shares.

Covered Services – A Service or Supply that is specifically described as a benefit of this Plan and which otherwise meets all provisions or requirements for coverage.

Custodial Care – Non-medical care that helps individuals with his or her activities of daily living, preparation of special diets and self-administration of medication not requiring constant attention of medical personnel.

Deductible – The portion of the cost of Covered Services you are obligated to pay before the Plan will provide payment for benefits that are subject to the Deductible. Both the Deductible and Out-of-Pocket Maximum are accumulated on a Calendar Year basis. When applying any Deductibles or Out-of-Pocket Maximums of the prior plan, we will credit any applicable Deductibles and Out-of-Pocket Maximums incurred by you. This means the Deductible and Out-of-Pocket Maximum credit shall be given only to the extent the expenses are recognized under the terms of this Plan and are subject to a similar Deductible or Out-of-Pocket Maximum. Please contact your Plan Administrator for complete details.

DRAFTER'S NOTE: Will not populate for employee only coverage. Will populate for employee/Dependent and employee/child only coverage.

[Dependent – Any individual who is or may become eligible for coverage under the terms of the Plan because of a relationship to a covered employee.]

Disease – An Illness or sickness characterized by specific signs and symptoms which negatively affects the structure or function of an individual.

Durable Medical Equipment (DME) – An item that can withstand repeated use, primarily used to serve a medical purpose, generally not useful to a person in the absence of Illness and/or

Injury and is appropriate for use in your home. Examples include oxygen equipment and wheelchairs.

Eligibility – The requirements that you must meet in order to qualify for and remain enrolled in the Plan. See "Eligibility and Enrollment" for more information.

Eligible Employee – An employee of the Employer that has satisfied the Eligibility requirements established by the Employer. The Eligibility requirements must in all cases meet the following standards:

- The work hours requirement that are set by your Employer, but cannot be less than the minimum required by law and a single, uniform requirement must apply to all employees of the Employer; and
- A Waiting Period requirement cannot exceed 90 days and a single, uniform requirement must apply to all employees of the Employer.

An Eligible Employee does not include an employee who works on a temporary, seasonal, or substitute basis.

Eligible Expense or Charge – The Usual, Customary, or Reasonable Charge assessed on an itemized bill, for Medically Necessary medical treatment as provided by this Plan.

Emergency Medical Condition or Medical Emergency – A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or unborn child in the case of a pregnant woman, in serious jeopardy; result in serious impairment to bodily functions; result in serious dysfunction of any bodily organ or part; with respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another Hospital before delivery or for which a transfer can pose a threat to the health or safety of the woman or the unborn child; or is a Behavioral Health Crisis.

Emergency Medical Screening Exam – The medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Emergency Medical Transportation – Ambulance Services for an Emergency Medical Condition. Types of Emergency Medical Transportation may include transportation by air, land, or sea. The Plan may not cover all types of Emergency Medical Transportation or may pay less for certain types.

Emergency Room Care – Services to check for an Emergency Medical Condition and treat you to keep an Emergency Medical Condition from getting worse. These Services may be provided in a licensed Hospital's emergency room or other place that provides care for Emergency Medical Conditions.

Emergency Services – With respect to a Medical Emergency Condition, an Emergency Medical Screening Exam or Behavioral Health Assessment that is within the capability of the emergency department of a Hospital, including ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Conditions. It further includes medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a Hospital. Emergency Services are covered without Prior Authorization.

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

Employer – The Employer that has entered into a Group Policy with Samaritan Health Plans for the benefit of its Eligible Employees [and their Dependents] (which is the "sponsoring Employer"). Where the context so implies, an "Employer" also includes a member of a controlled group of companies within the meaning of IRC § 414(b), (c) or (m) that includes the sponsoring Employer, and which the sponsoring Employer has extended participation in the Plan.

Essential Health Benefits (EHB) – Essential Health Benefits (EHB) must include items and Services within at least the following 10 categories: ambulatory patient services; Emergency Services; Hospitalization; pregnancy, maternity, and newborn care; Mental Health and Substance Use Disorder Services, including behavioral health treatment; Prescription Drugs; Rehabilitative and Habilitative Services and devices; laboratory Services; preventive and wellness Services and chronic disease management; and pediatric Services, including oral and vision care. The Plan covers all required Essential Health Benefits. There are no annual or lifetime dollar limits imposed on these benefits.

Experimental and/or Investigational – A Service, Supply, or drug that Samaritan Health Plans has classified as Experimental and/or Investigational for purposes of diagnosing or treating an Illness, Injury or Disease. In order to determine whether a Service, Supply, or drug is Experimental and/or Investigational, Samaritan Health Plans will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, or other appropriate publications, and information obtained from the treating provider. Among other factors, Samaritan Health Plans will consider the following in reaching a determination as to whether a Service, Supply, or drug is Experimental and/or Investigational:

- If a drug or device, the health intervention must have final approval from the United States Food and Drug Administration (FDA) as being safe and efficacious for general marketing. However, if a drug is prescribed for other than its FDA-approved use and is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a drug must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant peer-reviewed medical literature or by the United States Secretary of Health and Human Services.

- The scientific evidence must permit conclusions concerning the effect of the Service, Supply, or drug on health outcomes, which include the disease process, Injury or Illness, length of life, ability to function, and quality of life.
- The Service, Supply, or drug must improve net health outcome.
- The scientific evidence must show that the Service, Supply, or drug is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

When Samaritan Health Plans receives a request for Prior Authorization that includes all information necessary to make a decision, you will be informed within two business days if the Service, Supply, or drug is considered Experimental or Investigational. To determine the necessary documentation, contact our Customer Service Department.

Gender Dysphoria – An individual's internal sense of being a gender different from the gender assigned to the individual at birth, a transgender person or neither male or female. The Plan does not discriminate against Members on the basis that a treatment is for Gender Dysphoria issues.

Genetic Information – Information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Grievance – A communication from a Member or Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to appeal or review, that is:

- In writing, for internal appeal or an external review; or
- In writing or orally, for an expedited response or an expedited external review; or

A written complaint submitted by a Member or Authorized Representative regarding the:

- Availability, delivery or quality of health care service;
- Claims payment, handling or reimbursement for health care Services and, unless the Member has not submitted a request for an internal appeal, the complaint is not disputing an Adverse Benefit Determination; or
- Matters pertaining to the contractual relationship between a Member, Employer, and Samaritan Health Plans.

Group Certificate – This certificate, which sets forth the terms and conditions of the benefits that Samaritan Health Plans has contracted to provide to eligible Members. The Group Certificate serves as the Services provided by Samaritan Health Plans and responsibilities between Samaritan Health Plans and the Employer, and when benefit coverage is distributed to a Member, as the "Member Certificate".

Group Policy – This Group Certificate, the Group's Contract Application (which is incorporated herein by reference), and any amendments, exhibits, supplements, addenda, attachments, endorsements, applications, vision plans, health statements or riders, and any information incorporated or submitted as part of the Application for this Group Policy.

Habilitative Services – Health care Services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These Services may include physical and occupational therapy, Speech Therapy and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Home Health Care – Services and Supplies that a licensed home health agency provides to a homebound patient. Health care Services and Supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home Health Care usually doesn't include help with non-medical tasks (Custodial Care), such as cooking, cleaning, or driving.

Hospice – Services to provide comfort and support for persons in the last stages of a terminal Illness and their families.

Hospital – A facility that provides diagnostic and treatment Services for inpatient surgical and medical care of persons who are injured or ill. It must be licensed under applicable laws as a general Hospital. Its Services must be under the supervision of a staff of physicians and must include 24-hour-a-day nursing services by registered nurses. Facilities that are primarily for rest, the aged or convalescence are not considered Hospitals, and neither are facilities operated by the state or federal government.

Hospitalization – Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient – Care in a Hospital that usually does not require an overnight stay.

Illness – A physical or mental condition or ailment. Physical illness is a disease or bodily disorder; mental illness is a psychological disorder characterized by pain or distress and substantial impairment of basic functioning.

In-Network – A provider or facility who has a contract with Samaritan Health Plans and who has agreed to provide Services to Members of a plan. You generally will have a reduced out-of-pocket expense if you see a provider in the network.

In-Network Coinsurance – The percent (for example, 30%) you pay of the Allowed Amount for covered health care Services provided by an In-Network provider. In-Network Coinsurance usually is less than Out-of-Network Coinsurance. Refer to your Schedule of Benefits for Cost Share information.

In-Network Copayment (Copay) – A fixed amount (for example, $35) you pay for covered health care Services provided by an In-Network provider. In-Network Copayments usually are

less than Out-of-Network Copayments. Refer to your Schedule of Benefits for Cost Share information.

Incur – The expense of a Service is applied on the day the Service is rendered, and the expense of a Supply is applied on the day the covered person receives it.

Injury – Personal bodily harm or damage caused directly and independently of all other causes by external, violent, and/or accidental means.

Intensive Outpatient Services – Services targeted to individuals who require more intensive Services than outpatient counseling Services. These Services are provided in a concentrated manner and generally involve multiple outpatient visits per week, over a period of time. They include both individual and group therapy, for individuals requiring stabilization.

Mastectomy – The surgical removal of all or part of the breast or a breast tumor suspected to be malignant. Refer to the Reconstructive Services/Surgery benefit for more information.

The Women's Health and Cancer Rights Act (WHCRA) requires that Samaritan Health Plans cover Services that support rehabilitation and reconstruction in the instance that a Member receives these Services due to cancer and related treatment.

Maxillofacial Prosthetic Services – Services to restore and manage head and facial structures that cannot be replaced with living tissue.

Medical Supplies – Items of a disposable nature that may be essential to effectively carry out the care a physician has ordered for the treatment or diagnosis of an Illness, Injury, or Disease.

Medically Necessary – Healthcare Services or Supplies that a Professional Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating an Illness, Injury, Disease, or its symptoms, are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate or medically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury, or Disease;
- Not primarily for the convenience of the patient, physician, or other healthcare 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;
- In Samaritan Health Plan's determination as based on available information and documentation, and in accordance with the terms of the Plan; and
- The least costly of the alternative Supplies or levels of Service which can be safely provided to the patient. This means, for example, that care rendered in a Hospital inpatient setting is not Medically Necessary if it could have been provided in a less expensive setting, such as a Skilled Nursing Facility or by a nurse in the patient's home, without harm to the patient.

Services and Supplies intended to diagnose or screen for a medical condition are not considered Medically Necessary in the absence of signs or symptoms of the condition, or abnormalities on prior testing. Medically Necessary care does not include Custodial Care.

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.

The fact that a physician can prescribe, order, recommend, or approve a Service or Supply does not, of itself, make the Service or Supply Medically Necessary or covered under the Plan.

Samaritan Health Plans reserves the right to review or otherwise deny Services that are not found to be Medically Necessary.

Member – An Eligible Employee, Dependent of the Eligible Employee or an individual otherwise eligible for coverage and who has enrolled for coverage under the terms of this Plan and under procedures established by your Employer. A Member may sometimes be referred to as an "enrollee".

Mental Health – All disorders defined in the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)". This definition includes the terms 'mental disorder' and 'mental illness'.

Mental Health Parity Protections – In general, limits applied to Mental Health and Substance Use Disorder Services cannot be more restrictive than limits applied to medical and surgical Services. The kinds of limits covered by the parity protections include:

- Financial (e.g. Deductibles, Copayments, Coinsurance, and Out-of-Pocket Limits)
- Treatment (e.g. limits to the number of days or visits covered or Prior Authorization requirements)

Mental Health and Substance Use Disorder: Eligible Providers – Samaritan Health Plans has contracted with a full panel of outpatient and inpatient Mental Health and Substance Use Disorder providers, as well as those Professional Providers defined in this section. Refer to the Provider Directory for a list of In-Network providers or contact our Customer Service Department for further information.

DRAFTERS NOTE: Language will populate for employee/Dependent and employee/child only coverage.

Open Enrollment Period – The time each year during which Eligible Employees may change elections regarding coverage [and add eligible Dependents who may not have been previously enrolled].

Out-of-Network Coinsurance – The percent (for example, 70%) you pay of the Allowed Amount for covered health care Services to providers who are not In-Network providers. Out-of-Network Coinsurance usually costs you more than In-Network Coinsurance.

Out-of-Network Copayment (Copay) – A fixed amount (for example, $40) you pay for covered health care Services from providers who are not In-Network providers. Out-of-Network Copayments usually are more than In-Network Copayments.

Out-of-Network Providers – Hospitals, physicians, providers, professionals and facilities that have not contracted with Samaritan Health Plans to provide benefits to persons covered under this Plan (sometimes referred to as non-participating providers). You will usually pay more to see an Out-of-Network Provider than an In-Network provider.

Out-of-Network Providers will be reimbursed at the allowable fee for the Service provided.

Out-of-Pocket Limit (Maximum) – The maximum amount you must pay for Essential Health Benefits and non-essential health benefits (for example, for Deductibles, Coinsurance and Copays) during a Calendar Year before the plan begins to pay 100% of the Allowed Amount. This limit never includes your premium, balance-billed charges or health care your Plan doesn't cover. The Out-of-Pocket Limit for a Calendar Year will not exceed the annual cost sharing limit for such year as established by the Internal Revenue Service (IRS). The Out-of-Pocket Limit is accumulated on a Calendar Year. Refer to your Schedule of Benefits for more information on which expenses do not count towards this limit.

Participant – An employee, or a former employee (such as an employee receiving COBRA continuation coverage) who is enrolled in the Plan.

Pervasive Developmental Disorder – A neurological condition that includes Asperger's syndrome, autism, developmental delay, or developmental disability. This does not include educational delays in mathematics, reading, or any school development if provided through other means, such as in a school setting.

Plan – This Plan of benefits established and maintained by the Employer, the benefits of which are provided under the Group Policy.

Preventive Care (Services) – Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover Illness, Disease, or other health problems. See the Preventive Care section of this Group Certificate.

Primary Care Provider (PCP) – Can include, and is not limited to, a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), pediatric physician, naturopathic physician, family medicine, OB-GYN physician, internal medicine, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care Services for the indicated specialties within the scope of their care.

Prior Authorization – A decision by Samaritan Health Plans that a health care Service, treatment plan, Prescription Drug or DME is Medically Necessary. Samaritan Health Plans can require Prior Authorization for certain Services before you receive them, except in an emergency. See the Prior Authorization section of this Group Certificate.

Professional Provider – Can include, and is not limited to, any of the following for Medically Necessary Services which are provided within the scope of the Professional Provider's state license or registry:

- Acupuncturist, massage therapist, chiropractor
- Certified nurse practitioner
- Clinical social worker and counselors
- Dentist (Doctor of Medical Dentistry, Doctor of Dental Surgery, or denturist) and expanded practice dental hygienist
- Naturopathic Doctor or Physician
- Optometrist
- Pediatrician
- Pharmacist
- Physician (Doctor of Medicine or Osteopathy)
- Physician Assistant (to be paid as if submitted by the supervising physician)
- Podiatrist
- Professional Counselor or Marriage and Family Therapist
- Psychologist
- Registered Nurse or Licensed Practical Nurse, but only for those Services for which nurses customarily bill a patient
- Registered Physical, Occupational, Speech, or Audiological Therapist
- Women's healthcare provider

Samaritan Health Plans does not discriminate against Professional Providers acting within the scope of their own licensure or certification.

Professional Services – Services of a professional medical provider for medically appropriate diagnosis or treatment of Illness or Injury, and for Preventive Care Services.

Prosthetics and Orthotics – Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a Mastectomy. These Services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

DRAFTERS NOTE: Language will populate for employee/Dependent coverage.

[**Qualified Domestic Partner** – Either a "statutory domestic partner" or a "non-statutory domestic partner."

- A "statutory domestic partner" is a person of the same sex as the employee who, with the employee, has been issued a Certificate of Registered Domestic Partnership by the Clerk of an Oregon County described in ORS 106.320 or who has otherwise entered into a legally-recognized civil contract in regard to such domestic partnership.
- A "non-statutory domestic partner" is a person of either the same sex or opposite sex as the employee who is not a statutory domestic partner, but who lives with an employee in a long-term, committed relationship. The Employer may, but is not required to, offer coverage under the Plan to non-statutory domestic partners. In addition, it may offer coverage to same sex domestic partners without offering coverage to opposite sex domestic partners, or vice versa.

The same rights and benefits provided to Spouses under the Plan will be provided on the same terms to covered domestic partners. Your Employer, and not Samaritan, will establish the conditions and procedures for determining whether a person qualifies as a domestic partner who is eligible for coverage.]

Reconstructive – Services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, Disease, or for treatment of Gender Dysphoria. It is generally performed to improve function but can also be done to approximate a normal appearance. Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, Accidents, Injuries, or medical conditions.

Rehabilitative/Rehabilitation Services – Health care Services that help a person re-obtain, get back or improve skill and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These Services may include physical and occupational therapy, speech-language pathology, and psychiatric Rehabilitation Services in a variety of inpatient and/or outpatient settings.

Residential/Partial Hospitalization/Day Care – Care in a Residential facility, Hospital or other facility which provides an organized full-day or part-day program of treatment and is licensed or approved for the particular level of care for which reimbursement is being sought.

Self-Injectable Drugs (Medications) – Outpatient injectable Prescription Drugs intended for self-administration and approved by us for self-injection.

Services – Health care diagnosis, treatments, procedures, equipment, medications, or devices. Services include Supplies to support a Service.

Service Area – The state of Oregon. A group entity must be physically located in the state of Oregon in order to qualify as an Employer and recipient of the Group Policy. In-Network

providers are located within and outside the state of Oregon. Refer to 'Service Area and Provider Network' section for more information.

Skilled Nursing Facility (SNF) – An institution primarily engaged in providing skilled nursing care or restorative Services for the treatment of injured, disabled or sick persons and is not, except incidentally, a place for the aged or those suffering from Substance Use Disorder. Nor is it an institution providing primarily Custodial Care. The facility must provide 24-hour-a-day nursing Services supervised by registered nurses.

Specialist or Specialty Care – A physician Specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician Specialist is a provider who has more training in a specific area of health care.

Specialist Provider – Services provided by any provider who is not defined under the definition of Primary Care Provider (PCP).

Speech Therapy – Therapeutic treatment of impairments and disorders of speech, voice, language, communication, and swallowing.

DRAFTERS NOTE: Language will populate for employee/Dependent coverage.

[Spouse – The person to whom you are legally married.]

Substance Use Disorder – A substance-related disorder (including alcoholism), as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, (DSM-5), except for those related to foods, tobacco or tobacco products.

Supplies – Consumable goods to support health care Services.

Tobacco Use – The use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that Tobacco Use does not include religious or ceremonial use of tobacco.

Transplant – A procedure or a series of procedures by which an organ or tissue is either: removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient) or removed from and replaced in the same person's body (called a self-donor). In treatment of cancer, the term Transplant includes any chemotherapy and related course of treatment, which supports the Transplant.

Urgent Care Services – Care for an Illness, Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.

USERRA – The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all regulations promulgated thereto.

Usual, Customary and Reasonable (UCR) Charge(s) – Part of the basis upon which this Plan pays an Out-of-Network Provider for Covered Services, which takes into consideration fees that the health care provider most frequently charges the majority of patients for the Service or Supply. The cost to the health care provider for providing the Services, the prevailing range of fees charged in the same geographical locale or area by health care providers of similar training and experience for the Service or Supply, and the Medicare reimbursement rates. The term "same geographic locale" and/or "area" is defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of health care providers, persons or organizations rendering such treatment, Services, or Supplies for which a specific charge is made. To be "Usual and Customary", fees 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.

Usual, Customary and Reasonable Charges may alternatively be determined and established by Samaritan Health Plans 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.

Waiting Period – The period of employment or membership with the Employer or a group that an Eligible Employee must complete before becoming eligible for coverage under the Plan, as established by the Employer. The Waiting Period may not exceed 90 days.

Pharmacy Definitions

Brand Name Drugs (Medication) – A drug marketed under a proprietary, trademark-protected name.

Closed Formulary – A method used to provide Prescription Drug benefits in which only specified FDA-approved Prescription Drug products are covered, as determined by the insurer, but in which medical exceptions are allowed. Maximum benefits or coverage can be limited to Formulary drugs in a health benefit plan with a Closed Formulary.

Compound Drug (Medication) – Two or more drugs that a Pharmacist mixes together. In order to be covered, Compound Drugs must contain, in therapeutic amount, either one federal legend drug or one state restricted drug. Cost Share amounts are assessed on each covered Prescription Drug benefit.

Formulary – A list of drugs your Plan covers. A Formulary may include how much your share of the cost is for each drug. Your Plan may put drugs in different cost sharing levels or tiers. For example, a Formulary may include Generic Drug and Brand Name Drug tiers and different cost sharing amounts will apply to each tier.

The drugs listed in the Formulary are subject to change. The presence of a drug in the Formulary does not guarantee that you will be prescribed that drug by your Primary Care Physician or Professional Provider for a particular medical condition. Drugs can be subject to Prior Authorization. As new Generic Drugs become available, the corresponding Brand Name Drug will no longer be considered a preferred agent.

Generic Drug (Medication) – An equivalent of a Brand Name Drug, with the same ingredients, safety profile and method of administration.

Multi-Source Brand Coverage – When a Generic Drug is available, but the Pharmacy dispenses the Brand Name Drug for any reason, the Member pays the difference between the Brand Name Drug and the Generic Drug plus the Brand Name Drug Cost Share Dispense As Written (DAW) penalty.

Pharmacist – An individual licensed to dispense Prescription Drugs and who must act within the scope of a valid license for benefits to be payable.

Pharmacy – Any licensed outlet in which Prescription Drugs are regularly dispensed and/or compounded. When you enroll in the Plan, you will automatically have Prescription Drug Coverage. To take advantage of the Prescription Drug Coverage, you must fill your prescription at an In-Network Pharmacy.

Prescription Drug Coverage – Coverage under a plan that helps pay for Prescription Drugs. If the plan's Formulary uses "tiers" (levels), Prescription Drugs are grouped together by type or

cost. The amount you'll pay in cost sharing will be different for each "tier" of covered Prescription Drugs.

Prescription Drugs (Medications) – Drugs and biologicals that by law require a prescription. These drugs must bear the legend: "RX ONLY" or "Caution-Federal law prohibits dispensing without a prescription;" or which are specifically designated by Samaritan Health Plans. Coverage of Prescription Drugs will be based on medical necessity, the provisions of this Plan and where required by law.

Prescription Medication Exception – You may ask us to make a medication exception to our coverage rules. This includes exceptions for:

- Coverage of your drug even if it is not on the Formulary;
- Waiving coverage restrictions or limits on your drug; and
- Providing a higher level of coverage for your drug.

Please note, if we grant your request to cover a drug that is not on our Formulary, we will not provide a higher level of benefit for that drug than you would be entitled to had you chosen a medication on the Formulary. Exception approvals for standard non-formulary medications will process at the highest non-specialty Copay. Exception approvals for non-formulary specialty drugs will process at the highest specialty Copay.

We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. Generally, we will only approve your request for an exception if the alternative drugs included on the Plan's Formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your medication exception request.

If we approve your medication exception request, the approval time will be made on a case-by-case basis. We will continue to pay for the drug for the duration of the approval time, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your medication exception request, you can appeal our decision.

Prescription Order – A written or verbal request for Prescription Drugs issued by a professional licensed provider.

Prescription Out-of-Pocket Maximum – The maximum out-of-pocket cost on prescriptions for your Plan, can be found in your Schedule of Benefits.

DRAFTERS NOTE: Language will populate for employee/Dependent or employee/child coverage.

Prescription Urgent and Emergent Drugs – Prescriptions purchased at other locations in urgent and emergent situations are covered. If you utilize a non-participating Pharmacy during an

urgent or emergent situation, this Plan will cover Prescription Drugs received from that Pharmacy. You [or Dependents] must first pay the total cost of the prescription out-of-pocket and then submit the receipt and completed Prescription Reimbursement form to the pharmacy Claims Administrator for payment. Each Claim is reviewed and evaluated to determine whether it qualifies for reimbursement based upon emergent-based usage. You will either be reimbursed or notified if the Claim does not meet emergent-based usage. Forms for submitting these Claims are available online at samhealthplans.org.

Prior Authorization – The Plan requires that you or your physician get Prior Authorization from Samaritan Health Plans for certain drugs. This means that you will need to get approval from us before we will pay for your prescriptions.

Quantity Limits – Certain drugs have Quantity Limits, where the Plan will not pay for quantities above the FDA-approved maximum dosing without an approved Prescription Medication Exception.

Self-Injectable Drugs (Medications) – Outpatient injectable Prescription Drugs intended for self-administration and approved by us for self-injection.

Step Therapy – In some cases, the Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

Synchronization – Samaritan Health Plans allows early re-fills for Members when they would like to fill and synchronize all of their drugs at one time. This courtesy has some limitations. Please call our Customer Service Department for more information.