Samaritan Health Plans

Samaritan Momentum

2017 Endorsement Changes

Effective Nov. 1, 2017

Section and Page	2017 Member Certificate	2017 Endorsement	Summary of Change
Definitions page 1	**Benefit year** – The benefit year for a group's coverage is based on when an employer group signs an employer group contract.	**Benefit year** – The benefit year for a group's coverage is based on the effective date listed in the employer group contract.	Updated language.
Definitions page 2	**Eligibility** – The requirements that you must meet in order to qualify for and remain in your plan option and is not based on Medicaid.	**Eligibility** – The requirements that you must meet in order to qualify for and remain enrolled in the Plan. See 'Your eligibility' on page 17 for more information.	Updated language.
Definitions page 3	**Essential Health Benefits (EHB)** – A set of health care service categories that must be covered by certain plans, starting in 2014. Essential Health Benefits (EHB) must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; 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. Samaritan Health Plans meets these requirements as described in this document. There are no dollar limits set on these benefits.		Removed language as EHBs do not apply to Large Groups.
Definitions page 3	**Experimental and Investigational** – means a service, supply, or drug that the plan has classified as investigational. Samaritan will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating provider regarding the service, supply, or drug to determine if it is investigational. A service, supply, or drug not meeting all of the following criteria is, in Samaritan's judgment, investigational: • If a medication or device, the health intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication 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 medication 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	**Experimental and Investigational** – Means a service, supply, or drug that the plan has classified as investigational. Samaritan will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating provider regarding the service, supply, or drug to determine if it is investigational. A service, supply, or drug not meeting all of the following criteria is, in Samaritan's judgment, investigational: • If a medication or device, the health intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication 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 medication 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	Corrected authorization timeframe.

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	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 receives a claim or request for preauthorization that includes all information necessary to make a decision, you will be informed within 20 business days if the service, supply, or drug is considered experimental or investigational. To determine the necessary documentation, call Member Services Department at (541) 768-4550, toll free1-800-832-4580 or TTY 1-800-735-2900	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 receives a claim or request for preauthorization that includes all information necessary to make a decision, you will be informed within 2 business days if the service, supply, or drug is considered experimental or investigational. To determine the necessary documentation, call Member Services Department at (541) 768-4550, toll free1-800-832-4580 or TTY 1-800-735-2900.	
Definitions page 3	**Grievance** – A verbal or written complaint submitted by or on behalf of an enrollee regarding • Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the plan through a prior authorization • Claims payment, handling or reimbursement for health care services; or • Matters pertaining to the contractual relationship between a member and Samaritan	**Grievance** – A verbal or written complaint submitted by or on behalf of an enrollee regarding • Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the plan through a prior authorization • Claims payment, handling or reimbursement for health care services • Matters pertaining to the contractual relationship between a member, the employer group, or Plan Sponsor, and Samaritan Health Plans	Updated language.
Definitions page 5	**Maximum out-of-pocket** – The maximum amount you will incur in a Benefit year before the plan begins paying at 100% for eligible medical costs.	**Maximum out-of-pocket** – The maximum amount you will incur in a calendar year before the plan begins paying at 100% for eligible medical costs.	Updated language from 'benefit year' to 'calendar year'.
Definitions page 5	**Medically necessary** – Health care services or supplies that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are: • in accordance with generally accepted standards of medical practice; • clinically or medically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and • not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.	**Medically necessary** – Health care services or supplies that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, are: • In accordance with generally accepted standards of medical practice • Clinically 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 health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease	Added language.

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	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.	• In Samaritan's determination as based on available information and documentation, and in accordance with the terms of the Plan 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.	
Definitions page 6	**Out-of-pocket limit** – The most you pay during a benefit plan year before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes our premium, balance billed charges or services your health insurance or plan doesn't cover. Some health insurance or plans do not count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses towards this limit. Both the deductible and out of pocket max (OOP max) are accumulated on a calendar year.	**Out-of-pocket limit** – The most you pay during a calendar year before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes our premium, balance billed charges or services your health insurance or plan doesn't cover. Some health insurance or plans do not count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses towards this limit. Both the deductible and out of pocket max (OOP max) are accumulated on a calendar year.	Updated language from 'benefit year' to 'calendar year'.
Definitions page 6	**Plan term** – The group plan becomes effective at 12:01 a.m. on the date written in the Summary of Benefits and Coverage, 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 as described below.	**Plan term** – The group plan becomes effective at 12:01 a.m. on the date written in the member certificate, 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.	Updated language.
Definitions page 6		**Plan Sponsor** – A designated party, usually a company or employer, that sets up a healthcare plan for the benefit of the organization's employees.	Added definition.
Definitions page 6	**Premium** – The amount that must be paid for your health insurance or plan. You and/or your employer pay a portion every pay-period. Premiums do not accumulate towards your out-of-pocket maximums or deductibles.	**Premium** – The amount that must be paid for your health insurance or plan. You and/or your employer pay a portion every month. Premiums do not accumulate towards your out-of-pocket maximums or deductibles.	Updated language.
Definitions page 7	**Professional provider** – Licensed or Registered Medical Providers that provide Medically Necessary covered services within the scope of their license or registry.	**Professional provider** – Licensed or Registered Medical Providers that provide medically necessary covered services within the scope of their license or	Removed language from last paragraph.

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	Professional provider can mean, and is not limited to mean, any of the following, for medically necessary services, which are within the scope of the professional provider's state license or registry: • Acupuncturist, massage therapist, chiropractor, naturopath within the scope of their practice. • A physician (doctor of medicine or osteopathy); • podiatrist; • dentist (doctor of medical dentistry, doctor of dental surgery, dental hygienist with expanded practice or denturist); • pharmacist; • psychologist; • optometrist • Oregon-registered clinical social worker and counselors; including and when acting within the scope of their practice, professional counselors, marriage and family therapists licensed under ORS 675.715 to 675.835. • certified nurse practitioner; • registered nurse or licensed practical nurse, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill a patient; • physician assistant (to be paid as if submitted by the supervising physician); or • Registered physical, occupational, speech, or Audiological therapist. • Women's health care provider or pediatrician For certain providers, coverage can exist under the **Dental Benefits** or **Vision Benefits** of the plan. Samaritan Health Plans does not discriminate against providers acting within the scope of their own licensure or certification.	registry. Professional provider can mean, and is not limited to mean, any of the following, for medically necessary services, which are within the scope of the professional provider's state license or registry: • Acupuncturist, massage therapist, chiropractor, naturopath within the scope of their practice • A physician (doctor of medicine or osteopathy) • Podiatrist • Dentist (doctor of medical dentistry, doctor of dental surgery, dental hygienist with expanded practice or denturist) • Pharmacist • Psychologist • Optometrist • Oregon-registered clinical social worker and counselors; including and when acting within the scope of their practice, professional counselors, marriage and family therapists licensed under ORS 675.715 to 675.835 • Certified nurse practitioner • Registered nurse or licensed practical nurse, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill a patient • Physician assistant (to be paid as if submitted by the supervising physician) • Registered physical, occupational, speech, or Audiological therapist • Women's health care provider or pediatrician Samaritan Health Plans does not discriminate against providers acting within the scope of their own licensure or certification.	
Definitions page 8	**Service area** – Samaritan Momentum Plan options are available statewide.	**Service area** – Samaritan Momentum Plan options are available for purchase statewide in the State of Oregon for Oregon domiciled businesses.	Updated language.
Definitions page 8	**Usual, Customary and Reasonable (UCR) charges** – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount. Samaritan Health Plans members can be responsible for UCR charges if services are provided by out-of-network	**Usual, Customary and Reasonable charges (UCR)** – Part of the definition of Covered Charge and, therefore, part of the basis upon which this Plan pays for Covered Services, taking into consideration fee(s) which 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	Updated definition.

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	providers.	same "area" by Health Care Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be 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", fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. The term "usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred. The term "customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age, and who receive such services or supplies within the same geographic locale. Usual and Customary Rates may alternatively be determined and established by the Plan using normative data including Medicare cost-to-charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.	
Definitions page 8	**Waiting period** – Group eligibility waiting period means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins. Waiting periods, defined by 45 CFR § 147.116, may not have exceed 90 days.	**Waiting period** – Group eligibility waiting period means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins. Waiting periods, defined by 45 CFR § 147.116, may not exceed 90 days.	Updated language for readability.
Definitions page 8	**When coverage begins** – • The first of the month after we have received your completed enrollment materials from the Employer, • From birth or placement for adoption, in the case of a newborn or adoptee enrolled in accordance with the requirements of the Plan. **When coverage ends – is when you have:** • Not paid your premiums. • Moved out of state.	**When coverage begins** – • The first of the month after we have received your completed enrollment materials from the Plan Sponsor, after any applicable waiting periods • In the case of a 90 day waiting period, the 91st day • From birth or placement for adoption, in the case of a newborn or adoptee enrolled in accordance with the requirements of the Plan. **When coverage ends is when you have:**	Updated language.

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	• Your employer group has taken residence out of our service area. • Otherwise fail to satisfy the eligibility requirements of Samaritan Health Plans and your employer.	• Not paid your premiums. • Your employer group has taken residence out of state. • Otherwise fail to satisfy the eligibility requirements of Samaritan Health Plans and your Plan Sponsor.	
General Provisions Eligibility and enrollment page 10	**Eligibility criteria** Eligibility and enrollment are determined and processed through your employer. You will need to contact your employer to determine whether or not you meet the eligibility criteria to be enrolled on to this plan. Samaritan Health Plans 2300 NW Walnut Boulevard Corvallis, OR 97330 (541) 768-4550 1-800-832-4580; TTY 1-800-735-2900 **Disenrollment** Your employer determines enrollment and disenrollment of participants and is responsible for notifying you of your disenrollment. You may be disenrolled from Samaritan Health Plans for various reasons such as: • You might move outside of the service area of the health plan. If you move outside of the service area of the health plan, you must contact your employer • Your personal situation may change and you may no longer be eligible for this program. • You did not pay your premium on time and are no longer eligible for the Plan. If this is the case you have a 10 day grace period to pay your premium. • Once you have been disenrolled from Samaritan Health Plans, you will receive a notification of your rights, continuation options and your termination notice within 10 days of termination by Samaritan Health Plans. • You die. Termination of coverage will be your date of death, in which case any premiums will be retroactively adjusted and refunded.	**Eligibility criteria** Eligibility and enrollment are determined and processed through your Plan Sponsor. You will need to contact your Plan Sponsor to determine whether or not you meet the eligibility criteria to be enrolled on to this plan. **Disenrollment** Your Plan Sponsor determines enrollment and disenrollment of participants and is responsible for notifying you of your disenrollment. You may be disenrolled from Samaritan Health Plans for various reasons such as: • Your personal situation may change and you may no longer be eligible for this program. • You die. Termination of coverage will be your date of death, in which case any premiums will be retroactively adjusted and refunded. Samaritan Health Plans will provide your group policyholder with a termination notice that includes your rights and continuation options within 10 days of the effective date of the termination, when your coverage is not replaced by another group policy.	Updated language. 'Employer' changed to 'Plan Sponsor'. Language removed that does not apply or can be found in group contract.
Out-of-pocket maximums and deductibles page 11	**Out-of-pocket maximums and deductibles** This is only a brief summary of benefits. Please refer to the additional information throughout this Plan Document for further explanations of your benefits including limitations and exclusions. **Your out-of-pocket limits** This plan has an out-of-pocket limit to protect you from excessive medical expenses. The Summary of Benefits shows your plan's annual out-of-pocket limit. If you	**Out-of-pocket maximums and deductibles** This is only a brief summary of benefits. Please refer to the additional information throughout this Certificate for further explanations of your benefits including limitations and exclusions. **Your annual out-of-pocket limit** This plan has an out-of-pocket limit to protect you from excessive medical expenses. The Summary of Benefits shows your plan's annual out-of-pocket limit. If you	Updated language. EHB language removed.

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	incur covered expenses over that amount, this plan will pay 100% of eligible charges for the rest of the benefit year. Those services that do not apply to your out-of-pocket limit will not be covered at 100% after your out-of-pocket limit has been met. Regular cost sharing will apply to these benefits. Both the deductible and out of pocket max (OOP max) are accumulated on a calendar year. **Expenses for the following DO NOT count toward your out-of-pocket limit:** • Charges over usual, customary, and reasonable amounts • Benefits paid in full • Incurred charges that exceed amounts allowed under this plan • Non-medically necessary services, such as excluded services or those deemed to be not medically necessary by the plan. • Non-covered services, including those where a third party is responsible (COB, settlements, motor vehicle claims) • Other services called out in any plan document **Information about your deductible** **Deductible** This is the portion of covered benefit costs each member is obligated to pay before Samaritan Health Plans will provide benefits. The deductible amount for individuals and families is listed in your Member Benefit Summary. No family will have to satisfy more than the Family Maximum Deductible each calendar year. Both the deductible and out of pocket max (OOP max) are accumulated on a calendar year. Some services do not apply to your deductible obligation. To find out which services will or will not apply to your deductible, please call our Member Services representatives at (541) 768-4550 or toll free 1-800-832-4580. In-network provider benefit: Patient receives care from a preferred provider or facility, which has an effective in-network provider Plan contract with Samaritan Health Plans to provide services and supplies to the covered individuals. **Out-of-network provider benefit:** Patient receives care from a provider that has no affiliation or contractual arrangement with the Plan. At the out-of-network benefit level, payment to providers is based on the Samaritan Health Plans fee allowance or the billed	incur covered expenses over that amount, this plan will pay 100% of eligible charges for the rest of the calendar year. Those services that do not apply to your out-of-pocket limit will not be covered at 100% after your out-of-pocket limit has been met. Regular cost sharing will apply to these covered benefits, according to your Summary of Benefits. The in-network and out-of-network out-of-pocket accumulate separately and are not combined. Both the deductible and out-of-pocket max (OOP max) are accumulated on a calendar year. **Expenses for the following DO NOT count toward your out-of-pocket limit:** • Charges over usual, customary, and reasonable amounts • Benefits paid in full • Incurred charges that exceed amounts allowed under this plan • Non-medically necessary services, such as excluded services or those deemed to be not medically necessary by the plan. • Non-covered services, including those where a third party is responsible (COB, settlements, motor vehicle claims) • Bariatric and Gastric banding surgery co-pays • Other services called out in any plan document **Information about your deductible** **Deductible** This is the portion of covered benefit costs each member is obligated to pay before Samaritan Health Plans will provide benefits. The deductible amount for individuals and families is listed in your Summary of Benefits. No family will have to satisfy more than the Family Deductible each calendar year. The in-network and out-of-network deductible accumulate separately and are not combined. Both the deductible and out-of-pocket max (OOP max) are accumulated on a calendar year. Some services do not apply to your deductible obligation. To find out which services will or will not apply to your deductible, see your Summary of Benefits or call our Member Services representatives at (541) 768-4550 or toll free 1-800-832-4580. **In-network provider benefit:** Patient receives care from a preferred provider or facility, which has an effective in-network provider Plan contract with Samaritan Health Plans to provide services and supplies	

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	amount, whichever is less. The fee allowance is often lower than, or discounted from, the physician's usual charge. **Lifetime and annual limits on essential benefits are prohibited.** The essential health benefits cover the following general categories of services: • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care	to the covered individuals. **Out-of-network provider benefit:** Patient receives care from a provider that has no affiliation or contractual arrangement with the Plan. At the out-of-network benefit level, payment to providers is based on the Samaritan Health Plans fee allowance or the billed amount, whichever is less. The fee allowance is often lower than, or discounted from, the physician's usual charge.	
Health Savings Account (HSA) eligibility page 12	Some Samaritan Momentum Plans meet the definition of a High Deductible Health Plan (HDHP) and may be3 eligible for HSA plans in these instances: • When the deductible amount is $1,300 for an individual and $2,600 for a family or higher, making the plan a High-Deductible Health Plan (HDHP); and • When the out-of-pocket limit is $6,550 for an individual and $13,100 for a family or higher, making the plan a High-Deductible Health Plan (HDHP) HSA Rules under Samaritan Health Plans: 1. All covered services outlined in this plan, unless specifically identified, apply to the deductible. Please see the Summary of Benefits that outline your cost share for in and out-of-network benefit coverage. The Summary of Benefits also outlines those services that apply to your deductible. 2. Once the deductible has been met your co-pays and co-insurances will begin. You are not responsible for meeting your co-pay or co-insurance UNTIL your deductible has been met. 3. Any contributions made on behalf of your employer will be added to your accumulating deductible amounts.	Some Samaritan Momentum Plans meet the definition of a High Deductible Health Plan (HDHP) and are eligible for HSA plans in these instances: • When the deductible amount is $1,300 for an individual and $2,600 for a family or higher, making the plan a High-Deductible Health Plan (HDHP). All covered services outlined in this plan, unless specifically identified, apply to the deductible. The Summary of Benefits also outlines those services that apply to your deductible. • When the out-of-pocket limit is $6,550 for an individual and $13,100 for a family or higher, making the plan a High-Deductible Health Plan (HDHP) HSA Rules under Samaritan Health Plans: 1. Once the deductible has been met your copays and coinsurances will begin. You are not responsible for paying your copay or coinsurance UNTIL your deductible has been met. 2. Any contributions made on behalf of your employer will be added to your accumulating deductible amounts. **NOTE**: Not all plans meet the criteria, please contact your Plan Sponsor if you have any questions regarding your coverage.	Updated language.

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	NOTE: Not all plans meet the criteria, please contact your employer if you have any questions regarding your coverage.		
Service area and provider network page 13	**The Samaritan Health Plans service area is statewide.** Samaritan Momentum Plans are available to participating employers or plan sponsors domiciled in Oregon. 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 uses the First Choice Health Network to supplement its provider panel in Oregon. The First Choice Health Network also extends to 7 other states in the Northwest. For contracted provider coverage in the remainder of the United States, Samaritan uses the First Health Network. **Urgent and emergent services are always covered at the in-network provider level, as are services provided by in-area contracted providers.** **Not all providers in our service area are considered to be an in-network provider. Please call our Member Services Department or visit samhealthplans.org to verify the network status of your provider before getting services. Contact us at (541) 768-4550; toll free1-800-832-4580 or TTY 1-800-735-2900.** Urgent and emergent care has the same cost share regardless of being in-network or out-of-network. If the urgent or emergency department is considered out-of-network, all applicable costs and/or charges will go to the out-of network deductible and/or out-of-pocket accumulators. **Out of the Country coverage** Samaritan Momentum 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 Form, and provide all receipts and pertinent documentation of their covered health care expenditures to the Plan for evaluation and reimbursement. All member reimbursement requests must be submitted to Samaritan Health Plans within	Samaritan Momentum Plan options are available for purchase statewide in the State of Oregon for Oregon domiciled businesses. 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, Samaritan uses the First Choice Health Network to supplement its provider panel in Oregon. The First Choice Health Network also extends to 7 other states in the Northwest. For contracted provider coverage in the remainder of the United States, Samaritan uses the First Health Network. **Not all providers in our service area are considered to be an in-network provider. Please call our Member Services Department or visit samhealthplans.org to verify the network status of your provider before getting services. Contact us at (541) 768-4550; toll free1-800-832-4580 or TTY 1-800-735-2900.** Urgent and emergent care has the same cost share regardless of being in-network or out-of-network. If the urgent or emergency department is considered out-of-network, all applicable costs and/or charges will go to the out-of-network deductible and/or out-of-pocket accumulators. **Coverage outside of the United States** Samaritan Momentum 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 Form, and provide all receipts and pertinent documentation of their 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 foreign claim request for reimbursement please include the following information: • Member ID number	Updated language.

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	365 days of the date services were obtained. When submitting a foreign claim request for reimbursement please include the following information: • Member ID number • Member name • Services rendered • Date of service • Provider name • Charged amount by service received • Where you received services • Diagnosis • Procedure Code • Total charge on bill • Units received for each service • Currency type submitted on bill and conversion rates for that particular time. If this is not provided, Samaritan Health Plans will convert currency at the rate that it is at that time Samaritan Health Plans does not cover services for the sole purpose of school, work or occupation (for example, immunizations, routine physicals, or laboratory services). We will only cover medications up to a ninety (90) day supply, even when medications are needed for vacations, travel, school or work for long periods of time, (except for oral or patch contraceptives that are covered up to 15 months).	• Member name • Services rendered • Date of service • Provider name • Charged amount by service received • Where you received services • Diagnosis • Procedure Code • Total charge on bill • Units received for each service • 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 Samaritan Health Plans does not cover services for the sole purpose of school, work or occupation (for example, immunizations, routine physicals, or laboratory services). We will only cover medications up to a ninety (90) day supply, even when medications are needed for vacations, travel, school or work for long periods of time, (except for oral or patch contraceptives that are covered up to 15 months).	
Becoming a Samaritan member page 15	When you become a member of Samaritan Health Plans, you receive a New Member Packet, electronically where possible. The following information and materials are found in your packet. This packet will include a summary of your benefit coverage and important information about your appeal rights. You can, at any time, request a copy of these materials. If requested, we will send you a copy of the requested materials within 30 days of your request. You can obtain your electronic member packets through MyHealthPlan.samhealth.org **Enrollment period** Please refer to your employer for enrollment periods and dates. There is no exclusion period administered by Samaritan Health Plans. **Please keep these materials for future reference:**	When you become a member of Samaritan Health Plans, you will receive new member materials from your Plan Sponsor. The following information and materials are found in your new member materials. This includes a summary of your benefit coverage and important information about your appeal rights. You can, at any time, request a copy of these materials. If requested, we will send you a copy of the requested materials within 30 days of your request. **Please keep these materials for future reference:** • Welcome letter • Member Certificate (this document) • Summary of Benefits	Updated language. Choosing a PCP language removed as SHP does not require PCP assignment.

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	• Welcome letter • Notice of Privacy Practices pamphlet • Summary of benefits • Member Certificate (this document), which includes the program' • Educational materials (optional) • Annual summaries for quality, utilization review policies, other plan accessibility and provider networks In addition to your new member packet, you will receive a member identification (ID) card once you have been enrolled. You must present this card when you receive services. It lists information about you, needed at your appointment for your physician's office to bill for services correctly. If you have misplaced, changed personal information or added new members, please call our Member Services Department to order a new one. If you are missing any of these materials please call the Member Services Department at (541) 768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900. **Choosing your Primary Care Provider (PCP)** As a Samaritan Health Plan member, you may choose a Primary Care Provider (PCP) for yourself and each family member. The plan does not require you to do this. **Your Samaritan Health Plans member identification (ID) card** You will receive a Samaritan Health Plan member identification (ID) card. You must present this card when you receive services. It lists information about you, needed at your appointment for your physician's office to bill for services correctly. If you lose your Samaritan Health Plan member ID card, please call us and we will send you a new one. **Interpreter services** If you need a foreign language interpreter at your medical appointments, please contact Samaritan Health Plan's Member Services 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	• Notice of Privacy Practices • Summary of Benefits & Coverage • Information for additional plans or riders purchased • Nondiscrimination notice • Multi-language insert If you are missing any of these materials please call the Member Services Department at (541) 768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900. **Enrollment period** Please refer to your Plan Sponsor for enrollment periods and dates. There is no exclusion period administered by Samaritan Health Plans. **Your Samaritan Health Plans member identification (ID) card** You will receive a Samaritan Health Plan member identification (ID) card. You must present this card when you receive services. It lists information about you, needed at your appointment for your physician's office to bill for services correctly. If you have misplaced, changed personal information or added new members, please call us and we will send you a new one. **Interpreter services** If you need a foreign language interpreter at your medical appointments, please contact Samaritan Health Plan's Member Services 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 call the Samaritan Health Plans Member Services Department at (541) 768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900 with all of the necessary information at least 72 hours before your appointment.	

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	• A home phone number • The date and the time of the appointment • The name of the health care provider • The full address of the appointment • The phone number of the provider's office • The reason for the appointment Please call the Samaritan Health Plans Member Services Department at (541) 768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900 with all of the necessary information at least 72 hours before your appointment. **Member portal** Your member portal at MyHealthPlan.samhealth.org provides you with secure, 24/7 access to: • Member policy • Summary of Benefits and Coverage • Formulary and pharmacy directory • Provider directories • Claims processed by your health plan • Details about your eligibility with the health plan, including the amount you have met toward your deductibles, your plan limits, and summary of benefits. • The National Library of Medicine's MedlinePlus Connect for consumer-friendly health information in both English and Spanish. In addition to all the benefits above, your new member portal offers you the convenience of a paperless option for member materials. For questions about your member portal and technical support if needed, please call Member Services Department at 541-768-4550, toll-free 1-800-832-4580 (For Hearing Impaired, call 1-800-735-2900), Mon.–Fri., 8 a.m. to 8 p.m. Member Services Department can also be reached via email at MemberServices@samhealth.org	**Member portal** Your member portal at MyHealthPlan.samhealth.org provides you with secure, 24/7 access to: • Provider directories • Claims processed by your health plan • Details about your eligibility with the health plan, including the amount you have met toward your deductibles and your Plan limits. For questions about your member portal and technical support if needed, please call Member Services Department at 541-768-4550, toll-free 1-800-832-4580 (For Hearing Impaired, call 1-800-735-2900), Mon.–Fri., 8 a.m. to 8 p.m. The Member Services Department can also be reached via email at MemberServices@samhealth.org	
Employees page 17	Your employer decides the minimum number of hours employees must work each week to be eligible for health insurance benefits. Your employer can also require new employees to satisfy a probationary waiting period before they are eligible for benefits. Your employer's eligibility requirements are shown on your Member Enrollment Form. All employees who meet those requirements are eligible for coverage.	Your Plan Sponsor decides the minimum number of hours employees must work each week to be eligible for health insurance benefits. Your Plan Sponsor can also require new employees to satisfy a probationary waiting period before they are eligible for benefits. All employees who meet their Plan Sponsor's requirements are eligible for coverage. Eligibility is not based on any health status-related factors.	Updated language.

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	Eligibility is not based on any health status-related factors.		
Qualified Medical Child Support Order (QMCSO)1 page 18	Samaritan Health Plans complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, which provides for health benefit coverage for the child of a plan member. If a court or state agency orders coverage for your spouse, domestic partner or child, they can enroll in this plan within a 31-day initial enrollment period beginning on the date of the order. Coverage will become effective on the first day of the month after Samaritan Health Plans receives the enrollment application. You can be required to submit a copy of the QMCSO to complete enrollment. Samaritan Health Plans will extend benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA. Samaritan Health Plans has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from our Customer Services Department.	Samaritan Health Plans complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, which provides for health benefit coverage for the child of a plan member. If a court or state agency orders coverage for your spouse, domestic partner or child, they can enroll in this plan within a 30-day initial enrollment period beginning on the date of the order. Coverage will become effective on the first day of the month after Samaritan Health Plans receives the enrollment application. You can be required to submit a copy of the QMCSO to complete enrollment. Samaritan Health Plans will extend benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA. Samaritan Health Plans has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from our Customer Services Department.	Updated timeframe for enrollment.
When you first become eligible page 18	The initial enrollment period is the 31-day period beginning on the date a person is first eligible for enrollment in this plan. Everyone who becomes eligible for coverage has an initial enrollment period. When you satisfy your employer's probationary waiting period at the hours required for eligibility and become eligible to enroll in this plan, you and your eligible family members must enroll within the initial enrollment period. If you miss your initial enrollment period, you can be subject to a waiting period. To enroll, you must complete and sign an enrollment application, which is available from your employer. The application must include complete information on yourself and your enrolling family members. Return the application to your employer, and your employer will send it to Samaritan Health Plans. Coverage for you and your enrolling family members begins on the first day of the month after you satisfy your employer's probationary waiting period. The probationary waiting period is shown on your Enrollment Form. Coverage will only begin if we receive your enrollment application and premium with your employer's premium payment for that month.	The initial enrollment period is the 30-day period beginning on the date a person is first eligible for enrollment in this plan. Everyone who becomes eligible for coverage has an initial enrollment period. When you satisfy your Plan Sponsor's probationary waiting period at the hours required for eligibility and become eligible to enroll in this plan, you and your eligible family members must enroll within the initial enrollment period. If you miss your initial enrollment period, you can be subject to a waiting period. To enroll, you must complete and sign an enrollment application, which is available from your Plan Sponsor. The application must include complete information on yourself and your enrolling family members. Return the application to your Plan Sponsor, who will send it to Samaritan Health Plans by the end of the 30-day period. Coverage for you and your enrolling family members begins on the first day of the month after you satisfy your Plan Sponsor's probationary waiting period. For 90-day waiting periods, coverage will begin the 91st day. Check with your Plan Sponsor for their probationary waiting period. Coverage will only begin if we receive your enrollment application and premium with your employer's premium payment for that month.	Updated and added language.
Newly	Newly hired employees and employees that begin	Newly hired employees and employees that begin	Updated timeframe for

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hired/eligible employees and their dependents page 18	working the hours required for eligibility may enroll themselves and their eligible dependents after satisfying the initial enrollment period stated. The newly eligible employee must complete and submit an enrollment form within 31 days of becoming eligible for enrollment. Coverage is effective on the first of the month following completion of the waiting period at the hours required for eligibility.	working the hours required for eligibility may enroll themselves and their eligible dependents after satisfying the initial enrollment period stated. The newly eligible employee must complete and submit to Samaritan Health Plans an enrollment form within 30 days of becoming eligible for enrollment. Coverage is effective on the first of the month following completion of the waiting period at the hours required for eligibility. For 90-day waiting periods, coverage will begin the 91st day.	enrollment and added language.
Returning to work after a layoff page 18	If you are laid off and then rehired by your employer within nine months, you will not have to satisfy another probationary 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 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 an enrollment application to Samaritan Health Plans within the 31-day initial enrollment period following your return to work. Failure to submit the application within the 31-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. Employees returning to work after a layoff are not subject to new exclusion periods for other conditions. If the employee's exclusion periods were satisfied (or partially satisfied) before the layoff, they will be credited at the same level when the employee returns to work.	If you are laid off and then rehired by your employer within nine months, you will not have to satisfy another probationary 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 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 an enrollment 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. Employees returning to work after a layoff are not subject to new exclusion periods for other conditions. If the employee's exclusion periods were satisfied (or partially satisfied) before the layoff, they will be credited at the same level when the employee returns to work.	Updated timeframe for enrollment.
Return to work after a leave of absence (LOA) page 18	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 an enrollment application to Samaritan Health Plans within the 31-day initial enrollment period following your return to work. Failure to submit the application within the 31-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. Employees returning to work after a LOA are not	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 an enrollment 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. Employees returning to work after a LOA are not	Updated timeframe for enrollment.

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	subject to new exclusion periods for other conditions. If the employee's exclusion periods were satisfied (or partially satisfied) before the layoff, they will be credited at the same level when the employee returns to work.	subject to new exclusion periods for other conditions. If the employee's exclusion periods were satisfied (or partially satisfied) before the layoff, they will be credited at the same level when the employee returns to work.	
Newborns page 19	Your, your spouse's or your domestic partner's newborn baby is eligible for enrollment under this plan during the 31-day initial enrollment period after birth. To add the child to your coverage, you must submit an enrollment 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 can be required to submit a copy of the newborn's birth certificate to complete enrollment. If additional premium is required, then the baby's eligibility for enrollment will end 31 days after birth if Samaritan Health Plans has not received an enrollment application and premium. 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 an enrollment application listing the child as your dependent.	Your, your spouse's or your domestic partner's newborn baby is eligible for enrollment under this plan during the 30-day initial enrollment period after birth. To add the child to your coverage, you must submit an enrollment 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 can be required to submit a copy of the newborn's birth certificate to complete enrollment. If additional premium is required, then the baby's eligibility for enrollment will end 30 days after birth if Samaritan Health Plans has not received an enrollment application and premium. 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 an enrollment application listing the child as your dependent within 30 days of birth.	Updated timeframe for enrollment.
Adopted children page 19	When a child is placed in your home for adoption, the child is eligible for enrollment under this plan during the 31-day initial enrollment period after placement for adoption. 'Placement for adoption' means the assumption and retention by you, your spouse, or your 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 an enrollment 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 additional premium is required, then the child's eligibility for enrollment will end 31-days after placement if Samaritan Health Plans has not received an enrollment application and premium. 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 an enrollment application listing the child as your dependent.	When a child is placed in your home for adoption, the child is eligible for enrollment under this plan 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 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 an enrollment 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 additional premium is required, then the child's eligibility for enrollment will end 30 days after placement if Samaritan Health Plans has not received an enrollment application and premium. 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 an enrollment application listing the child as your dependent within	Updated timeframe for enrollment.

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		30 days of adoption.	
Family members acquired by marriage page 19	If you marry, you can add your new spouse and any newly eligible dependent children to your coverage during the 31-day initial enrollment period after the marriage. Samaritan Health Plans must receive your enrollment 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 marriage. You can be required to submit a copy of your marriage certificate to complete enrollment. This health benefit plan does not discriminate between married and unmarried women or between children of married and unmarried women.	If you marry, you can add your new spouse and any newly eligible dependent children to your coverage during the 30-day initial enrollment period after the marriage. Samaritan Health Plans must receive your enrollment 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 marriage. You can be required to submit a copy of your marriage certificate to complete enrollment. This health benefit plan does not discriminate between married and unmarried women or between children of married and unmarried women.	Updated timeframe for enrollment.
Family members acquired by domestic partnership page 19	Your qualified domestic partner can enroll by submitting an enrollment application and completed Domestic Partnership Affidavit at the time of your initial enrollment or within 30 days of the partnership first becoming eligible according to the criteria stated under Your eligibility. All other domestic partner applications will be subject to late enrollment provisions. The Oregon Family Fairness Act recognizes and authorizes domestic partnerships in Oregon. A domestic partnership is defined as "a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon." Requirements beyond this are not allowed for same sex domestic partners. Any time that coverage is extended to a spouse it must also extend to a domestic partner.	Your qualified domestic partner can enroll by submitting an enrollment application at the time of your initial enrollment or within 30 days of the partnership first becoming eligible according to the criteria stated under Your eligibility. All other domestic partner applications will be subject to late enrollment provisions. The Oregon Family Fairness Act recognizes and authorizes domestic partnerships in Oregon. A domestic partnership is defined as "a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon." Requirements beyond this are not allowed for same sex domestic partners. Any time that coverage is extended to a spouse it must also extend to a domestic partner.	Removed affidavit language as this is handled between the employee and Plan Sponsor.
Family members placed in your guardianship page 20	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, registered or otherwise; • Under the age of 26; and • Expected to live in your household for at least a year, unless otherwise ordered by court. We must receive your enrollment application and additional premium during the 31-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 can be required to submit a copy of the court order to complete enrollment.	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, registered or otherwise • Under the age of 26 • Expected to live in your household for at least a year, unless otherwise ordered by court We must receive your enrollment 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 can be required to submit a copy of the court order to complete enrollment.	Updated timeframe for enrollment.
Waiver of	You may waive coverage under the Plan for yourself.	The employee may waive coverage under the Plan for	Updated language.

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coverage page 20	You may also waive coverage for any of your eligible dependents. If you waive coverage for yourself, your dependents are not eligible for coverage. To waive coverage, you must file a Declination of Coverage form with the Human Resources office specifying the reason for the waiver. The form must list by name each of the dependents for which you waive coverage.	themselves or any eligible dependents. If the employee waives coverage for themselves, the employee's dependents are not eligible for coverage. To waive coverage, the employee must turn in the Enrollment, Change, Waiver form to the Plan Sponsor, specifying the reason for the waiver. The form must list by name each of the dependents for which the employee waives coverage.	
Subsequent enrollment page 20	If you do not enroll yourself and/or your eligible dependents within 30 days of first becoming eligible, you may be considered a "late enrollee." If so, you must wait until the next Annual Enrollment period (which is the month of December) to enroll. If you then enroll, coverage will become effective as of the following January 1.	If you do not enroll yourself and/or your eligible dependents within 30 days of first becoming eligible, you may be considered a "late enrollee." If so, you must wait until the next open enrollment period to enroll.	Updated language.
Special enrollment periods page 20	Some employers have agreements with Samaritan Health Plans allowing employees with other health coverage to waive this plan's coverage. In that case, both you and your family members can decline coverage during your initial enrollment period. If you are eligible to decline coverage and you wish to do so, you must submit a written waiver of coverage to Samaritan Health Plans through your employer. You and your family members can enroll in this plan later if you qualify under Rule #1, Rule #2, or Rule #3 below. If the agreement between Samaritan Health Plans and your employer requires all eligible employees to participate in this plan, you must enroll during your initial enrollment period. However, your family members can decline coverage, and they can enroll in the plan later if they qualify under Rule #1, Rule #2, or Rule #3 below. To find out if your employer's plan allows employees to decline coverage, ask your Plan Administrator. **Special enrollment rule #1** If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members can enroll in the plan later if the other coverage ends involuntarily. 'Involuntarily' means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, the other insurance plan was discontinued, the 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, you must request enrollment within 31 days after the other health insurance	Some employers have agreements with Samaritan Health Plans allowing employees with other health coverage to waive this plan's coverage. In that case, the employee and family members 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 the Enrollment, Change, Waiver form to the Plan Sponsor. The employee and family members can enroll in this plan later if the employee qualifies under Rule #1, Rule #2, or Rule #3 below. If the agreement between Samaritan Health Plans and the Plan Sponsor requires all eligible employees to participate in this plan, the employee must enroll during the initial enrollment period. However, the employee's family members can decline coverage, and they can enroll in the plan later if they qualify under Rule #1, Rule #2, or Rule #3 below. To find out if the Plan Sponsor allows employees to decline coverage, ask your Plan Sponsor. **Special enrollment rule #1** If the employee declined enrollment for themselves or family members because of other health insurance coverage, the employee or family members can enroll in the plan later if the other coverage ends involuntarily. Family members 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 the Plan Sponsor's minimum requirement, the other insurance plan was discontinued, the employer's premium contributions toward the other insurance plan ended, or because of	Updated language.

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	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). Coverage will begin on the first day of the month after the other coverage ends. **Special enrollment rule #2** If you acquire new dependents because of marriage, domestic partnership, birth, or placement for adoption, you can enroll yourself and/or your newly acquired dependents at that time. To do so, you must request enrollment within 31 days after the marriage, registration of the domestic partnership, birth, or placement for adoption. In the case of marriage and domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement. **Special enrollment rule #3** If you or your dependents become eligible for a premium assistance subsidy under Medicare or a State Children's Health Insurance Program (CHIP), you can enroll yourself and/or your dependents at that time. To do so, you must request enrollment within 60 days of the date you and/or your dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.	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). Coverage will begin on the first day of the month after the other coverage ends. **Special enrollment rule #2** If the employee acquires new dependents because of marriage, domestic partnership, birth, or placement for adoption, the employee can enroll themselves and/or your newly acquired dependents at that time. To do so, the employee must request enrollment within 30 days after the marriage, registration of the domestic partnership, birth, or placement for adoption. In the case of marriage and domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement. **Special enrollment rule #3** If the employee or the employee's dependents become eligible for a premium assistance subsidy or Medicaid coverage under Medicaid or a State Children's Health Insurance Program (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 eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.	
Late enrollment page 21	If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the plan's anniversary date. A 'late enrollee' is an otherwise eligible employee or dependent who does not qualify for a special enrollment period explained above, and who: • Did not enroll during the 31-day initial enrollment period; or • Enrolled during the initial enrollment period but discontinued coverage later. A late enrollee can enroll by submitting an enrollment application to your employer during an open enrollment period designated by your employer, just prior to the plan's anniversary date. When you or your dependents enroll during the open enrollment period,	If the employee did not enroll during the initial enrollment period and does not qualify for a special enrollment period, enrollment will be delayed until the plan's anniversary date. A 'late enrollee' is an otherwise eligible employee or dependent who does not qualify for a special enrollment period explained above, and who: • Did not enroll during the 30-day initial enrollment period • Enrolled during the initial enrollment period but discontinued coverage later A late enrollee can enroll by submitting an enrollment application to the Plan Sponsor during an open enrollment period designated by the Plan Sponsor, just prior to the plan's anniversary date. When the employee and/or employee's dependents enroll during	Updated language.

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	plan coverage begins on the plan's anniversary date.	the open enrollment period, plan coverage begins on the plan's anniversary date.	
Divorced spouses or legal separation page 21	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 of the divorce or separation, and continuation coverage can be available for your spouse. If there are special child custody circumstances, please contact the Plan's Member Services Department. See Continuation Coverage for more information.	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 Plan Sponsor of the divorce or separation, and continuation coverage can be available for your spouse. If there are special child custody circumstances, please contact the Plan's Member Services Department. See Continuation Coverage for more information.	Updated language.
Dissolution of domestic partnership page 21	Coverage for your domestic partner and any children of a domestic partner (not related to the enrolled employee by birth or adoption) will terminate upon the death of the employee or termination of the domestic partnership, whichever comes first. The employee and partner are required by the domestic partnership affidavit to give written notice to the employer within 30 days of any change in qualifying criteria. Domestic partners and their children may continue this policy's coverage under COBRA. See **Continuation Coverage**.	If you dissolve your 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 Plan Sponsor of the dissolution of the domestic partnership. Continuation coverage may be available for the covered children. See Continuation Coverage.	Updated language.
Circumstances causing ineligibility or loss of benefits page 23	• The Plan contains numerous conditions and limitations that may affect your or your family's right to participate or receive benefits. This section will highlight just a few such conditions and limitations. You or your family's rights may be affected by any of the following: • Not timely submitting an election to participate (see "How and When to Enroll" on page 18). • Failing timely to submit claims for reimbursement (see "Claims Information" and "Grievances and Appeals" on page 59 and 51). • Reaching a benefit maximum on non-essential benefits (see "Benefit Limitations and Exclusions" on page 42 and elsewhere for other maximum limits). • Failing to reimburse the Plan under its right of subrogation (see "General Provisions" on page 46).		Language removed.
Continuation coverage page 24	**USERRA continuation** 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 family members 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	**USERRA continuation** 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 family members 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	Updated language.

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	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 31 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. Your employer will include your continuation premium in the group's regular monthly payment. Samaritan Health Plans cannot accept the premium directly from you. • Your employer must still be insured by Samaritan Health Plans. If your employer discontinues this plan, you will no longer qualify for continuation through SHP. **COBRA continuation** If you work for an employer that had at least 20 employees on more than 50 percent of its typical business days in the previous calendar year, your employer is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Please contact your employer for information about how to continue coverage under COBRA. Domestic partners are recognized as qualified beneficiaries under federal COBRA continuation laws and thus cannot continue this policy's coverage under COBRA. Their covered children as qualified beneficiaries can continue this policy's coverage if all COBRA requirements are met. **Work stoppage** **Labor unions** If you are a union member, you have certain continuation rights in the event of a labor strike or lockout. Your union is responsible for collecting your premium and can answer questions about coverage during the strike. **Samaritan Health Plans provides continuation of coverage for a covered hospitalized individual if the policy is canceled and immediately replaced by another insurance carrier.**	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. Your employer will include your continuation premium in the group's regular monthly payment. Samaritan Health Plans cannot accept the premium directly from you. • Your employer must still be insured by Samaritan Health Plans. If your employer discontinues this plan, you will no longer qualify for continuation through SHP. **COBRA continuation** Federal law requires that most employers sponsoring group health plans offer employees and their family members the opportunity to continue their group health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. If you work for an employer that had at least 20 employees on more than 50 percent of its typical business days in the previous calendar year, your employer is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Please contact your Plan Sponsor for information about how to continue coverage under COBRA. Domestic partners are not recognized as qualified beneficiaries under federal COBRA continuation laws and thus cannot continue this policy's coverage under COBRA. Their covered children as qualified beneficiaries can continue this policy's coverage if all COBRA requirements are met. **Work stoppage** **Labor unions** If you are a union member, you have certain continuation rights in the event of a labor strike or lockout. Your Plan Administrator is responsible for collecting your premium and can answer questions about coverage during the strike.	

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		This Plan provides coverage in accordance with the Oregon Revised Statutes for a covered individual who is hospitalized on the date of termination of this Plan if it is terminated and immediately replaced by a group health insurance policy issued by another insurer. Any payment required under this Plan pursuant to this section is subject to all applicable terms, limitations and conditions on benefits.	
Prescription drug benefits page 26, 35	**Page 26** **Tier 1** – Preventive Tier offers a $0 co-pay for ACA preventive medications. Tier 1 also includes nine generic drugs, including metformin, glyburide, glipizide, simvastatin, lovastatin, lisinopril, enalapril, atenolol and warfarin. Tobacco cessation and asthma medications are included. Zero ($0) cost share for Diabetic administration of insulin includes needles, and syringes. **Tier 2** – Preferred Generic drugs provide the same high quality medicinal and therapeutic benefit found in brand-name medications without the brand-name cost. **Tier 3** – Preferred drugs, in most cases brand name drugs, provide high quality, effective and affordable prescription benefits to Samaritan Health Plans members. Preferred drugs are either more effective or equally effective, but less costly than other alternative medications not included on the preferred drug list. They are often the preferred agent in a class of medications that has many alternatives and will treat most health conditions. **Tier 4** – Non-Preferred drugs are available generically, and it is your choice to receive brand name rather than the therapeutic generic equivalent. If your medication is categorized as a Tier 4 medication and does not have an equivalent generic available, you may request a tier exception for your medication to be paid at Tier 3 as long as the medication is listed on the formulary and does not require a prior authorization. **Tier 5** – High-cost specialty medications encompass specified medications. This category is subject to change, throughout the year, upon review by the Plans' Pharmacy and Therapeutics Committee. You may be charged this coinsurance if the medication is received in another setting (for example, infusion). **IMPORTANT NOTES:** • Over the Counter (OTC) medications will not be covered by Samaritan Health Plans without a prescription. Reference the formulary for more	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. You can also contact our Member Services Department at 541-768-4550 or 1-800-832-4580. You and your physician can find out more about additional requirements or limits on covered medications by contacting our Member Services Department. **Tier 1** – Preventive offers a $0 co-pay for ACA preventive medications. Tier 1 also includes nine generic drugs, including metformin, glyburide, glipizide, simvastatin, lovastatin, lisinopril, enalapril, atenolol and warfarin. Tobacco cessation and asthma medications are included. Zero ($0) cost share for Diabetic administration of insulin includes needles, and syringes. **Tier 2** – Generic drugs provide the same high quality medicinal and therapeutic benefit found in brand-name medications without the brand-name cost. **Tier 3** – Preferred drugs, in most cases brand name drugs, provide high quality, effective and affordable prescription benefits to Samaritan Health Plans members. Preferred drugs are either more effective or equally effective, but less costly than other alternative medications not included on the preferred drug list. They are often the preferred agent in a class of medications that has many alternatives and will treat most health conditions. **Tier 4** – Non-Preferred drugs are available generically, and it is your choice to receive brand name rather than the therapeutic generic equivalent. If your medication is categorized as a Tier 4 medication and does not have an equivalent generic available, you may request a tier exception for your medication to be paid at Tier 3 as long as the medication is listed on the formulary and does not require a prior authorization. **Tier 5** – High-cost specialty drugs encompass specified medications. This category is subject to change,	Language reorganized into one section. Added and updated language.

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	specific medication coverage. Some preventive OTC medications are covered with a prescription. Please reference your formulary. • The Therapeutic benefit for the administration of insulin applies to all Samaritan Momentum Plans. • All medications covered by Momentum are subject to the Pharmacy & Therapeutics Committee and are approved to be on the formulary list of covered drugs. Reference the formulary for more specific medication coverage information. Samaritan Health Plans covers both brand name drugs and generic drugs in its formulary. Generic drugs are approved by the FDA as having the same active ingredient as the brand name drug. Generally, when a generic version of a drug is available Samaritan Health Plans will require that the generic be used by members unless it is medically necessary for a member to use the brand version of a drug. Samaritan Health Plans uses a formulary, which lists the covered prescription medications. Some covered medications can have additional requirements or limits on coverage. These requirements can include: Prior authorization: We require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from the Plan before we will pay for your prescriptions. Quantity Limits: For certain drugs the Plan limits the amount or quantity of the drug that is covered. 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. You can find out more about additional requirements or limits on covered medication by contacting our Member Services Department or your physician. The Samaritan Health Plans formulary is made available to you on the Samaritan Health Plans' member portal at MyHealthPlan.samhealth.org. A printed copy of your formulary can be mailed to you upon request. We will cover one early refill of a prescription for eye drops to treat glaucoma under certain conditions as described in Oregon Revised Statutes. Compound medications can be covered with a prior authorization. We cover Orally administered anticancer medications a described in Oregon Revised Statutes because we provide coverage for cancer chemotherapy treatment. **Page 35**	throughout the year, upon review by the Plans' Pharmacy and Therapeutics Committee. You may be charged this coinsurance if the medication is received in another setting (for example, infusion). The following are important terms used under this benefit: **Closed formulary** – A method used by an insurer 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. **Multi-source brand coverage** – When a generic is available but the pharmacy dispenses the brand for any reason, member pays the difference between the brand and the generic plus the brand copay 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 medications are regularly compounded and dispensed. When you choose one of the Samaritan Health medical plans, you will automatically have prescription drug coverage. To take advantage of the prescription drug coverage, you must fill your prescription at a contracted pharmacy. **Prescription formulary** – The medications listed in the formulary are subject to change. The presence of a medication in the formulary does not guarantee that you as a plan member will be prescribed that drug by your primary care physician or contracted provider for a particular medical condition. Medications can be subject to prior authorization. As new generics become available, the corresponding brand name drug will no longer be considered a preferred agent. **Prescription drugs** – Drugs, biologicals, and compounded prescriptions approved by the FDA which can be dispensed only pursuant to a prescription order, and which by law must bear the Rx legend: "Caution-Federal law prohibits dispensing without a prescription;" or which are specifically designated by Samaritan Health Plans. **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	

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	In addition to the definitions found in the Definitions section, the following are definitions of some important terms used under this benefit: **Closed formulary** – A method used by an insurer 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. **Multi-source brand coverage** – When a generic is available but the pharmacy dispenses the brand for any reason, member pays the difference between the brand and the generic plus the brand copay 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** – An establishment which is registered as a pharmacy with the appropriate state licensing agency and in which prescription drugs are regularly compounded and dispensed by a pharmacist. Prescription drugs – Drugs, biologicals, and compounded prescriptions approved by the FDA which can be dispensed only pursuant to a prescription order, and which by law must bear the Rx legend: "Caution-Federal law prohibits dispensing without a prescription;" or which are specifically designated by Samaritan Health Plans. **Prescription order** – A written or verbal request for prescription drugs issued by a professional licensed provider. **Usual and customary charges** – Charges that the claims administrator determines fall within a range of those most frequently made for prescription drugs and insulin. **Synchronization** – Samaritan Health Plans allows early re-fills for members when they would like to fill and synchronize all of their medications at one time, this courtesy has some limitations. Please call the Member Services Department for more information at 541-768-4550 or 800-832-4580. **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. **Pharmacies** – When you choose one of the Samaritan Health medical plans, you will automatically have prescription drug coverage. To take advantage of the prescription drug coverage, you must fill your	• Waiving coverage restrictions or limits on your drug • 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. 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 Summary of Benefits. **Prescription urgent and emergent drugs** – Prescriptions purchased at other locations in urgent and emergent situations are covered. If you utilize a non-contracted pharmacy during an urgent or emergent situation, this Plan will cover prescription drugs received from that pharmacy. You or a family member must first pay the total cost of the prescription out-of-pocket and then submit the receipt and completed reimbursement claim 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 www.samhealthplans.org. **Prior authorization** – The Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from the Plan before we will pay for your prescriptions. **Quantity Limits** – For certain drugs, the Plan limits	

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	prescription at a contracted pharmacy. **Preventive tier** – This tier includes ACA preventive medications and includes generic drugs that are intended to control selected medical conditions that have been targeted by Samaritan Health Plans. The Therapeutic tier offers a $0 co-pay for identified generic drugs, including metformin, glyburide, glipizide, simvastatin, lovastatin, lisinopril, and enalapril. Tobacco cessation and asthma medications are included as well as diabetic insulin, needles, and syringes Your most cost-effective option is to use generic drugs whenever available. Name brands are covered, but you most often will pay more for them. How much you pay depends on which tier a specific drug is categorized in. Samaritan Health Plans maintains the right to direct where your prescriptions and related services are provided. Covered prescriptions must be medically necessary for diagnosis and/or treatment of an illness or injury. Compound medications are covered with a prior authorization. We cover orally administered anticancer medications **Prescription formulary** – Medications listed in the formulary are subject to change. The presence of a medication in the formulary does not guarantee that you as a plan member will be prescribed that drug by your primary care physician or contracted provider for a particular medical condition. Medications can be subject to Prior Authorization. As new generics become available, the corresponding brand name drug will no longer be considered a preferred agent. The level of prescription drug coverage is determined through a five-tier system. The tiers are as follows: **Tier 1** – Preventive Tier offers a $0 co-pay for identified ACA preventive medications. Tier 1 also includes a $0 co-pay for nine generic drugs, including metformin, glyburide, glipizide, simvastatin, lovastatin, lisinopril, enalapril, atenolol and warfarin. Tobacco cessation and asthma medications are included. Zero ($0) cost share for Diabetic administration of insulin includes, needles, and syringes. **Tier 2** – Preferred generic drugs provide the same high quality medicinal and therapeutic benefit found in brand-name medications without the brand-name cost. **Tier 3** – Preferred drugs, in most cases brand name drugs, provide high quality, effective and affordable prescription benefits to Samaritan Health Plans members. Preferred drugs are either more effective or equally effective, but less costly than other alternative	the amount or quantity of the drug that is covered. **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 medications at one time. This courtesy has some limitations. Please call the Member Services Department for more information at 541-768-4550 or 800-832-4580. **Usual and customary charges (UCR)** – Part of the definition of Covered Charge and, therefore, part of the basis upon which this Plan pays for Covered Services, taking into consideration fee(s) which 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 "area" by Health Care Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be 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", fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. The term "usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred. The term "customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age, and who receive such services or supplies within the same geographic locale. Usual and Customary Rates may alternatively be determined and established by the Plan using normative data including Medicare cost-to-charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies	

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	medications not included on the preferred drug list. They are often the preferred agent in a class of medications that has many alternatives and will treat most health conditions. **Tier 4** – Non-preferred drugs are available generically, and it is your choice to receive brand name rather than the therapeutic generic equivalent. If your medication is categorized as a Tier 4 medication and does not have an equivalent generic available, you may request a tier exception for your medication to be paid at Tier 3 as long as the medication is listed on the formulary and does not require a prior authorization. **Tier 5** – High-cost specialty medications encompass specified medications. This category is subject to change, throughout the year, upon review by the Plans' Pharmacy and Therapeutics Committee. You may be charged this coinsurance if the medication is received in another setting (for example, infusion **Please note:** We will only cover medications up to a ninety (90) day supply, even when medications are needed for vacations, school or work for long periods of time. To find out which Tier a specific drug is covered in or if there are any specific limits or authorization requirements, contact (541) 768-4550 or toll free 800-832-4580. **Prescription medication exception** – You can ask us to make a medication exception to our coverage rules. This includes exceptions for: • Covering your drug even if it is not on the formulary; • Waiving coverage restrictions or limits on your drug; • 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, you can't ask us to provide a higher level of coverage for that drug. **Prescription exceptions** – 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	and devices. Your most cost-effective option is to use generic drugs whenever available. Name brands are covered, but you most often will pay more for them. How much you pay depends on which tier a specific drug is categorized in. Samaritan Health Plans maintains the right to direct where your prescriptions and related services are provided. Covered prescriptions must be medically necessary for diagnosis and/or treatment of an illness or injury. Contraceptives are covered for all plan options. Compound medications can be covered with an approved prior authorization. **IMPORTANT NOTES:** • We will only cover medications up to a ninety (90) day supply, even when medications are needed for vacations, school or work for long periods of time. • Over the Counter (OTC) medications will not be covered by Samaritan Health Plans without a prescription. Reference the formulary for more specific medication coverage. Some preventive OTC medications are covered with a prescription. Please reference your formulary. • All medications covered by Samaritan Momentum Plans are subject to the Pharmacy & Therapeutics Committee and are approved to be on the formulary list of covered drugs. Reference the formulary for more specific medication coverage information. • Compound medications can be covered with an approved authorization. • We must provide coverage of a drug, even if it is not FDA approved, for a prescribed medical condition only if the Oregon Health Resources Commission determines the use is effective. • We will cover hormonal contraceptive patches and self-administered oral hormonal contraceptives if prescribed and dispensed by a pharmacist, as outlined in HB 2879. • We will cover prescription drugs that are dispensed by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic. • Allow for a 90-day transition period on selected non-formulary Mental Health and behavioral drugs. For more information contact (541) 768-4550 or toll-free 800-832-4580 as this list is regularly updated as new medications and generics become available. Samaritan Health Plans covers both brand name drugs and generic drugs in its formulary. Generic drugs are	

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	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. Allow for a 90-day transition period on selected non-formulary Mental Health and behavioral drugs. For more information contact (541) 768-4550 or toll free 800-832-4580 as this list is regularly updated as new medications and generics become available. **Prescription urgent and emergent drugs** – Prescriptions purchased at other locations in urgent and emergent situations. If you utilize a non-Samaritan pharmacy during an urgent or emergent situation, this plan will cover prescription drugs received from that pharmacy. You or a family member must first pay the total cost of the prescription out-of-pocket and then submit the receipt and completed reimbursement claim form to the Claims Administrator for payment. Forms for submitting these claims are available at any SHS retail pharmacy and online at www.samhealthplans.org. We will cover one early refill of a prescription for eye drops to treat glaucoma under certain conditions. Samaritan Health Plans 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 an insured 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. 4. The prescription has not been refilled more than once during the 30-day period prior to the request for an early refill. Each claim is reviewed by the Plan and evaluated to determine whether it qualifies for reimbursement based upon emergent-based usage. You will either be reimbursed as specified above or notified if the claim does not meet emergent-based usage. Prescription out-of-pocket maximum – The maximum out-of-pocket cost on prescriptions, for your plan, can be found in your Summary of Benefits and Coverage.	approved by the FDA as having the same active ingredient as the brand name drug. Generally, when a generic version of a drug is available Samaritan Health Plans will require that the generic be used by members unless it is medically necessary for a member to use the brand version of a drug. Samaritan Health Plans uses a formulary, which lists the covered prescription medications. Samaritan Health Plans offers a closed formulary to their members. A closed formulary is a method used by an insurer 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. Samaritan Health Plans 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 an insured less than 30 days after the later of: a. The date the original prescription was dispensed to the insured 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 4. The prescription has not been refilled more than once during the 30-day period prior to the request for an early refill	
Circumcision	is covered for purposes of this benefit a newborn/infant	Is covered. For purposes of this benefit a	Limit language

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page 28	is defined as any child being 3 months of age or younger. Any circumcisions for anyone older than 3 months, other outpatient or inpatient costs will apply. Circumcision is covered up to a $300 limit per newborn/infant for those on the Basic Plan option only.	newborn/infant is defined as any child being 3 months of age or younger. Any circumcisions for anyone older than 3 months, outpatient or inpatient costs will apply.	removed.
Dental services page 30	Dental services of a dentist or physician, to medically treat the injury of the jaw or natural teeth are also covered when the services presented are not considered to be reimbursable as a dental service or covered by a dental plan. When a major dental procedure is necessary and considered to be reimbursable as a medical benefit, such as: • 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. • Craniofacial abnormalities • 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. Please refer to the applicable sections of this policy to determine the coverage that will be provided. The following will not be allowed for reimbursement under the medical policy: Hospitalization because of the patient's apprehension or convenience • Treatment and services for Temporal-Mandibular Joint (TMJ) dysfunctions are not covered. The plan pays for outpatient care, general anesthesia, and special supplies. • Emergency room visits as a result of tooth or mouth pain of an unknown origin are covered if you are not presenting an already determined dental issue. **Treatment and services for TMJ are not covered.** – Medical dental services and medically	Services of a dentist or physician, to treat an injury of the jaw or natural teeth may be covered under this Plan as a medical benefit. Emergency room visits as a result of tooth or mouth pain of an unknown origin are covered if you are not presenting an already determined dental issue. The following major dental procedures may be reimbursable as a medical benefit: • 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. • Craniofacial abnormalities • 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 Please refer to the applicable benefit category of this policy to determine the coverage that will be provided.	Updated and reorganized language. Some language moved to Exclusions section.

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	necessary orthodontic treatment are covered. Examples include but are not limited to tumors, leukoplakia and premalignant lesions, trauma to jaw, acute damage to teeth, jaw fracture, lacerations in the mouth, infection beyond tooth or gum (facial cellulites, infection beyond tonsillar pillar, systemic disease manifestations in the mouth such as, lichen planus, and Sjogren's syndrome) and craniofacial anomalies. The plan pays for outpatient care, general anesthesia, and special supplies. Emergency room visits as a result of tooth or mouth pain of an unknown origin are covered if you are not presenting an already determined dental issue.		
Dialysis page 31	is covered.	Is covered and paid based on where services are rendered.	Added clarifying language.
Multidisciplinary programs page 34	are defined as, but not are not limited to pain management and child development and rehabilitation center (CDRC) programs. These programs do not require an authorization; however some services done as a result of treatment can require prior authorization. These services usually consist of a team of providers coordinating and working for the benefit of one member. Specific services that are a part of the member's treatment plan can require authorization; for example, MRIs, hospitalizations, or genetic testing, and including all services on the authorization list. See Prior authorization. Services provided in coordination with a multidisciplinary program are covered by the type of service you receive. For example, physical therapy, outpatient procedures, specialist office visits, etc.	Are defined as, but are not limited to, pain management and child development and rehabilitation center (CDRC) programs. These programs do not require an authorization; however some services done as a result of treatment can require prior authorization. These services usually consist of a team of providers coordinating and working for the benefit of one member.	Updated language.
Preventive immunizations page 37	Immunizations recommended by the Center of Disease Control and Prevention, if medically necessary are covered. 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 for female beneficiaries of this plan is covered if medically necessary if determined by a physician. See Benefit exclusions.	Immunizations recommended by the Center of Disease Control and Prevention, if medically necessary are covered. 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 for beneficiaries of this plan is covered if medically necessary. See Benefit exclusions.	Updated language.
Preventive women's exams page 38	We cover women's breast, pelvic, and Pap smear examinations once every benefit year. However, we cover more frequent examinations if they are medically necessary and the woman's health care provider recommends them. By breast examination, we mean a complete and thorough exam of the breast for women age 18, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of	We cover women's breast, pelvic, and Pap smear examinations once every benefit year. However, we cover more frequent examinations if they are medically necessary and the woman's health care provider recommends them. By breast examination, we mean a complete and thorough exam of the breast for women age 18, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of	Updated breastfeeding supplies language.

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	early detection and prevention of breast cancer. Mammograms will be paid as medically necessary, determined by their provider Any medically necessary follow up exams will be covered according to the general medical benefits of this plan and subject to any cost-sharing. We cover any covered expenses for laboratory, X-ray procedures, or mammography that accompany the examination according to the diagnostic X-rays and laboratory services. This plan permits a female enrollee to designate a women's healthcare provider as her PCP. These services are also covered, but not limited to: • Gestational diabetes screening • Domestic and interpersonal violence screening and counseling. • FDA-approved contraceptive methods, and contraceptive education and counseling. • Breastfeeding support, supplies, and counseling. Breast pumps and supplies are considered preventive only when rented. • HPV DNA testing, for women 30 or older. • Sexually transmitted infections counseling for sexually-active women. • HIV screening and counseling for sexually active women.	early detection and prevention of breast cancer. Mammograms will be paid as medically necessary, determined by their provider Any medically necessary follow up exams will be covered according to the general medical benefits of this plan and subject to any cost-sharing. We cover any covered expenses for laboratory, X-ray procedures, or mammography that accompany the examination according to the diagnostic X-rays and laboratory services. This plan permits a female enrollee to designate a women's healthcare provider as her PCP. These services are also covered, but not limited to: • Gestational diabetes screening • Domestic and interpersonal violence screening and counseling • FDA-approved contraceptive methods, and contraceptive education and counseling • Breastfeeding support, supplies, and counseling • HPV DNA testing, for women 30 or older • Sexually transmitted infections counseling for sexually-active women • HIV screening and counseling for sexually active women	
Radiology page 39	Services provided by a physician, or prescribed by a physician and provided by a lab or radiology facility. Covered services include (but are not limited to) diagnostic and therapeutic services, fluoroscopy, x-rays, MRIs, CT scans, and electrocardiograms. Please see your Summary of Benefit Coverage for your cost-share description for these services; not all radiology services will have the same cost-share. Please ensure you are aware of your cost sharing for these benefits. Some of these services will have different cost share based on what benefit they fall under. For example, if they are preventive, they may not have a cost share to the member. They will have higher cost share than normal radiology services.	Services provided by a physician, or prescribed by a physician and provided by a lab or radiology facility. Covered services include (but are not limited to) diagnostic and therapeutic services, fluoroscopy, x-rays, MRIs, CT scans, and electrocardiograms. Please see your Summary of Benefit Coverage for your cost-share description for these services; not all radiology services will have the same cost-share. Please ensure you are aware of your cost sharing for these benefits. Some of these services will have different cost share based on what benefit they fall under. For example, if they are preventive, they may not have a cost share to the member.	Last sentence removed.
Skilled nursing facility (SNF) page 39	Services of a skilled nursing facility are covered for up to 60 days per benefit year of extended care. Custodial care is not a covered benefit. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services).	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. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services).	Updated language.
Specialized surgical and radiological	The value base co-pay for these procedures and services are in addition to potentially regular co-payment, or coinsurance as applicable.	The value base copay for these procedures and services are in addition to, potentially regular copayment, or coinsurance as applicable. See your Summary of	Updated language.

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services page 39	The radiology tier is a cost group that requires plan members to pay a co-pay for each of the following diagnostic tests and imaging services: • MRIs • CT scans • PET scans The procedures tier is a cost group that requires plan members to pay a co-pay for each of the following procedures: • Spine surgery for pain • Arthroscopies • Shoulder surgery for Osteoarthritis	Benefits for cost share information.	
Tubal ligation and vasectomy procedures page 40	Are covered	Are covered and paid based on place of service, provider type, and how the services are billed.	Added clarifying language.
Wellness benefits page 41	Your plan includes the following wellness benefits: • Individual wellness assessment – This assessment is not done prior to enrollment and is only done after you have been enrolled and have chosen a plan and in no way will affect your coverage. This assessment is used to help you determine your health risks. • Health risk screening – This screening is not done prior to enrollment and is only done after you have been enrolled and have chosen a plan and in no way will affect your coverage. The screening can include lab work for cholesterol and glucose levels, weight, height, BMI and other measurements. • Personal health coaching – Is available for you for services such as dietician services and personal trainer services.	Your plan includes the following wellness benefits. See your Summary of Benefits for more information. • 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.	Updated language.
Excluded services page 42	• Any treatment or services provided by an alternative medicine provider are not covered under this plan, unless specified in this document.	• Alternative care treatment or services, except as outlined in the Samaritan Alternative Care Rider when purchased by Plan Sponsor	Updated language.
Excluded services page 43	• Alternative medicine services such as chiropractic, acupuncture or massage or massage therapy. •	• Alternative medicine services such as chiropractic, acupuncture or massage therapy, except as outlined in the Samaritan Alternative Care Rider when purchased by the Plan Sponsor	Updated language.
Excluded services page 43		• Services related to surrogacy	Added exclusion.

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Excluded services page 43	• Treatment incurred prior to enrollment and coverage under this Plan, or after coverage terminates. The only exception is that if this plan 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;	• Treatment incurred prior to enrollment and coverage under this Plan, or after coverage terminates. The only exception is that if this plan is terminated and immediately replaced by another group health policy while you are hospitalized, Samaritan Health Plans will continue paying covered hospital expenses in accordance with Oregon Revised Statutes.	Updated language.
Excluded services page 44		• Treatment incurred as a result of a Worker's Compensation injury or illness, including any claims that are resolved related to a disputed claim settlement. The Plan does not cover any services and 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 Worker's Compensation coverage. The only exception is if the member is exempt from state or federal workers' compensation law. • Treatment incurred as a result of an injury or 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 Claimant whether or not the Claimant makes a claim under such coverage. Further, the Claimant 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, expired, or considered to no longer be injury related under the no-fault provisions of the contract, benefits will be provided according to this contract.	Added exclusions.
Prior authorization page 45	Medically necessary services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are: • Consistent with the symptoms of a health condition or treatment of a health condition; • Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective; • Not solely for the convenience of member or a provider of the service or medical supplies; and • The most cost effective of the alternative levels of medical services or medical supplies, which can be safely provided to member in the PCP's judgment.	Medically necessary services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, are: • Consistent with the symptoms of a health condition or treatment of a health condition • Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective • Not solely for the convenience of member or a provider of the service or medical supplies • The most cost effective of the alternative levels of medical services or medical supplies, which can be safely provided to the member in the provider's judgment • In Samaritan's determination as based on available	Added last bullet.

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		information and documentation, and in accordance with the terms of the Plan	
When the hospital bills you page 47	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 service area that can be paid by the provisions of this plan. In order to request reimbursement according to 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; and • 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 billing and include a receipt. Reimbursement forms are available online or by calling our Member Services Department at 541-768-4550, toll-free at 1-800-832-4580; TTY 1-800-735-2900; Monday through Friday 8 a.m. to 5:00 p.m. 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 current rate of exchange at the time of service.	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 request reimbursement according to 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 billing and include a receipt. Reimbursement forms are available online or by calling our Member Services Department at 541-768-4550, toll-free at 1-800-832-4580; TTY 1-800-735-2900; Monday through Friday 8 a.m. to 5:00 p.m. 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 current rate of exchange at the time of service.	Updated language.
Third party liability and right of subrogation page 50	As long as you or your covered dependent has signed a trust agreement, we will allow a deduction of a proportionate share of the reasonable expenses of getting a recovery, such as attorney fees and court expenses from the amount to be reimbursed to us.	We expect full reimbursement before any amounts are deducted from the policy, proceeds, award, judgement settlement, or other arrangement. This obligation to reimburse the Plan shall be equally binding upon the Covered Person 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.	Updated language.
Medicare page 51	In certain situations, this plan is primary to Medicare. This Medicare and this policy at the same time, we pay benefits for eligible charges first and Medicare pays second. Those situations are: • When you or your spouse is age 65 or over and by law Medicare is secondary to your employer group health plan. • When you or your covered dependent incurs eligible charges for kidney transplant or kidney dialysis and by law Medicare is secondary to your employer group health plan; and • When you or your covered dependent is entitled to	In certain situations, this Plan is primary to Medicare. When you are covered by Medicare and this policy at the same time, we pay benefits for eligible charges first and Medicare pays second in specific situations. Those situations are: • When you or your spouse is age 65 or over and by law Medicare is secondary to your employer group health plan. • When you or your covered dependent incurs eligible charges for kidney transplant or kidney dialysis and by law Medicare is secondary to your employer group health plan; and	Updated language.

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	benefits under section 226(b) of the social Security Act (Medicare disability) and by law Medicare is secondary to your employer group health plan. In all other instances, we will not pay benefits toward any part of a covered cost to the extent the covered cost is actually paid under Medicare Part B had you or your covered dependent properly applied for benefits. Furthermore, when we are paying secondary to Medicare we will cover member incurred services.	• When you or your covered dependent is entitled to benefits under section 226(b) of the social Security Act (Medicare disability) and by law Medicare is secondary to your employer group health plan. For additional information on how this Plan coordinates with Medicare, please see www.medicare.gov.	
Workers' Compensation page 54	We are required to provide coverage for claims for covered services denied or not yet adjudicated by the workers' compensation carrier.	We are required to provide coverage for claims for covered services denied or not yet adjudicated by the workers' compensation carrier. We provide 24-hour coverage for owners, officers, or partners not covered by Workers' Compensation and non-subject workers who are Members under the Group Contract.	Updated language.
Other authorities and responsibilities page 72	Samaritan Health Plans (SHP) is not the named fiduciary or plan administrator under ERISA of the Plan. SHP does not have discretionary authority with regards to administration of the Plan and does not make Group or Member eligibility determinations. SHP may make factual determinations relating to benefits provided under the Plan. SHP 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.	Samaritan Health Plans (SHP) 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 Group or 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.	Added 'Plan Sponsor'.
Changing this contract (certificate) page 72	This document is your contract with Samaritan Health Plans as Samaritan Everyday Choices. This contract cannot be changed except by a written endorsement or notification to you issued by us or your employer that have been approved by an officer of Samaritan Health Plans. We may change this contract by giving you 60-days advance written notice; but we can do so only if we are changing all contracts of the same form and class and approved by your employer. The client and Plan will determine and agree upon adjusted deductibles and other accumulators as it applies to their mid-year enrollment. All benefit plan years will be administered January 1 – December 31 following a mid-year enrollment.	This Contract explains the benefits available to you under the group insurance contract entered into by and between Samaritan Health Plans and your Plan Sponsor (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 Plan Sponsor 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 Plan Sponsor for additional information on the contract between Samaritan Health Plans and your employer.	Updated language.
Group contract	The Contract will renew automatically from year to year	The Group contract will renew automatically from year	Updated language.

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renewal and termination page 72	unless terminated as otherwise provided in the Contract. Termination of the member under the Contract for any reason will completely end all obligations of the Company to provide the member with Benefits after the date of termination, except where required by Oregon Revised Statutes which provides coverage for hospital or medical services or expenses under the provisions of the 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.	to year unless terminated as otherwise provided in the Group contract. Termination of the member under the Group contract for any reason will completely end all obligations of the Company to provide the member with Benefits after the date of termination, except where required by Oregon Revised Statutes, which provides coverage for hospital or medical services or expenses under the provisions of the 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.	
Rescinding coverage page 72	A carrier may not rescind a group health benefit plan unless: (a) The plan sponsor or a representative of the plan sponsor: A. Performs an act, practice or omission that constitutes fraud; or B. Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan; (b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and (c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule. 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.	A carrier may not rescind a group health benefit plan unless: (a) The plan sponsor: 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) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the Division of Financial Regulation, to each plan enrollee who would be affected by the rescission of coverage (c) The carrier provides notice of the rescission to the Division of Financial Regulation in the form, manner and time frame prescribed by the Division of Financial Regulation by rule. 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.	Removed 'or a representative of the plan sponsor'. Updated 'department' to 'Division of Financial Regulation'.
Legal action page 73	No action at law or in equity shall be brought to recover on this policy prior to the expiration of 90 days after written proof of loss has been furnished in accordance with the policy. No action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished after two years from the date of issue of the policy no misstatements, except fraudulent misstatements, made by the applicant shall be used to void the policy or to deny a claim. We acknowledge that misstatements, misrepresentations, omissions, or concealments on the part of the insured 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 insured,	No action at law or in equity shall be brought to recover on this policy 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. Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such	Updated language according to rule.

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	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. After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability, as defined in the policy, commencing after two years from the date of issue of this policy 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 this policy.	time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. We acknowledge that misstatements, misrepresentations, omissions, or concealments on the part of the insured 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 insured, 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. After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability, as defined in the policy, commencing after two years from the date of issue of this policy 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 this policy.	

NOTE: The information shared above are changes that may have affect your coverage or eligibility to receive coverage. There were other changes made to the Samaritan Everyday Choices endorsement that do not affect your coverage status or eligibility. Those minor changes were not included in this summary.