Samaritan Health Plans

Samaritan Everyday Choices

ENDORSEMENT

This document provides changes made to your Medical and Pharmacy benefits effective January 1, 2017 or the date on which Your medical plan becomes effective or renews with Us, whichever is later. If you do not have a 2017 Samaritan Everyday Choices Member Certificate, please contact your Plan Sponsor or call our Customer Service Department at 541-768-4550; Toll-free at 1-800-832-4580; TTY 1-800-735-2900.

KEEP THIS NOTICE WITH YOUR 2017 SAMARITAN EVERYDAY CHOICES PLAN DOCUMENTS. THIS IS A LEGAL PART OF YOUR MEMBER CERTIFICATE.

Please read this notice carefully and keep it where you can find it. This notice has important information about changes to your Medical & Pharmacy Plan Documents. You may request a copy of any plan document by contacting your Plan Sponsor or Samaritan Health Plans' Customer Service at 541-768-4550 or toll-free 1-800-832-4580 (TTY 1-800-735-2900), Monday through Friday, from 8 a.m. to 8 p.m.

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SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE

Samaritan Health Plans
Corvallis, Oregon

An approved OREGON PPO Group Health Benefit Plan

Kelley Kaiser, MPH
Chief Executive Officer

🡻 🡻 🡻 THIS LANGUAGE REPLACES THE INTRODUCTION ON PAGE II IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE 🡻 🡻 🡻

Introduction

This document describes the Medical and Pharmacy benefits for eligible participants of Everyday Choices. We guarantee to offer to any employer all products that are approved for sale in the applicable market, and must accept any employer that applies for any of those products where eligible. We guarantee coverage based on eligibility and provisions of this document, not based on health status, race, creed, genetic information or disability in accordance with Oregon Statute.

Every effort has been made to make these explanations as accurate as possible in accordance with the Life and Health Insurance Policy Language Simplification Act, Patient Protection and Affordable Care Act (PPACA) of 2009 and Oregon Revised Statutes. For more information, contact Samaritan Health Plans at (541)768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900; Monday through Friday 8 a.m. to 8 p.m.

Or Visit…

Samaritan Health Plans
2300 NW Walnut Boulevard
Corvallis, OR 97330

(541) 768-4550
1-800-832-4580
TTY 1-800-735-2900

www.samhealthplans.org

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES DEFINITIONS STARTING ON PAGE 1 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Benefit year – The benefit year for a group's coverage is based on the effective date listed in the employer group contract.

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.

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 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.

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

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.

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
- 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.

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.

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.

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.

Professional provider – Licensed or Registered Medical Providers that provide medically necessary covered services within the scope of their license or 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.

Service area – Samaritan Everyday Choices Plan options are available for purchase statewide in the State of Oregon for Oregon domiciled businesses.

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 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.

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.

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:

- 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.

⬇ ⬇ ⬇ THIS DEFINITION IS REMOVED FROM THE DEFINITIONS SECTION ON PAGE 3 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

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.

⬇ ⬇ ⬇ THIS DEFINITION IS ADDED TO THE DEFINITIONS SECTION ON PAGE 6 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Plan Sponsor – A designated party, usually a company or employer, that sets up a healthcare plan for the benefit of the organization's employees.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE ELIGIBILITY AND ENROLLMENT LANGUAGE ON PAGE 10 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Eligibility and enrollment

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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS LANGUAGE ON PAGE 11 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Deductibles and out-of-pocket maximums

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 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 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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE HEALTH SAVINGS ACCOUNT (HSA) ELIGIBILITY LANGUAGE ON PAGE 12 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Health Savings Account (HSA) eligibility

Some Samaritan Everyday Choices 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.

🡻 🡻 🡻 THIS LANGUAGE REPLACES THE SERVICE AREA LANGUAGE ON PAGE 13 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE 🡻 🡻 🡻

Service area and provider network

Samaritan Everyday Choices 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 www.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 Everyday Choices 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
- 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).

PLEASE NOTE:

Not all providers or pharmacies in our service area are considered to be an in-network provider.
Not all providers or pharmacies outside our service area are considered to be an out-of-network provider.
Please call Member Services to verify the network status of your provider or pharmacy before obtaining services at: (541) 768-4550 or 800-832-4580.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE BECOMING A SAMARITAN MEMBER LANGUAGE ON PAGE 14 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Becoming a Samaritan member

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
- 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.

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

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE SPECIFIC SECTIONS ON PAGE 16 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Employees

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.

Qualified Medical Child Support Order (QMCSO)[1]

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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE HOW AND WHEN TO ENROLL LANGUAGE ON PAGE 17 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

How and when to enroll

When you first become eligible

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.

Newly hired/eligible employees and their dependents

Newly hired employees and employees that begin 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.

Returning to work after a layoff

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

Returning to work after a leave of absence (LOA)

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

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

You must re-enroll your family members by submitting 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 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

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.

Adopted children

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.

Family members acquired by marriage

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.

Family members acquired by domestic partnership

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.

Family members placed in your guardianship

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

- Not in a domestic partnership, 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.

Waiver of coverage

The employee may waive coverage under the Plan for 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

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.

🡻 🡻 🡻 THIS LANGUAGE REPLACES THE LANGUAGE ON PAGE 19 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE 🡻 🡻 🡻

Special enrollment periods

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 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

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 the open enrollment period, plan coverage begins on the plan's anniversary date.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE TERMINATING COVERAGE LANGUAGE ON PAGE 20 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Terminating coverage

If you leave your job for any reason or your work hours are reduced below your employer's minimum requirement, coverage for you and your enrolled family members will end. Coverage ends on the last day of the last month in which you worked full time and for which a premium was paid. You can, however, be eligible to continue coverage for a limited time; see **Continuation Coverage** for more information. Any termination of coverage will be based on your date of termination, in which case, coverage will term the end of the month you were terminated.

You can voluntarily discontinue coverage for your enrolled family members at any time by completing an Enrollment Change form and submitting it to your employer. Keep in mind that once coverage is discontinued, your family members can be subject to the late enrollment waiting period if they wish to re-enroll later.

Termination of group

Samaritan Health Plans must receive written notice of termination from the Group. Samaritan Health Plans must receive the notice at least 30 days in advance of the proposed termination date. Group must provide in writing whether Samaritan Health Plans is being replaced by another group policy. Group shall continue to be liable for Plan premiums for all Members enrolled in Plan through Group through the end of the first full month requested and agreed upon termination date.

Divorced spouses or legal separation

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.

Dependent children

When your enrolled child no longer qualifies as a dependent, coverage will end the last day of the month in which the dependent attains the age of 26. See **Your eligibility** for information on when your dependent child is eligible beyond age 25. See **Continuation Coverage** and **Special Enrollment Periods** where you can find more information on other coverage options for those who no longer qualify for coverage.

Dissolution of domestic partnership

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**.

Certificates of creditable coverage

For questions or requests regarding certificates of creditable coverage, you will need to contact your group Plan Administrator.

⬇ ⬇ ⬇ THIS LANGUAGE IS REMOVED ON PAGE 23 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Circumstances causing ineligibility or loss of benefits

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 10).
- 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 **Error! Bookmark not defined.** and elsewhere for other maximum limits).
- Failing to reimburse the Plan under its right of subrogation (see "General Provisions" on page 46).

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE CONTINUATION COVERAGE LANGUAGE ON PAGE 22 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

State and Federal Continuation coverage

State continuation

If you are the spouse of an employee that works for an employer that has at least 20 employees on a typical business day during the preceding calendar year, you may be eligible for a specific type of state continuation coverage. You must be 55 years of age or older, and be separated, divorced, or your spouse (employee) dies, for you and your dependents to be eligible to continue your coverage. Please contact your Plan Administrator for information on how to continue coverage under this state law. If you are covered by federal (COBRA) or state continuation coverage, and your employer changed size, contact your Plan Administrator to verify your continuation coverage benefits.

Continuation of coverage is not available to a covered person or qualified beneficiary who is eligible for: (a) Medicare; or (b) The same coverage under any other program that was not covering the covered person or qualified beneficiary on the day before a qualifying event.

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 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.

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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE PRESCRIPTION DRUG BENEFITS LANGUAGE STARTING ON PAGE 24 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Prescription drug benefits

The level of prescription drug coverage is determined through a five-tier system. To find out which tier a specific drug is covered in or if there are any specific limits or authorization requirements, see the formulary at samhealthplans.org. 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, 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
- 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 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 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 Everyday Choices 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 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

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE PLAN BENEFITS LANGUAGE STARTING ON PAGE 27 IN YOUR 2017 SAMARITAN EVERYDAY CHOICES MEMBER CERTIFICATE ⬇ ⬇ ⬇

Circumcision – Is covered. For purposes of this benefit a 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.

Dental services – 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.

Dialysis – Is covered and paid based on where services are rendered.

Multidisciplinary programs – 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.

Preventive immunizations – 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.**

Preventive women's exams – 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 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 – 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.

Skilled nursing facility (SNF) – 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).

Specialized surgical and radiological services – The value base copay for these procedures and services are in addition to, potentially regular copayment, or coinsurance as applicable. See your Summary of Benefits for cost share information.

Tubal ligation and vasectomy procedures – Are covered and paid based on place of service, provider type, and how the services are billed.

Wellness benefits – 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.

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Prescription drug benefits

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 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 rel*a*ted 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 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 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:

5. 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.

6. The prescriber indicates on the original prescription that a specific number of refills will be needed.
7. The refill does not exceed the number of refills that the prescriber indicated in number 2 above.
8. 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**.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE BENEFIT EXCLUSIONS STARTING ON PAGE 39 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Benefit exclusions

Some exclusions are described specifically under the benefit category sections in **Plan Benefits.**

Least costly setting for services

Covered services must be performed in the least costly setting where they can be provided safely. For example, if a procedure that can be done safely on an outpatient basis is done in a hospital inpatient setting, this plan will only pay what it would have paid for the procedure on an outpatient basis.

Excluded services

This plan covers only the services and conditions specifically identified in this Member Certificate. Unless a service or condition fits into one of the specific benefit definitions, it is excluded.

This plan does not cover the following surgeries and procedures:

- Alternative care treatment or services, except as outlined in the Samaritan Alternative Care Rider when purchased by Plan Sponsor
- Cosmetic or reconstructive surgery except when medically necessary
- Abdominoplasty
- Treatment for infertility, including artificial insemination, in vitro fertilization, or GIFT procedures
- Surgery to reverse voluntary sterilization
- Routine foot care such as treatment for corns and calluses, toenail conditions, hypertrophy or hyperplasia of the skin and nails **unless, the patient has diabetes, peripheral vascular disease, or recurrent infections**
- Surgical procedures that alter the refractive character of the eye, unless medically necessary
- Treatment to augment or reduce the upper or lower jaw, except when necessary
- Temporomandibular joint (TMJ) or myofascial pain treatment, advice, or appliances
- Services for dental implants, or improving placement of dentures
- Sex transformations are excluded when not medically necessary or when not related to a mental health condition
- Sexual Dysfunction is excluded when not medically necessary or when not related to a mental health condition
- Eye surgeries to improve vision such as, Lasik, unless medically necessary or when not related to a mental health condition
- Myeloablative high dose chemotherapy, except when the related transplant is covered
- Services, supplies, testing or treatment for sterility, infertility, impotency, frigidity, or sexual inadequacy, unless medically necessary or when not related to a mental health condition
- Custodial care, including routine nursing care and rest cures and hospitalization for environmental change

This plan does not cover the following drugs and medications:

- Prescription drugs used primarily for weight control or obesity, regardless of the diagnosis (including, but not limited to, amphetamines)
- Non-prescription drugs**:** Drugs, which by law do not require a prescription order, except for insulin, and certain over-the-counter (OTC) drugs specifically covered by this Prescription Drug coverage. Those medications covered by the Plan considered OTC, require a written prescription from a physician to be covered under the plan. **Note:** You or your physician may submit a medication exception request for OTC medications not listed in the formulary.
- Immunizations or services in anticipation of exposure through travel or work
- Vitamins except those which by law require a prescription order, or are required by law to be covered by the plan
- Drugs with no proven therapeutic indication
- Drugs used for other than medically necessary indications
- The following miscellaneous drugs are specifically excluded:
  - Rogaine
  - Yohimbine
- Drugs for which claims are submitted 12 months or more after the date of purchase
- Drugs or devices used for infertility
- Drugs or devices used for impotence (e.g., Viagra, MUSE, Yohimbine, etc.) , unless medically necessary or as a result of a mental health diagnosis
- Drugs or devices used for cosmetic reasons (e.g., Propecia, Botox, Renova, etc.), unless medically necessary

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

- Eyeglasses or contact lenses (exclusion applies to adults only), vision therapy, orthoptics and visual appliances (colored lenses, prisms and special glasses) for reading, learning or behavioral disabilities or dyslexia
- Routine supplies and equipment used for comfort, convenience, cosmetic purposes, or environmental control. This includes appliances like air conditioners, air filters, whirlpools, hot tubs, heat lamps, or tanning lights. It also includes personal items like telephones and televisions, and maintenance supplies or equipment commonly used for purposes other than medical care.

This plan does not cover the following mental health and chemical dependency services, unless medically necessary within the scope of the provider or as ordered by the court:

- Marital, family, career, or personal growth counseling, unless it is a part of an individual's treatment plan and billed specifically for the individual
- Voluntary mutual support groups like Alcoholics Anonymous
- Counseling in the absence of illness
- Psychological testing that is not medically necessary
- Any mental health services unrelated to the treatment or diagnosis of a mental disorder

This plan does not cover the following health related conditions, services, or supplies, unless medically necessary within the scope of the provider or as ordered by the court:

- 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
- Homeopathic treatment
- Hypnosis
- Treatment that is not medically necessary for the treatment of an Illness or Injury
- Experimental or investigational
- Services related to surrogacy

Other services, supplies, and treatments this plan does not cover:

- Any charge over the Usual and Customary or Reasonable charge for services or supplies
- Hospital, Skilled Nursing Facility or other facility services that began before the Covered Person's coverage began, including services and supplies
- Treatment incurred prior to enrollment and coverage under 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.
- Services or supplies otherwise available (such services or supplies will be covered if otherwise required by law):

  - Services or supplies for which the covered person could receive partial or complete payment had the covered person applied under any city, county, state or federal law
  - Services or supplies the covered person could have received in a hospital or program operated by a government agency or authority
- Services provided by an immediate family member, including parents, grandparents, spouse/domestic partner, siblings, children and grandchildren
- Services or supplies for which no charge is made, or for which no charge is normally made in the absence of insurance
- Services or supplies for which the Covered Person is not charged or cannot be held liable because of an agreement between the provider rendering the service and another third-party payer that has already paid for the service
- Services or supplies with no charge, or which your employer would have paid for if you had applied
- Charges that are the responsibility of a third party, such as personal injury protection insurance, motor vehicle liability insurance, or uninsured or underinsured motorists
- Charges for services or supplies if you are not willing to release medical information to Samaritan Health Plans needs to determine eligibility for payment
- Charges for travel or work related expenses, telephone consultations, missed appointments, get acquainted visits, completion of claim forms or completion of reports requested by the Claims Administrator in order to process claims
- Care designed mainly to help with daily activities such as walking, getting out of bed, bathing, dressing, eating, and preparing meals
- Services and supplies not specifically described as benefits under this Plan
- 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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE PRIOR AUTHORIZATION SECTION ON PAGE 42 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Prior authorization

Coverage of certain medical services and surgical procedures requires Samaritan Health Plans' written authorization before the services are performed. Your provider can request prior authorization by phone, fax, or mail. If for any reason your provider will not or does not request prior authorization for you, you must contact the Plan yourself. In some cases, additional information or a second opinion can be required before authorizing coverage. **Prior authorization by Samaritan Health Plans is required for the following medical services and surgical procedures.**

- Continuous Glucose Monitors (CGM) and CGM supplies
- Durable Medical Equipment (DME) including prosthesis, oxygen and oxygen supplies, with line item prices over $1,000 in rental or purchase fees or rentals over (3) months.
- Procedures or services (for the following):
  - Bariatric surgery
  - Genetic testing except standard prenatal testing
  - Neck and back surgery (inpatient, outpatient and those done as in-office procedures)
- Potentially cosmetic, reconstructive and/or experimental surgery and services, including clinical trials.
- Radiological services (for the following):
  - Computer Axial Tomography (CAT) scans
  - Positron Emission Tomography (PET) scans
  - Magnetic Resonance Imaging (MRI)
  - Virtual Colonoscopy
  - Capsule Endoscopy
- Residential services for mental health and substance abuse/detoxification

- Uvulopalatopharyngoplasty
- Hospitalization for dental procedures
- Inpatient hospital care*, including:
  - Exception of maternity delivery services
  - Exception: Labor & delivery
  - Exception: Newborn less than 5 days
- Skilled Nursing Facility (SNF) services
- Therapeutic abortions
- Transplants, except corneal (including evaluation)

Emergency Services will not require prior authorization in accordance with Patient Protection and Affordability Care Act. We request notification of any emergency admissions and observation stays, which are not previously described in this document, which exceed 48 hours in order to ensure that all of the member's care is appropriately coordinated.

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 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.

Samaritan Health Plans reserves the right to review or otherwise deny services that are not found to be medically necessary.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE MEMBER CLAIM REIMBURSEMENTS SECTION ON PAGE 44 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Member claim reimbursements

When the hospital bills you

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.

Physicians' charges

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

- the patient's name and the group and identification number
- the date treatment was given

- the diagnosis
- an itemized description of the services given and the charges for them

If you have already paid the services and supplies, please note that fact boldly on the billing and include a receipt.

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

Physician reimbursement

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

Filing a lawsuit

Any legal action arising out of this plan and filed against us by a covered person or any third party must be filed within three years.

Other health care charges

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

Prescription medication rebates

Samaritan Health Plans participates in arrangements with medication manufacturer's which allows us to receive rebates based on volume of certain prescription medication purchased on behalf of covered individuals

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

Appliances

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

Ambulance service

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

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THIRD PARTY AND RIGHT OF SUBROGATION SECTION ON PAGE 47 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Third party liability and right of subrogation

This provision applies when you or a covered dependent incurs health care expenses in connection with an illness or injury for which one or more third parties can be responsible. In that situation, benefits for such expenses are excluded under this policy to the extent you or your covered dependent receives a recovery from or on behalf of the responsible third party.

Here are some rules, which apply in these third-party liability situations:

- If a claim for health care cost is filed with us and you have not yet received recovery from the responsible person, we can advance benefits for covered expenses if you or your covered dependent agrees to hold, or directs you or your covered

dependent attorney or other representative to hold, the recovery against the other party in trust for us up to the amount of benefits we paid in connection with the illness or injury. We will require that you or your covered dependent sign and deliver to us an agreement (called a trust agreement) guaranteeing our rights under this provision before we advance any benefits.

- If we pay benefits, we will be entitled to have the amount of the benefits we have paid separated from the proceeds of any recovery you or your covered dependent receives from or on behalf of the third party and held in trust for payment to us.
- We are entitled to the amount of benefits we have paid in connection with the illness or injury, regardless of whether you or your covered dependent has been made whole, from the proceeds of any settlement, arbitration award, or judgment that results in a recovery for you or your covered dependent, the third party's insurer, or any other insurance recovery. This is so regardless of whether: the third party or the third party's insurer admits liability; the health care expenses are itemized or expressly excluded in the third-party recovery; or the recovery includes any amount (in whole or in part) for services, supplies, or accommodations covered under the policy. The amount to be in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.
- If you make a recovery and fail to hold in trust for us the amount of paid benefits and to pay us that amount as required by this Third Party Liability (TPL) provision, we can limit future treatment or future medical benefits for the defined injury up to the amount of benefits we paid for the illness or injury caused by the third party. Not all TPL claims will go to subrogation. Samaritan Health Plans follows rules on Third Party Liability and subrogation to the full intent of the law.
- We expect full reimbursement before any amounts are deducted from the 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.
- If you or your dependent incurs health care expenses for treatment of the illness or injury after recovery, we will exclude benefits for otherwise eligible charges until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount.

The term "net recovery amount" is calculated as follows:

the amount of recovery; plus

the amount you or your covered dependent recovered from any other source such as other insurance as a result of the illness or injury;

Minus

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

Minus

the amount you or your covered dependent reimbursed to us out of the recovery for benefits we paid before the recovery;

Minus

the total expenses paid by you or your covered dependent or on your or your covered dependent's behalf in getting the recovery such as reasonable attorney fees and court expenses;

Shall equal

the "net recovery amount."

This provision applies if you or your covered dependent has made or is entitled to make a claim for workers' compensation. Benefits for treatment of an illness or injury arising out of or in the course of employment or self-employment for wages or profit are subject to review for proper adjudication. Services can be subject to additional recovery. The only exception would be if you or your covered dependent is exempt from state or federal workers' compensation law.

Here are some rules, which apply in situations where a workers' compensation claim has been filed:

- You must notify us in writing within 5 days of filing a workers' compensation claim.
- If the entity providing workers' compensation coverage denies your claims and you have filed an appeal, we may advance benefits if you or your covered dependent agrees in writing to hold any recovery you or your dependent obtains form the entity providing workers' compensation coverage in trust for us according to the Third-Party Liability provision.

🡻 🡻 🡻 THIS LANGUAGE REPLACES THE MEDICARE SECTION ON PAGE 48 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE 🡻 🡻 🡻

Medicare

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
- 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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE WORKERS' COMPENSATION SECTION ON PAGE 51 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Workers' Compensation

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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE OTHER AUTHORITIES AND RESPONSIBILITIES SECTION ON PAGE 68 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Other authorities and responsibilities

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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE CHANGING THIS CERTIFICATE SECTION ON PAGE 68 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Changing this certificate

This Certificate 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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE CONTRACT RENEWAL AND TERMINATION SECTION ON PAGE 68 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Group contract renewal and termination

The Group contract will renew automatically from year 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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE TERMINATION OF GROUP SECTION ON PAGE 68 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Termination of group

Samaritan Health Plans must receive written notice of termination from the employer group. Samaritan Health Plans must receive the notice at least 30 days in advance of the proposed termination date. The employer group must provide in writing whether Samaritan Health Plans is being replaced by another group policy. The employer group shall continue to be liable for Samaritan Health Plans premiums for all members enrolled in Samaritan Health Plans through the employer group until the agreed upon termination date.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE RESCINDING COVERAGE SECTION ON PAGE 69 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Rescinding coverage

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.

⬇ ⬇ ⬇ THIS LANGUAGE REPLACES THE LEGAL ACTION SECTION ON PAGE 69 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE ⬇ ⬇ ⬇

Legal action

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 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.

🡻 🡻 🡻 THIS LANGUAGE REPLACES THE RELATIONSHIP TO SAMARITAN HEALTH SERVICES SECTION ON PAGE 69 IN YOUR SAMARITAN EVERYDAY CHOICES 2017 MEMBER CERTIFICATE 🡻 🡻 🡻

Relationship to Samaritan Health Services

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

Samaritan Health Plans
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samhealthplans.org/members
Myhealthplan.samhealth.org