Samaritan Health Plans

SAMARITAN SMALL GROUP EMPLOYER CERTIFICATE

OREGON Health Benefit Plans

Samaritan Health Plans group certificate of medical, surgical, pharmacy and hospital insurance

Small Group Employer Contract
Samaritan Health Plans
2300 NW Walnut Boulevard
Corvallis, Oregon

Kelley Kaiser, MPH
Chief Executive Officer

Kim Whitley, MPH
Chief Operating Officer

Employer name: [Name of Employer]

Effective date of coverage: [Effective date]

Plan name: [Samaritan Oregon Standard Bronze, Samaritan Oregon Standard Silver, Samaritan Health and Wellbeing [deductible amount], Samaritan New Performance]

No. [Group Number]

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

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

This document and any endorsements, riders, amendments, applications or attached papers, if any, describes the benefit coverage for Medical, Pharmacy, and Comprehensive Care Management benefits for eligible participants issued by Samaritan Health Plans to the policy holder. This document serves as your member policy designed to explain your plan as of January 2017. We guarantee coverage based on eligibility and provisions of this document, not based on health status, race, creed, disability, or sexual orientation.

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 any applicable 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 8:00 p.m.

Or Visit…
Samaritan Small Group Plans
Samaritan Health Plans
2300 NW Walnut Boulevard
Corvallis, OR 97330

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

Alternate format information

If you need this handbook or other informational materials in another form, such as:

- Other languages
- Large print
- Braille
- Audio tape
- Computer disk
- Oral presentation

Please call Samaritan Health Plans Member Services Department at (541) 768-4550; 1-800-832-4580 or TTY 1-800-735-2900 to request the format you need.

Translations

(English)

If you need this booklet in another language, large print, Braille, on tape, or another format, call (541) 768-4550; 1-800-832-4580 or TTY 1-800-735-2900.

(Spanish)

Si necesita este folleto en otro idioma, letra más grande, Braille, cinta de audio, o en otro tipo de formato, llame al 1-800-832-4580 o al 1-800-735-2900 (TTY).

(Russian)

Если Вам нужна эта брошюра на другом языке, напечатанная большими буквами, шрифтом Брайля, на кассете или в каком-нибудь другом формате, пожалуйста, позвоните по телефону (541) 768-4550; 1-800-832-4580 или телетайпу 1-800-735-2900.

To the member

Dear Samaritan Health Plans Member:

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

Please read this document and your Summary of Benefits and Coverage carefully. It provides you with the details regarding your benefits and any limitations. You also have 24/7 access to this document and all member forms online at:www.samhealthplans.org. For questions about your medical, pharmacy or vision benefits, our Member Services Department is available to assist you, **Monday through Friday:**

- **By phone**, 8 a.m. to 8 p.m., at (541) 768-4550 or toll free at 1-800-832-4580 (TTY 1-800-735-2900)
- **By email,** 8 a.m. to 5 p.m., at MemberServices@samhealth.org
- **In person**, 8:30 a.m. to 5 p.m., at Samaritan Health Plans, 2300 NW Walnut Boulevard, Corvallis, Oregon 97330

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

We look forward to serving you!

Sincerely,

Kelley Kaiser | Chief Executive Officer
Samaritan Health Plans | Stronger, healthier, together.

Samaritan Health Plans

#1 Healthiest Employer In Oregon For 2013, 2014
#3 Healthiest 100 Workplaces In America For 2014

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Definitions

If you have questions about this document, please call Samaritan Health Plans at (541) 768-4550, toll free1-800-832-4580 or TTY 1-800-735-2900.

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

Allowed amount – This is the amount that is payable to the provider of service for medically necessary, covered services. This amount is the combination of the Samaritan Health Plans payment and any deductible, coinsurance, or co-payment owed by the member. Amounts allocated to deductible, coinsurance, or co-payments are so indicated by the Explanation of Benefits. Contracted Providers must write off, or not charge, the Samaritan Health Plans patient for balances other than the deductible, coinsurance, or co-payment. Providers can collect from members for services that are not covered benefits under this policy.

Ambulatory surgical center – A facility licensed by the appropriate state or federal agency to perform surgical procedures on an outpatient basis.

Annual enrollment – A period of time each year, (usually the month of December), when eligible employees who did not enroll themselves or their eligible dependents within their initial 30-day eligibility period, can enroll in the plan or make plan changes.

Appeal – A request for your health insurer or plan to review a decision or a grievance again.

Balance billing – When a non-contracted provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider can bill you for the remaining $30. An in-network provider cannot balance bill you.

Benefit year – The benefit year for a group's coverage is based on when an employer group signs an employer group contract.

Brand-name medication – A brand name drug is a drug marketed under a proprietary, trademark-protected name.

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

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

Chemical dependency – An addictive relationship a person has with any drug or alcohol agent. Chemical dependency can be either physical or psychological, or both, and interferes with a person's social, psychological or physical adjustment. Chemical dependency does not include dependence on tobacco products or food.

Claim – A request for payment under the terms of this plan.

Co-insurance – The percentage of charges that you must pay on a claim, i.e., the portion of the claim that you pay after we pay the maximum amount for that benefit. Co-insurance and co-pay descriptions can be found in your Summary of Benefits and Coverage. **American Indian/Native Alaskan members that meet State eligibility requirements do NOT have cost sharing for covered in-network services.**

Complications of pregnancy – Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and non-emergency caesarean sections are not complications of pregnancy.

Compound medication – Two or more medications that a pharmacist mixes together. In order to be covered, compound medications must contain, in therapeutic amount, either one federal legend medication or one state restricted medication. Co-payment amounts are assessed on each covered prescription medication claim.

Contracted agency – Any servicing provider with whom we have contracted to provide services and supplies under this contract.

Contracting durable medical equipment supplier – A supplier of durable medical equipment that has contracted to provide services and supplies to you under this plan.

Coordination of benefits – A method for determining the amount that each plan should pay, when a covered person is covered under two or more health care plans. It determines which plan is primary, and which plan is secondary, thus "coordinating" benefits between the two plans.

Co-payment – A co-payment, or co-pay, is a flat fee in place of or before the application of coinsurance. Members are responsible for co-payments regardless of the presence of any deductible. Co-payments and/or Co-insurance are not applied toward the deductible, including preventive service co-payments/ coinsurance. Members are responsible for payment of co-pays at the time of service. **American Indian/Native Alaskan members that meet State eligibility requirements do NOT have cost sharing for covered in-network services.**

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

Covered expenses – The amounts that this plan pays for covered services.

Covered person – A covered employee or a covered dependent who has completed the enrollment requirements and for whom applicable contribution or payroll deduction has been made in the current month.

Deductible – The portion of covered benefit costs each member is obligated to pay before Samaritan Health Plans will provide payment for benefits. Deductibles do not apply to preventive benefits. **American Indian/Native Alaskan members that meet State eligibility requirements do NOT have cost sharing for covered in-network services.**

Deductible credit – for mid-year carrier coverage changes, all accumulators will be transferred over when we have received all pertinent information to do so. Your deductible and out-of-pocket accumulators are based on a calendar year.

Durable medical equipment (DME) – An item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness and/or injury, and is appropriate for use in your home. Examples include wigs, oxygen equipment and wheelchairs.

Eligibility – The requirements that you must meet in order to qualify for and remain in your plan option and is not based on Medicaid.

Eligible employee – Based solely on weekly work hours and completion of a group eligibility waiting period, if applicable. Criteria must meet the following standards:

(a) The work hours requirement can range from 17.5 to 40 hours per week, but a single, uniform requirement must apply to all employees of the employer; and

(b) A waiting period requirement cannot exceed 90 days and a single, uniform requirement must apply to all employees of the employer.

This does not include employees who work on a temporary, seasonal, or substitute basis.

Eligible expense or charge – The usual, customary, or reasonable charge assessed on an itemized bill, for medically necessary medical treatment as provided by this plan.

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

Emergency medical screening exam – The medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency medical transportation – Ambulance or air services for an emergency medical condition.

Emergency room care – Emergency services received in an emergency room.

Emergency services – Those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required to stabilize your condition.

Employer – Participants and beneficiaries can receive from the Plan Administrator, upon written request, a complete list of affiliated entities adopting the plan. Employer also means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

Enrollee – An employee, dependent of the employee or an individual otherwise eligible for a group health benefit plan who has enrolled for coverage under the terms of this agreement. Enrollee is referred to as subscriber or member.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

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.

Exclusions – Specified conditions or circumstances, listed in this plan, for which we pay no benefits. Exclusions can apply to services that are medically necessary.

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 20 business days if the service, supply, or drug is considered experimental or investigational. To determine the necessary documentation, call Customer Service at (541) 768-4550, toll free1-800-832-4580 or TTY 1-800-735-2900.

Generic medication – A prescription medication that is an equivalent medication to the brand-name medication, is marketed and sold by more than one source, and is listed in widely accepted references as a generic medication based on manufacturer and price. Equivalent medication means the Food and Drug Administration (FDA) ensures that the generic has the same effectiveness as the brand-name medication.

Grievance – A verbal or written complaint submitted by or on behalf of an enrollee regarding:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the plan through a prior authorization
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a member and Samaritan

Habilitation services – Health care services that help a person **keep, learn or improve skills and functioning for daily living**. Examples include therapy for a child who isn't walking or talking at the expected age. These services can include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health benefit plan – Any hospital cost, medical cost, or hospital or medical cost policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by the Exchange.

Health coaching – These one-on-one services are designed to assist members in reaching health and wellness goals. The program will help you:

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

Health insurer – A contract that requires your health insurer to pay some or all of your health care costs, in exchange for a premium.

Home health care – Services and supplies that a licensed home health agency provides to a homebound patient.

Hospice – A program designed to provide comfort and supportive services to terminally ill patients and their families.

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

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

Hospital outpatient – Care in a hospital that usually doesn't require an overnight stay.

Illness – A physical or mental illness that results in a covered expense. Physical illness is a disease or bodily disorder; mental illness is a psychological disorder characterized by pain or distress and substantial impairment of basic functioning.

In-network – The covered services that you receive from providers that are contracted with Samaritan Health Plans to provide services for our commercial members.

In-network co-insurance – The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance. See your **Summary of Benefits and Coverage.**

In-network co-payment – A fixed amount (for example, $35) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments. See your **Summary of Benefits and Coverage.**

Incur – The expense of a service is incurred on the day the service is rendered, and the expense of a supply is incurred on the day the covered person receives it.

Injury – A personal bodily injury to you caused directly and independently of all other causes by external, violent, and accidental means.

Mastectomy – Surgical removal of all or part of the breast or a breast tumor suspected to be malignant. Surgery can also include associated lymph nodes and muscles, and lumpectomies.

Maximum out-of-pocket – The maximum amount you will incur in a Benefit year, before the plan begins paying at 100% for eligible medical costs.

Medical emergency – A medical emergency is an injury or sudden illness so severe that a prudent layperson would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person (or fetus). Examples of true medical emergencies include (but are not limited to):

- bleeding that does not stop
- sudden abdominal or chest pains
- suspected heart attacks
- broken bones
- serious burns
- onset of delivery

Medically necessary – Health care services or supplies that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

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

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.

Member – The eligible enrollee or dependent covered under Samaritan Health Plans.

Member certificate – Written legal description of the plan, also called your certificate or policy. This document is your written legal description of the plan; your 'certificate'.

Network – Facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Obesity – A condition in which a person has a body mass index of at least 30.0 kg/m2 but less than 40.0 kg/m2.

Out-of-network – Covered services that you receive from providers that have **NO** contract with us to serve Samaritan Health Plan members. These providers may or may not be in our service area. Please contact the Health Plan for confirmation of provider participation.

Out-of-network co-insurance – The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network co-payment – A fixed amount (for example, $35) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-pocket limit – The most you pay during a benefit plan year before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes our premium, balance billed charges or healthcare 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. The client and/or members are responsible for meeting all deductible and benefit accumulators. There is no out-of-pocket maximum for out-of-network services.

Patient Protection and Affordable Care Act (PPACA) – A federal statute that was signed into law in the United States by President Barack Obama on March 23, 2010, along with the Health Care and Education Reconciliation Act of 2010. The Act is the product of the health care reform agenda and includes numerous health-related requirements that a health plan is required to adhere to.

Pharmacist – An individual licensed to dispense prescription medication and counsel a patient about how the medication works and its possible adverse effects.

Pharmacy – Any licensed outlet in which prescription medications are regularly compounded and dispensed.

Physician services – Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan – means Samaritan Health Plans "Samaritan", the insurance carrier who issues the Member Certificate(s) as sponsored by the Employer group. For Small Employer Groups, the Plan name is Samaritan Small Group Benefit Plans "Samaritan".

Plan Administrator is defined in ERISA § 3(16). The Plan Administrator is the Employer sponsoring this Plan unless a separate plan administrator has been specifically identified and named.

Plan support programs – We have the capability to develop support programs to compliment the medical advice of your healthcare provider.

Plan term – The group plan becomes effective at 12:01 a.m. on the date written in the Summary of Benefits and Coverage, and continues in effect for a period of 12 months, provided premiums are paid when due and in the required amounts. The group policy is automatically renewed from month to month thereafter unless modified or terminated as described below.

Policy – means this Agreement, Group's Contract Application, the Policy, and Member Certificates incorporated herein by reference, and any amendments, exhibits, supplements, addenda, attachments, endorsements, applications, Vison plans, health statements or riders, and any information submitted as part of the Application for this Agreement or for membership under this Agreement. A copy of the Group Agreement serves as the Group's services provided by SHP and responsibilities between SHP and Group, and when benefit coverage is distributed to a Member, as the Member Certificate.

Preauthorization – A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary; sometimes called prior authorization, prior approval or precertification. Your health insurance or plan can require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost. See **Prior authorization List.**

Pre-existing condition – means a health benefit plan provision applicable to an enrollee or late enrollee that excludes coverage for services (this is an exclusion period), charges or cost incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. Samaritan Health Plans does not have an exclusion period or a pre-existing conditions clause for any services.

Premium – The amount that must be paid for your health insurance or plan. You and/or your employer pay a portion every pay-period as agreed upon. Premiums are determined and finalized with the State to be effective January 1 of the coverage year.

Prescription drug coverage – Health insurance or plan that helps pay for prescription drugs and medications.

Prescription medication – Medications and biologicals that relate directly to the treatment of an illness or injury and that can legally be dispensed only with a prescription order. By law, they must bear the legend: "Caution – federal law prohibits dispensing without prescription." For purposes of the outpatient prescription medication benefit, prescription medications also include covered insulin and supplies used for the administration of insulin, Self-injectable medications, and compound medications. We require a prescription order for insulin and diabetic supplies.

Prescription order – A written prescription or oral request for prescription medications issued by a professional provider who is licensed to prescribe medications.

Primary care home – The Primary care home (PCH) practice provides relationship-based, primary health care that focuses on the health needs of the whole person. The PCH is responsible for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. They coordinate care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services.

Primary care provider (PCP) – Can mean, and is not limited to a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), Pediatric physician, Family medicine, OB-GYN physician, Internal medicine, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services for the indicated specialties.

Professional services – Services of a professional medical provider for medically appropriate diagnosis or treatment of illness or injury, and for preventive care services.

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
- A **physician** (doctor of medicine or osteopathy);
- **podiatrist;**
- **dentist** (doctor of medical dentistry, doctor of dental surgery, or denturist) and for an expanded practice **dental hygienist**;
- **pharmacist;**
- **psychologist;**
- **optometrist**
- **Oregon-registered clinical social worker and counselors;**
- **certified nurse practitioner;**
- **registered nurse or licensed practical nurse,** but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill a patient;
- **physician assistant** (to be paid as if submitted by the supervising physician); or
- **Registered physical, occupational, speech, or Audiological therapist.**
- **Women's health care provider or pediatrician**

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

For certain providers, coverage can exist under the **Vision Benefits** of the plan.

Provider – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility that provides health care services or supplies to our members who is licensed, certified or accredited as required by state law.

Reconstructive – Services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but can also be done to approximate a normal appearance.

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

Residential/partial hospitalization/day care – Care in a residential facility, hospital or other facility which provides an organized full-day or part-day program of treatment and is licensed or approved for the particular level of care for which

reimbursement is being sought by the Oregon Office of Alcohol and Drug Abuse Programs or by the Oregon Mental Health Division (or equivalent agencies, if the services are provided outside Oregon).

Self-injectable medications – Outpatient injectable prescription medications intended for self-administration and approved by us for self-injection.

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

Service area –Samaritan Health Benefit Plan options are available statewide.

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

Small employer group – An employer that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state and that employs at least one eligible employee on the first day of the plan year.

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

Spell of illness – The duration of a particular illness that lasts for a period of consecutive days beginning with the first day not part of a previous illness on which you are admitted to a hospital, and ending at the close of the first 60-day period thereafter during which you have neither been a hospital inpatient nor been confined in any other type of facility.

Spouse – To whom you are married and/or your domestic partner.

Supplies – Consumable goods to support health care services.

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

Urgent care services – Services for an unforeseen illness or injury that requires treatment within 24 hours to prevent serious deterioration of a patient's health. Urgent conditions are normally less severe than true medical emergencies. Examples of conditions that could need urgent care are sprains and strains, vomiting, cuts, and severe headaches.

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

Usual, Customary and Reasonable (UCR) charges – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount. Samaritan Health Plans members can be responsible for UCR charges if services are provided by out-of-network providers**.**

We, us, or our, – refers to Samaritan Health Plans, Inc.

When coverage begins:

- The first of the month after we have received your completed enrollment materials from the Employer,
- From birth or placement for adoption, in the case of a newborn or adoptee enrolled in accordance with the requirements of the Plan.

When coverage ends is when you have:

- Not paid your premiums.
- Your employer group has taken residence out of state.

- Moved out of our service area.
- Otherwise fail to satisfy the eligibility requirements of Samaritan Health Plans and your employer.

You or your – The person enrolled in Samaritan Health Plans.

Service area

The Samaritan Health Plans service area is statewide.

PLEASE NOTE: all out-of-area, non-urgent or non-emergent services shall be considered out-of-network provider services if provided through a non-contracted provider.

Samaritan Health Plans contracts directly with providers throughout the State of Oregon. In addition, Samarian uses the First Choice Health Network to supplement its provider panel in Oregon. The First Choice Health Network also extends to 7 other states in the Northwest. For contracted provider coverage in the remainder of the United States, Samaritan uses the First Health Network.

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.**

Out of the country coverage

We cover 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 at the time of service.

Urgent and emergent services are always covered at the in-network provider level, as are services provided by in-area contracted providers.

Coverage for out-of-area, non-urgent or non-emergent services are considered in-network if the provider is either directly contracted with Samaritan Health Plans, Inc. in Oregon, part of the First Choice Health Network in Oregon or 7 other Northwest States, or part of the First Health Network in the remainder of the United States.

For those urgent and emergent services out of country, 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 the covered health care expenditures to the Plan for evaluation and reimbursement. All member reimbursement requests must be submitted to Samaritan Health Plans within 365 days of the date services were obtained. When submitting a foreign claim request for reimbursement please include the following information:

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

Samaritan Health Plans does not cover services for the sole purpose of travel, 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.

Becoming a Samaritan member

When you become a member of Samaritan Health Plans, you receive a New Member Packet, electronically where possible. The following information and materials are found in your packet. This packet will include a summary of your benefit coverage and important information about your appeal rights. You can, at any time, request a copy of these materials. If requested, we will send you a copy of the requested materials within 30 days of your request.

Please keep these materials electronically for future reference:

- Welcome letter
- Notice of Privacy Practices pamphlet
- Summary of Benefits and Coverage
- Member Certificate
- Educational materials (optional)
- Annual benefit summaries

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.**

Your health plan member identification (ID) card

You will receive a member identification (ID) card once you have been enrolled. You must present this card when you receive services. It lists information about you, needed at your appointment for your physician's office to bill for services correctly. If you lose your member ID card, please call us and we will send you a new one.

Interpreter services

If you need a foreign language interpreter at your medical appointments, please contact Samaritan Health Plan's Member Services Department to make those arrangements. To make sure that an interpreter will be at your appointment, please have this information ready when you call:

- The name of the person or persons the appointment is for
- The member's ID number
- A home phone number
- The date and the time of the appointment
- The name of the health care provider
- The full address of the appointment
- The phone number of the provider's office
- The reason for the appointment

Please call the **Samaritan Health Plans Member Services Department at (541) 768-4550; toll free 1-800-832-4580 or TTY 1-800-735-2900** with all of the necessary information at least 72 hours before your appointment.

Member portal

Use a computer, tablet, or mobile device to conveniently access:

- Claims processed by your health plan
- Details about your eligibility with the health plan, including the amount you have met toward your deductibles, your plan limits, and summary of benefits
- The National Library of Medicine's MedlinePlus Connect for consumer-friendly health information in both English and Spanish

For questions about your member portal and technical support if needed, please call Member Services Department at 541-768-4550, toll-free 1-800-832-4580 (For Hearing Impaired, call 1-800-735-2900), Mon.–Fri., 8 a.m. to 8 p.m. Member Services Department can also be reached via email at MemberServices@samhealth.org.

Your eligibility

Small employer group is an employer that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the plan year.

Employees

Your employer decides the minimum number of hours employees must work each week to be eligible for health insurance benefits. Your employer can also require new employees to satisfy a probationary waiting period before they are eligible for benefits. Your employer's eligibility requirements are shown on your Member Enrollment Form. All employees who meet those requirements are eligible for coverage. Eligibility is not based on any health status-related factors.

Family members

While you are insured under this plan, the following family members are also eligible for coverage:

- Your legal spouse or qualified domestic partner.
- Your, your spouse's, or your domestic partner's dependent children until attaining the age of 26regardless of the child's place of residence, marital status, or financial dependence on you.
- Your siblings, nieces, nephews, or grandchildren until attaining the age of 26who are unmarried, not in a domestic partnership, registered or otherwise, and for whom you are the court appointed legal custodian or guardian with the expectation that the child will live in your household for at least a year.
- Your, your spouse's, or your domestic partner's dependent children until attaining the age of 26or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability.

Samaritan Health Plans requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage. No family or household members other than those listed above are eligible to enroll under your coverage.

Any dependent children until attaining the age of 26, and for purposes of coverage under the Plan, the term "child" includes:

- a biological child of you or your spouse;
- an adopted child of you or your spouse;
- a child actually placed with you while adoption proceedings are pending;
- a child for whom you are required to provide insurance coverage under a Qualified Medical Child Support Order (QMCSO)[1]
- a child for whom you are legal guardian; and
- a child of a qualified domestic partner of an employee.

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

Dependent parents, foster children, and any other relative not described above are not eligible for coverage under the Plan. Grandchildren are covered under the Plan only if they have been adopted or placed with you for adoption or for whom you have legal guardianship.

How and when to enroll

When you first become eligible

The initial enrollment period is the 31-day period beginning on the date a person is first eligible for enrollment in this plan. Everyone who becomes eligible for coverage has an initial enrollment period.

[1] You may obtain, without charge, a copy of our procedures governing QMCSO determinations by contacting our Member Services department at 800-832-4580 or (541) 768-4550.

When you satisfy your employer's probationary waiting period at the hours required for eligibility and become eligible to enroll in this plan, you and your eligible family members must enroll within the initial enrollment period. If you miss your initial enrollment period, you can be subject to a waiting period. To enroll, you must complete and sign an enrollment application, which is available from your employer. The application must include complete information on yourself and your enrolling family members. Return the application to your employer, and your employer will send it to Samaritan Health Plans by the end of the 31-day period.

Coverage for you and your enrolling family members begins on the first day of the month after you satisfy your employer's probationary waiting period. The probationary waiting period is shown on your Enrollment Form.

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 31 days of becoming eligible for enrollment. Coverage is effective on the first of the month following completion of the waiting period at the hours required for eligibility.

Newborns

Your, your spouse's, or your domestic partner's newborn baby is eligible for enrollment under this plan during the 31-day initial enrollment period after birth. To add the child to your coverage, you must submit an enrollment application listing the child as your dependent. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child. You can be required to submit a copy of the newborn's birth certificate to complete enrollment.

If additional premium is required, then the baby's eligibility for enrollment will end 31 days after birth if Samaritan Health Plans has not received an enrollment application and premium. Premium is charged from the date of birth and prorated for the first month.

If no additional premium is required, then the baby's eligibility continues as long as you are covered. However, Samaritan Health Plans cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.

Adopted children

When a child is placed in your home for adoption, the child is eligible for enrollment under this plan during the 31-day initial enrollment period after placement for adoption. 'Placement for adoption' means the assumption and retention by you, your spouse, or your domestic partner of a legal obligation for full or partial support and care of the child in anticipation of adoption of the child. To add the child to your coverage, you must complete and submit an enrollment application listing the child as your dependent. You can be required to submit a copy of the certificate of adoption or other legal documentation from a court or a child placement agency to complete enrollment.

If additional premium is required, then the child's eligibility for enrollment will end 31-days after placement if Samaritan Health Plans has not received an enrollment application and premium. Premium is charged from the date of placement and prorated for the first month.

If no additional premium is required, then the child's eligibility continues as long as you are covered. However, Samaritan Health Plans cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.

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 31-day initial enrollment period after the marriage. Samaritan Health Plans must receive your enrollment application and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the marriage. You can be required to submit a copy of your marriage certificate to complete enrollment. This health benefit plan does not discriminate between married and unmarried women or between children of married and unmarried women.

Family members acquired by domestic partnership

Your qualified domestic partner can enroll by submitting an enrollment application and completed Domestic Partnership Affidavit at the time of your initial enrollment or within 30 days of the partnership first becoming eligible according to the criteria stated under **Eligibility**. All other domestic partner applications will be subject to late enrollment provisions.

The Oregon Family Fairness Act (ORS 106.300 to 106.340) recognizes and authorizes domestic partnerships in Oregon. A domestic partnership is defined in ORS 106.310 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;
- until attaining the age of 26; and
- Expected to live in your household for at least a year, unless otherwise ordered by court.

We must receive your enrollment application and additional premium during the 31-day initial enrollment period beginning on the date of the court appointment. Coverage will then begin on the first day of the month following the date of the court order. You can be required to submit a copy of the court order to complete enrollment.

Qualified Medical Child Support Orders (QMCSO)

Samaritan Health Plans complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, which provides for health benefit coverage for the child of a plan member. If a court or state agency orders coverage for your spouse, domestic partner or child, they can enroll in this plan within a 31-day initial enrollment period beginning on the date of the order. Coverage will become effective on the first day of the month after Samaritan Health Plans receives the enrollment application. You can be required to submit a copy of the QMCSO to complete enrollment.

Samaritan Health Plans will extend benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA. Samaritan Health Plans has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from our Customer Services Department.

Waiver of coverage.

You may waive coverage under the Plan for yourself. You may also waive coverage for any of your eligible dependents. If you waive coverage for yourself, your dependents are not eligible for coverage. To waive coverage, you must file *a Declination of Coverage* form with the Human Resources office specifying the reason for the waiver. The form must list by name each of the dependents for which you waive coverage.

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 Annual Enrollment period (which is the month of December) to enroll. If you then enroll, coverage will become effective as of the following January 1.

Replacement of prior policy

If this group policy replaces an existing policy or contract of another insurance company, the following applies:

- When a member is hospitalized on the date this policy becomes effective, Samaritan will consider charges with a date of service coinciding with the member's effective date. Any benefits provided are subject to any prior carrier's obligations under state law or contract.
- In any situation where a determination of the prior plan's benefit is required, the member is responsible for furnishing evidence of the terms of the prior plan, and of claim payments made by the prior plan.

Enrolling after the initial enrollment period

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 31 day initial enrollment period following your return to work. Failure to submit the application within the 31 day initial enrollment period to Samaritan Health Plans will cause you to be considered a late enrollee and coverage will be deferred until the next open enrollment date.

Employees returning to work after a layoff are not subject to new exclusion periods for other conditions. If the employee's exclusion periods were satisfied (or partially satisfied) before the layoff, they will be credited at the same level when the employee returns to work.

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 31 day initial enrollment period following your return to work. Failure to submit the application within the 31 day initial enrollment period to Samaritan Health Plans will cause you to be considered a late enrollee and coverage will be deferred until the next open enrollment date.

Employees returning to work after a LOA are not 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.

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, both you and your family members can decline coverage during your initial enrollment period. If you are eligible to decline coverage and you wish to do so, you must submit a written waiver of coverage to Samaritan Health Plans through your employer. You and your family members can enroll in this plan later if you qualify under Rule #1, Rule #2, or Rule #3 below.

If the agreement between Samaritan Health Plans and your employer requires all eligible employees to participate in this plan, you must enroll during your initial enrollment period. However, your family members can decline coverage, and they can enroll in the plan later if they qualify under Rule #1, Rule #2, or Rule #3 below. To find out if your employer's plan allows employees to decline coverage, ask your Plan Administrator.

Special enrollment rule #1

If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members can enroll in the plan later if the other coverage ends involuntarily. 'Involuntarily' means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, the other insurance plan was discontinued, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse or domestic partner, divorce, or legal separation. To do so, you must request enrollment within 31 days after the other health insurance coverage ends (or within 60 days after the other health insurance

coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.

Special enrollment rule #2

If you acquire new dependents because of marriage, domestic partnership, birth, or placement for adoption, you can enroll yourself and/or your newly acquired dependents at that time. To do so, you must request enrollment within 31 days after the marriage, registration of the domestic partnership, birth, or placement for adoption. In the case of marriage and domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.

Special enrollment rule #3

If you or your dependents become eligible for a premium assistance subsidy under Medicare or a State Children's Health Insurance Program (CHIP), you can enroll yourself and/or your dependents at that time. To do so, you must request enrollment within 60 days of the date you and/or your dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late enrollment

If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the plan's anniversary date. A 'late enrollee' is an otherwise eligible employee or dependent who does not qualify for a special enrollment period explained above, and who:

- Did not enroll during the 31-day initial enrollment period; or
- Enrolled during the initial enrollment period but discontinued coverage later.

A late enrollee can enroll by submitting an enrollment application to your employer during an open enrollment period designated by your employer, just prior to the plan's anniversary date. When you or your dependents enroll during the open enrollment period, plan coverage begins on the plan's anniversary date.

Waiting periods

Samaritan Health Plans does not have waiting periods**.**

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 of Coverage** for more information. Any termination of coverage will be based on your date of termination, in which case any premiums will be retroactively adjusted and refunded.

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

SHP must receive written notice of termination from the Group. SHP must receive the notice at least 30 days in advance of the proposed termination date. Group must provide in writing whether SHP 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 employer of the divorce or separation, and continuation coverage can be available for your spouse. If there are special child custody circumstances, please contact the Plan's Member Services Department. See **Continuation of Coverage** for more information.

Dependent children

When your enrolled child no longer qualifies as a dependent, coverage will end on the last day of that month. See **Eligibility** for information on when your dependent child is eligible beyond age 25. See **Continuation of Coverage** 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 employer of the dissolution of the domestic partnership and continuation coverage can be available for your domestic partner and their covered children. See **Oregon State Continuation**.

Certificates of creditable coverage

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

Continuation of coverage

Under federal and state laws, you and your family members can have the right to continue this plan's coverage for a specified time. You and/or your dependents can be eligible for continuation of coverage if:

- You might move outside of the service area of the health plan. If you move outside of the service area of the health plan, you must contact your employer
- Your personal situation may change and you may no longer be eligible for this program.
- You did not pay your premium on time and are no longer eligible for the Plan. If this is the case you have a 10 day grace period to pay your premium.
- Once you have been disenrolled from Samaritan Health Plans, you will receive a notification of your rights, continuation options and your termination notice within 10 days of termination by Samaritan Health Plans.
- You die. Termination of coverage will be your date of death, in which case any premiums will be retroactively adjusted and refunded.

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

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 31 days after the last day of coverage under the group plan.
- You must pay continuation premium to your employer by the first of each month. Your employer will include your continuation premium in the group's regular monthly payment. Samaritan Health Plans cannot accept the premium directly from you.
- Your employer must still be insured by Samaritan Health Plans. If your employer discontinues this plan, you will no longer qualify for continuation through SHP.

COBRA continuation

If you work for an employer that had at least 20 employees on more than 50 percent of its typical business days in the previous calendar year, your employer is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). Please contact your employer for information about how to continue coverage under COBRA.

Domestic partners are recognized as qualified beneficiaries under federal COBRA continuation laws and thus can 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.

Oregon State continuation

Under this plan, you can have continuation coverage rights under Oregon state law.

State continuation eligibility when employer has less than 20 employees

If your employer has fewer than 20 employees, or if your group is not subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended, you can continue your coverage for up to nine months. You and your enrolled family members can continue coverage if you, the employee, no longer qualify for coverage under the plan (for example, if your work hours are reduced or you quit your job).

Your spouse or domestic partner and dependent children can also continue coverage under this plan if you divorce, dissolve your domestic partnership, become eligible for Medicare benefits that results in a loss of coverage, or die. Your children can also continue coverage under this plan if they no longer qualify as a dependent under the terms of this plan. Continuation coverage can last a maximum of nine months. Premium for continuation coverage is the responsibility of you or your family member. The following restrictions also apply to anyone electing Oregon continuation coverage:

- To qualify for continuation, you must have been covered under a group health insurance policy for at least three months before the date of the qualifying event. If your employer recently switched to this policy from another group health plan without a break in coverage, you will receive credit for time under the previous plan.
- Family members who were not enrolled in the group plan cannot elect 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 State Continuation Coverage Election Form within ten days after the date on your continuation notice or the date of your qualifying event, whichever is later.
- You must pay continuation premiums 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 this group policy.

When state continuation coverage ends

Although Oregon continuation coverage can last up to nine months, coverage will end early if any of the following occurs:

- If you do not pay the premium to your employer on time, coverage will end on the last day of the last month for which you paid a premium.
- If you become eligible for Medicare, your coverage will end on the last day of the month prior to the Medicare eligibility date.
- If your employer discontinues this group policy, your coverage will end on the last day the policy was in effect.
- If you and your dependents become eligible for another group health plan (such as a spouse's employer's plan or a plan at your new job), your coverage will end on the date you become eligible for that plan. When continuation coverage ends, you can be eligible to purchase an individual continuation policy.

Type of coverage

Under Oregon continuation, you can continue the coverage you had before the qualifying event. Oregon continuation benefits are always the same as your employer's current benefits. Your employer has the right to change the benefits of its health plan

or eliminate the plan entirely. If that happens, any changes to the group health plan will also apply to everyone enrolled in continuation coverage. We can provide you uninterrupted coverage when the existing policy is replaced.

State continuation

If your employer had 20 or more employees on a typical business day in the previous calendar year, your spouse and dependents that lose coverage due to a divorce, legal separation, or your death, can be eligible to continue their coverage. Please contact your employer for information about how to continue coverage under this Oregon law.

Employer contribution

Samaritan cannot deny a small employer's application for coverage under a health benefit plan based on participation or contribution requirements but can require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period.

For every group health benefit plan, the Plan Sponsor that chooses to enforce participation, contribution or eligibility requirements must:

- Specify in the plan all of participation, contribution, and eligibility requirements that have been agreed upon by the carrier and the group; and
- Apply the participation and eligibility requirements uniformly to all categories of eligible members and their dependents.

For a small group health benefit plan, a carrier:

- Can establish and apply contribution requirements for different categories of members and dependents that exceed the minimum contribution;
- Must apply participation requirements on an aggregate basis in which all categories of eligible employees of a small employer are combined;
- Must apply participation and eligibility requirements uniformly to all small employers with the same number of eligible employees;
- If a carrier requires 100 percent participation of eligible employees in a small group health benefit plan, the carrier cannot impose a contribution requirement upon the employer that exceeds 50 percent of the premium of an employee-only benefit plan; and
- Except as provided above, a carrier cannot increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer except at plan anniversary. At plan anniversary, the carrier can increase the requirements only to the extent those requirements are applicable to all other small employer groups of the same size. At the anniversary of a plan or at any time other than the anniversary, a small employer carrier can consider the existing small group as a new group for purposes of coverage if the eligibility requirements applicable to the group are changed by the employer.

Prescription drug benefits

Preventive drugs these are drugs prescribed for preventive treatment, which also include specified generic drugs, selected asthma medications, tobacco cessation drugs/ supplies, insulin and supplies required for the administration of insulin, and all ACA preventive drugs.

Preferred generic drugs provide the same high quality medicinal and therapeutic benefit found in brand-name medications without the brand-name cost.

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.

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 non-preferred medication and does not have an equivalent generic available, you can request a tier exception for your medication to be paid at the preferred tier as long as the medication is listed on the formulary and does not require a prior authorization.

High-cost specialty medications encompass specified medications. This category is subject to change, throughout the year, upon review by the Plan's Pharmacy and Therapeutics Committee. You can be charged this co-insurance if the medication is received in another setting (for example, infusion).

IMPORTANT NOTES:

- Specific plan options can have a combined (or integrated) deductible with medical expenses. You can find this information in your Summary of Benefits and Coverage documents.
- Over the Counter (OTC) medications will not be covered by Samaritan Health Plans without a prescription. Reference the formulary for more specific medication coverage.
- All medications covered by the Plan are subject to the Pharmacy & Therapeutics Committee and are approved to be on the formulary list of covered drugs. Reference the formulary for more specific medication coverage information.

Samaritan Health Plans covers both brand name drugs and generic drugs in its formulary. Generic drugs are approved by the FDA as having the same active ingredient as the brand name drug. Generally, when a generic version of a drug is available Samaritan Health Plans will require that the generic be used by members unless it is medically necessary for a member to use the brand version of a drug.

Samaritan Health Plans uses a formulary, which lists the covered prescription medications. 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.

Some covered medications can have additional requirements or limits on coverage. These requirements can include:

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, we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You can find out more about additional requirements or limits on covered medication by contacting our Member Services Department or your physician.

Compound medications can be covered with a prior authorization. In accordance to ORS 743A.068, we provide coverage for prescribed, orally administered anticancer medications because we provide coverage for cancer chemotherapy treatment.

Plan benefits

This plan provides benefits for the following services and supplies as outlined and referenced in Oregon Rule as standard coverage and service definitions. These services and supplies can require you to make a co-payment and/or coinsurance, and they can be subject to additional limitations. Please see **Summary of benefits and Coverage** and the **Benefit exclusions** for more information. Benefit limitations are described within **Plan benefits**. These services are identified throughout the document.

Acupuncture – covered under any Non-Standard Plan (Samaritan Health and Wellbeing Plans and Samaritan New Performance Plan).

Alternative services – covered under any Non-Standard Plan (Samaritan Health and Wellbeing Plans and Samaritan New Performance Plan). Chiropractic, Massage and Acupuncture is covered.

Ambulance – services of a state-certified ambulance are covered. The cost of ground transportation is covered to or from the nearest hospital. Air transportation is also covered to the nearest hospital capable of treatment, when ground transportation is not medically appropriate, and when medically necessary. Coverage and payments are made directly to the billing provider.

Artificial limbs and eyes – that are not power assisted, are covered. **If the cost is over $800, Samaritan Health Plans must prior authorize the expense**. Repairs to existing prosthetics (even if acquired by non-Samaritan providers or before Samaritan Health Plans coverage) are also covered, up to the cost of replacement.

Bilateral cochlear implants – are covered 1 for each affected ear, every 4 years.

Biofeedback – is covered for migraine headaches and urinary incontinence. Limited to 10 lifetime visits.

Blood transfusions – including the cost of blood or blood plasma and storage, are covered.

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

1. have a heart condition where exercise is standard treatment, and
2. need medical monitoring and supervision for exercise for safety, and
3. the exercise program is ordered by a physician, PA or NP.

The benefit is as follows:

- Phase I (inpatient) services are covered under inpatient hospital benefits.
- Phase II (short term outpatient) services are covered under outpatient therapy benefits.
- Phase III (long term outpatient) services are not covered.

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

Chemical dependency services – This plan covers treatment provided in healthcare facilities, residential program or facilities, day or partial hospitalization programs, or outpatient services. See also **Mental health and chemical dependency services**.

Samaritan Health Plans covers services and treatment for those mental health and chemical dependency diagnosis as it is intended under the Mental Health Parity Act.

Chemotherapy – is covered and paid based on the type of chemotherapy you receive and where services are rendered. There sometimes will be cost sharing for medications used. See **Prescription drug services**. In accordance to ORS 743A.068, we provide coverage for prescribed, orally administered anticancer medications because we provide coverage for cancer chemotherapy treatment.

Chiropractic – covered under any Non-Standard Plan (Samaritan Health and Wellbeing Plans and Samaritan New Performance Plan). However for Standard Plans (Samaritan Oregon Standard Silver and Samaritan Oregon Standard Bronze), services provided by a chiropractor that are within their license and otherwise covered are required under provider non-discrimination law.

Circumcision – is covered. For purposes of this benefit a newborn/infant is defined as any child being 3 months of age or younger. Outpatient or inpatient costs will apply for circumcisions for anyone older than 3 months.

Clinical trial – Services are covered when the member is enrolled in and participating in a qualified clinical trial. The experimental portion of the clinical trials are typically not covered, however the services that are normally covered under the plan will be covered under the applicable benefit and in accordance to the provisions outlined by the services billed by the provider and will follow all provisions of this plan document.

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

Effective January 1, 2014, the ACA requires that if a "qualified individual" is in an "approved clinical trial," the plan cannot deny coverage for related services. Plans are not required to cover treatments that fall outside the designated class of approved clinical trials, and plans may not deny coverage because a member is participating in an approved clinical trial conducted outside of the state in which the member lives.

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

- An "approved clinical trial" means a clinical trial that is:
- Funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;
- Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;
- Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the United States Food and Drug Administration; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

"Routine costs" means all medically necessary conventional care, items, or services consistent with the coverage provided by the health benefit plan if typically provided to a patient who is not enrolled in a clinical trial.

A "qualified individual" is someone who is eligible to participate in an "approved clinical trial".

If an in-network provider is participating in an approved clinical trial, the plan can require the individual to participate in the trial through that in-network provider if the provider will accept the individual as a participant in the trial.

Cochlear implants – are covered 1 for each affected ear, every 4 years.

Colonoscopy (non preventive) – When receiving non preventive colonoscopy services (non preventive is having services done with a predetermined diagnosis or presenting an applicable health problem) the benefit will be paid as an outpatient procedure.

Contraceptives – We provide coverage for all FDA approved contraceptives at no cost to the member.

Cosmetic and/or reconstructive surgery - Some cosmetic or potentially cosmetic services and surgery will not be covered under the following circumstances, unless medically necessary:

- Reconstructive surgery to primarily correct a functional disorder
- Breast reconstruction following medically necessary mastectomy, including reconstruction of the opposite breast to achieve cosmetic symmetry
- Reconstructive surgery necessitated by an accidental injury
- Surgery to correct a facial scar or defect resulting from medically necessary surgery that was covered or would have been covered, under this plan
- Surgery to correct a scar or defect resulting from surgery for cancer
- Surgery to correct a congenital defect

For cosmetic and/or reconstructive surgeries, the following additional limitations apply:

- Only one (1) attempt at reconstruction is covered following initial injury or surgery.

Additional reconstructive surgery that is medically necessary to correct a functional disorder resulting from the initial injury or surgery, will be covered.

WHCRA

The Women's Health and Cancer Rights Act of 1998 requires Samaritan Health Plans to notify you, as a participant or beneficiary, of the Samaritan Small Group Benefit Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy including lymphedema.
- These benefits are subject to the plan's regular deductible and co-pays/co-insurance. See your **Summary of Benefits and Coverage** for details.

Keep this notice for your records and call Samaritan Health Plans for more information.

Dental hospitalization – Dental services can be reimbursable under the medical plan in certain circumstances as outlined in this policy or required by law. Dental Hospitalization must be prior authorized and considered medically necessary. Only charges for the hospital, anesthesiologist, and physician assistant are covered related to the hospitalization.

Dental services – of a dentist or physician, to medically treat the injury of the jaw or natural teeth are also covered when the services presented are not considered to be reimbursable as a dental service or covered by a dental plan.

When a major dental procedure is necessary and considered to be reimbursable as a medical benefit, such as:

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

Please refer to the applicable benefit category of this policy to determine the coverage that will be provided.

The following will not be allowed for reimbursement under the medical policy:

- Hospitalization because of the patient's apprehension or convenience
- Treatment and services for Temporal-Mandibular Joint (TMJ) dysfunctions are not covered. The plan pays for outpatient care, general anesthesia, and special supplies.

- Emergency room visits as a result of tooth or mouth pain of an unknown origin are covered if you are not presenting an already determined dental issue.

Treatment and services for TMJ are not covered – Medical dental services and medically necessary orthodontic treatment are covered Examples include but are not limited to tumors, leukoplakia and premalignant lesions, trauma to jaw, acute damage to teeth, jaw fracture, lacerations in the mouth, infection beyond tooth or gum (facial cellulites, infection beyond tonsillar pillar, systemic disease manifestations in the mouth such as, lichen planus, and Sjogren's syndrome) and craniofacial anomalies.

The plan pays for outpatient care, general anesthesia, and special supplies. Emergency room visits as a result of tooth or mouth pain of an unknown origin are covered if you are not presenting an already determined dental issue.

Developmental and learning disabilities – Services will be covered for developmental and/or learning disabilities.

We will cover, for members who have been diagnosed with a pervasive developmental disorder, all medical services, including rehabilitation and habilitative services, which are medically necessary and are otherwise covered under the plan. These services may have exclusions based on the provisions of the plan and this document.

Diabetic education – Services of a Certified Diabetes Educator (CDE) for **diabetes self-management education programs** are covered. This means outpatient instruction for diabetics about the disease and its control, taught by a CDE. Services, medications, and supplies that are medically necessary for a woman to manage her diabetes during the period of each pregnancy, beginning with conception and ending six weeks postpartum.

Diabetic supplies – are covered and are defined as gauzes, syringes, needles, lancets, alcohol and alcohol swabs, betadine swabs and diabetic shoes and inserts and the fitting. See also **DME, Diabetic equipment** for additional information. Some items can be purchased at a pharmacy.

Dialysis – is covered.

Durable medical equipment (DME), orthotics and prosthetics –- Purchase or rental of durable medical equipment including crutches, wigs, wheelchairs, orthopedic braces, prosthetics, glucometers, and equipment for administering oxygen are covered. Durable medical equipment must be prescribed in writing by a licensed MD, DO, DDS, DMD, or DPM. If the purchase or rental price is over $1,000 per line item, or if the item is to be rented for longer than three months, Samaritan Health Plans must prior authorize the expense. See also **Artificial Limbs and Eyes** for coverage specifics. See **Benefit exclusions**.

Bras – following a mastectomy are covered under Samaritan Health Plans DME benefit. No authorization is needed and there is no limit to the number of bras allowed per year. Swimwear is not covered for any reason under the Plan.

Breast prosthesis – either internal or external breast prosthesis as a result of a mastectomy regardless where the original service took place. Removal or replacement of breast prosthesis is covered only when medically necessary. Please contact Samaritan Health Plans at (541) 768-4550 or 1-800-832-4580 for more information. The Women's Health and Cancer Rights Act (WHCRA) requires that Samaritan Health Plans cover services that support rehabilitation and reconstruction services in the instance that a member receive these services due to cancer and related treatment.

Breast pumps – are covered under the preventive benefit. Breast pump *supplies* are also covered under the preventive benefit.

Diabetic equipment – is covered under Durable medical equipment. Items including gauzes, lancets, syringes, needles and alcohol swabs are considered diabetic supplies. Diabetic *supplies* are considered a separate benefit from Diabetic equipment. The following diabetic equipment is covered at 100%: diabetic pumps, glucose monitors, and test strips. See **Diabetic supplies** for more information.

Maxillofacial prosthetic services – To restore and manage head and facial structures that cannot be replaced with living tissue. The treatment must be necessary to control or eliminate infection or pain. Treatment is only covered when the damage results from disease, trauma, birth or developmental deformities. Cosmetic procedures are not covered. t. **If the cost is over $800, Samaritan Health Plans must prior authorize the expense**. Repairs to existing prosthetics (even if acquired by non-Samaritan providers or before Samaritan Health Plans coverage) are also covered, up to the cost of replacement.

Medical foods – Nonprescription enteral formula for home use (1) include coverage for a nonprescription elemental enteral formula for home use, if the formula is medically necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition; **this will require authorization**. If non-prescription elemental enteral formula is ordered by a physician, the physician must write a prescription for the item and the member will need to submit a Member Reimbursement form. See also **inborn errors of metabolism.**

Orthotics – medically necessary custom made or fitted foot orthotics**.** A licensed physician or podiatrist must prescribe the device. Coverage is based on coverage that is determined by Medicare.

Prosthetics – that are not power assisted are covered. If the cost is over $800, Samaritan Health Plans must prior authorize the expense. Repairs to existing prosthetics (even if acquired by non-Samaritan providers or before Samaritan Health Plans coverage) are also covered, up to the cost of replacement. Coverage is based on coverage that is determined by Medicare.

Vision hardware – After cataract surgery or due to medical needs is covered under the DME benefit. Hardware needed after cataract surgery is a one-time per eye benefit.

Emergency services – Medically necessary emergency care. In a medical emergency, emergency care is covered at the in-network provider benefit shown on the Summary of Benefits and Coverage, even if you are treated at an out-of-network hospital. See **Definitions** for information about emergencies. **Emergency care for any reason does not require a prior authorization.**

If you or a member of your family needs immediate assistance for a medical emergency, call 911.

Gastric bypass – or any other bariatric surgery is not covered.

Genetic testing – is covered as determined through our prior authorization process. Samaritan Health Plans **requires** prior authorization for genetic testing, except for standard prenatal testing which includes (but is not limited to) genetic testing for cystic fibrosis and Verifi®.

Habilitative services – Learning new skills or functions – as distinguished from rehabilitation, which focuses on relearning existing skills or functions. An example of habilitative services is speech therapy for a child who is not talking at the expected age. Limited to 30-60 visits per benefit year depending on condition. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services)

Hearing aids – are covered. Repairs or accessories to hearing aids will be paid through the annual limit. These are considered DME. Batteries are not covered. This benefit is limited to1 pair every 4 years for each impaired ear.

Home health – is covered. Services provided during your home health visit can apply to other benefits and other cost shares will apply. For example, physical therapy can be done in your home. This service will be paid under the physical therapy benefit.

Hospice - is covered. Respite care is covered with a maximum of 5 consecutive days and 30 days lifetime.

Infusion – is covered and is paid by the plan based on the type of infusion you receive and where you receive it. You can have pharmacy costs for the drugs used during your infusion services**. See Prescription Benefits for more information.**

Injections – can be done by your Primary care provider or a specialist provider in an office setting. If you are receiving an injection drug at a pharmacy, only your pharmacy benefit will be applied. **See Prescription Benefit** for more information. Allergy injections and growth hormone injections are covered.

Inpatient hospital – medically necessary hospital inpatient services. Charges for a semi-private hospital room are covered, and charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit, or private room for septicemic-caused isolation. Please see the Prior authorization list of this document. Covered inpatient hospital services can include (but are not limited to):

- Semi-private room
- Cardiac care unit
- Operating room
- Anesthesia and post-anesthesia recovery
- Respiratory care

- Inpatient medications
- Lab and radiology services
- Dressings, equipment, and other necessary supplies
- Delivery, post-partum, newborn care
- Blood or blood products

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

Inpatient habilitative services – as medically necessary to help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. The services must be consistent with the condition being treated, and must be part of a formal written treatment program prescribed by a physician. This is covered with a maximum of 30 days per calendar year. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services)

Inpatient rehabilitative services – as medically necessary to restore and improve lost body functions after illness or injury. The services must be consistent with the condition being treated, and must be part of a formal written treatment program prescribed by a physician. This is covered with a maximum of 30 days per calendar year. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services)

Inborn errors of metabolism – Treatment and services of inborn errors of metabolism involving amino acid, carbohydrate, and fat metabolism when medically standard methods of diagnosis, treatment, and monitoring exist are covered.

Medically necessary PKU formulas (nonprescription elemental enteral formula) for home use when ordered by your authorized physician are covered as long as:

- The formula is medically necessary for the treatment of severe intestinal mal-absorption, inborn errors of metabolism that involve amino acids, carbohydrates and fat metabolisms.
- The formula comprises the sole or an essential source of your nutrition.
- Nutritional supplies and medical assessment equipment necessary to diagnose, monitor and control disorders of inborn metabolic disorders.

Medical foods – are covered under the DME benefit and require authorization when the cost will be greater than $800. Nonprescription enteral formula for home use (1) include coverage for a nonprescription elemental enteral formula for home use, if the formula is medically necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition.

Laboratory services – Provided by a physician, or prescribed by a physician and provided by a lab. Please see your Summary of Benefits and Coverage for your cost-share description for these services; not all laboratory services will have the same cost-share.

Mastectomy services – Either internal or external breast prosthesis as a result of a mastectomy regardless where the original service took place. Removal or replacement of breast prosthesis is covered only according to certain criteria to determine medical necessity. Bras following a mastectomy are covered under Samaritan Health Plans DME benefit. No authorization is needed for bras and there is no limit to the number of bras allowed per year. Swimwear is not covered for any reason under the Plan.

Please contact Samaritan Health Plans at (541) 768-4550 or 1-800-832-4580 for more information. The Women's Health and Cancer Rights Act (WHCRA) requires that Samaritan Health Plans cover services that support rehabilitation and reconstruction services in the instance that a member receive these services due to cancer and related treatment.

Maternity care – Services of a physician or certified nurse midwife (CNM) for maternity care are covered. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness. We cover the care necessary to support a healthy pregnancy and care related to labor and delivery. We cover those whose mothers have taken medication containing diethylstilbestrol prior to the insured's birth, as described in ORS 743A.088.

Under federal law, the Plan can't restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery (less than 96 hours following a caesarean section), or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

Mental health: parity protections for mental health services – Samaritan Health Plans provides certain "parity" protections between mental health and substance abuse benefits on the one hand, and medical and surgical benefits on the other.

This means that in general, limits applied to mental health and substance abuse services can't be more restrictive than limits applied to medical and surgical services. The kinds of limits covered by the parity protections include:

- Financial, like deductibles, copayments, coinsurance, and out-of-pocket limits
- Treatment, like limits to the number of days or visits covered
- Care management, like being required to get authorization of treatment before getting it

Mental Health: inpatient – Services are considered "inpatient" when you are admitted to a facility. You pay an inpatient copay for facility charges at a preferred facility; see the benefit summary for details. Professional services (for example, doctors) may be billed separately from the facility charges. The plan pays for these services according to the network status of the provider, unless your condition is a medical emergency. All covered professional services are paid based on the allowed amount.

Mental Health: outpatient – Outpatient mental health services are covered the same as any other medical service. The plan pays based on the allowed amount and the network status of the provider. Preauthorization for outpatient mental health services is not required in most cases; see the prior authorization list.

Mental health and chemical dependency services – This plan covers medically necessary treatment of mental health conditions and chemical dependency. Refer to **Benefit exclusions** for more information on services not covered by this plan.

Mental health: prior authorization and review requirements – Samaritan Health Plans must prior authorize coverage of all inpatient and residential treatment. Only emergency admissions are covered without prior approval, and then Samaritan Health Plans must be notified within 48 hours, or as soon as reasonably possible.

This plan covers, but is not limited to the following mental health services:

- Assessment and evaluation in order to diagnose a mental disorder, or determine if a mental disorder exists,
- Treatment of mental illness or disorders which are subject to significant improvement through evidence-based therapeutics, and
- Treatment provided in healthcare facilities, residential programs or facilities, day or partial hospitalization programs, or outpatient services.
- Treatment provided at a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited wilderness therapy program that has been licensed by the State of Oregon as residential treatment for mental health and addiction services.

Samaritan Health Plans covers services and treatment for those mental health and chemical dependency diagnosis as it is intended under the Mental Health Parity Act.

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

Specific services that are a part of the member's treatment plan can require authorization; for example, MRIs, hospitalizations, or genetic testing, and all other services on the authorization list. See **Prior Authorization** list. Services provided in coordination with a multidisciplinary program are covered by the type of service you receive. For example, physical therapy, outpatient procedures, specialist office visits, etc.

Nursery care – Routine nursery care, of eligible newborns, while the mother is hospitalized and eligible for maternity benefits under this plan are covered.

Nutritional therapy and/or counseling – Services of a Registered and Licensed Dietician for nutritional counseling for the treatment of celiac sprue, hyperlipidemia, eating disorders, obesity, or otherwise stated as medically necessary by a physician referral will be paid by type of service rendered. Registered and Licensed Dieticians are considered specialists. Limited to 5 visits in a lifetime when medically necessary for the management of anorexia nervosa or bulimia nervosa. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services)

Occupational therapy – is covered. Services must be prescribed by a licensed MD, DO, DDS, DMD, or DPM. The written prescription must include site, modality, duration, and frequency of treatment. A maximum of 30 days per calendar year, except in cases of neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problem), can be considered for additional benefits, not to exceed 30 days per condition. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services)

Orthotics – medically necessary custom made or fitted foot orthotics**.** A licensed physician or podiatrist must prescribe the device.

Osteopathic manipulation – is covered only for the treatment of disorders of the musculoskeletal system. This service will be paid based on the type of provider who performs the service within the scope of their practice. Any accumulators or limits will apply if done by those service providers who provide services with accumulators or limits.

Outpatient drugs – Outpatient drugs that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Benefits under this section are provided only for outpatient drugs which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Outpatient surgery – For approved, medically necessary procedures, that can be performed safely on an outpatient basis. Outpatient settings include hospital outpatient departments, ambulatory surgical facilities and clinics. Selected outpatient surgery procedures require prior authorization. See **Prior Authorization** list for details.

Pain management – Services provided as a part of a pain management treatment plan or done within a pain management clinic are covered by the type of service you receive. For example, physical therapy, outpatient procedures, mental health, specialist office visits, etc.

Pediatric vision – is covered. See **Vision Benefits**

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

Physical therapy – direct access physical therapy services of a licensed physical therapist for physical therapy are covered. This service does not require a physician referral; members can self-refer. A maximum of 30 days per calendar year, except in cases neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problem, and other problems associated with pervasive developmental disorders), can be considered for additional benefits, not to exceed 30 days per condition. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services)

Prescription drug benefits

The following are additional 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.

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.

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.

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 – Charges that the claims administrator determines fall within a range of those most frequently made for prescription drugs and insulin. The range is determined by pharmacy industry and managed by our Pharmacy Benefits Administrator.

Pharmacies – When you choose one of the Samaritan Small Employer Group Plan options, you will automatically have prescription drug coverage. To take advantage of the prescription drug coverage, you must fill your prescription at a contracted pharmacy. You can request a pharmacy directory, view it online or call our Member Services Department for more information.

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.**

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.

The level of prescription drug coverage is determined through a five-tier system. The tiers are as follows:

- **Preventive drugs** – these are drugs prescribed for preventive treatment, which also include specified generic drugs, selected asthma medications, tobacco cessation drugs/ supplies, insulin and supplies required for the administration of insulin, and all ACA preventive drugs.
- **Preferred generic** – drugs that provide the same high quality medicinal and therapeutic benefit found in brand-name medications without the brand-name cost.
- **Preferred drugs** – In most cases Brand drugs, provide high quality, effective and affordable prescription benefits to Samaritan Health Plan 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.
- **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 non-preferred medication and does not have an equivalent generic available, you can request a tier exception for your medication to be paid at the preferred tier as long as the medication is listed on the formulary and does not require a prior authorization.
- **High-cost specialty medications** – encompass specified medications. This category is subject to change throughout the year, upon review by our **Pharmacy and Therapeutics Committee**. You can be charged this co-insurance 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, travel, school or work for long periods of time, (except for oral or patch contraceptives, which are covered up to 15 months at a 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 1 800-832-4580.

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.

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. Forms for submitting these claims are available online at MyHealthPlan.samhealth.org.

As defined by ORS 743A.065 Samaritan Health Plans will provide coverage for one early refill of prescription eye drops to treat glaucoma if all of the following criteria are met:

1. The refill is requested by an insured less than 30 days after the later of:
    a. The date the original prescription was dispensed to the insured; or
    b. The date that the last refill of the prescription was dispensed to the insured.
2. The prescriber indicates on the original prescription that a specific number of refills will be needed.
3. The refill does not exceed the number of refills that the prescriber indicated in number 2 above.
4. The prescription has not been refilled more than once during the 30-day period prior to the request for an early refill.

Each claim is reviewed by the administrator 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 – Specific plan options will have an integrated deductible with medical expenses. You can find this information in your Summary of Benefits and Coverage documents.

Preventive care services

Preventive care services and chronic disease management do not require co-pays or cost sharing when received by an in-network provider. Out-of-network services will have cost sharing applied. Health care reform preventative services requirements are developed through the guidelines provided by the US Preventative Task Force (USPTF), Advisory Committee on Immunizations Practices of the Centers of Disease Control and Health Resources and Services Administration (HRSA). Prior authorizations are *not* required for preventive benefits.

http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

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

This plan allows for reasonable charges of a physician, physician assistant, nurse practitioner, or other covered medical provider (refer to **Definitions**) for preventive care services as medically necessary.

If you have question(s) as to whether a service is preventive, please contact our Member Services Department at (541)768-4550 or (800) 832-4580.

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

PKU testing – We cover PKU testing to detect the presence of Phenylketonuria (PKU). This is recommended testing for newborns. If the test detects the presence of PKU, we cover the formulas determined to be medically necessary for the treatment of PKU. We cover necessary formulas for treatment under the DME benefit of this plan.

Preventive colorectal screenings – We cover services for colorectal cancer screening for any individual at high risk, and as a part of the individual's routine preventive care.

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.

Those that are at high risk for colorectal cancer for the purpose of this plan are:

- Individuals who have a family history of colorectal cancer; or
- A prior occurrence of cancer or precursor neoplastic; polyps; or a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, chronic disease, or ulcerative colitis

Preventive gynecological exams – Routine pelvic exams and Pap smears are covered. The USPSTF recommends screening for cervical cancer in women ages 18 to 64 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.

Preventive immunizations – We cover immunizations recommended by the Centers for Disease Control and Prevention, as medically necessary. Covered expenses **do not** include immunizations for the sole purpose of travel, school, work/ occupation, or residence in a foreign country. Human papilloma virus (HPV) vaccine for female beneficiaries of this plan is covered if medically necessary if determined by a physician. See **Benefit exclusions.**

Preventive prostate screening exams – Each calendar year for men age 50 and over or for those considered high risk.

Preventive routine physical exams – Routine physical exams can include related lab and radiology services, and bone density screening for patients considered at risk per Medicare guidelines.

Preventive screening mammograms – and clinical breast exams are covered. The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.

Preventive well child care – is covered. Recommendations are for 12 well baby exams in the first 36 months of life, then annually after that.

Preventive women's exams – Annual women's exams are covered, although it is recognized that several visits can be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.

- 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

Primary care provider (PCP) – services are covered.

Professional provider – Services of a Professional provider are covered for diagnosis or medically necessary treatment of illness or injury, and for covered preventive services. Not all professional services will assess the same co-payment. Please review your **Summary of Benefits and Coverage** or call Samaritan Health Plans to determine cost-share. Services that CAN be considered professional include, but are not limited to PCP office visit, specialist visit, care management services, education services, radiology and laboratory readings, and professional surgeon services.

Care received from certain professional providers must meet specific criteria as described below.

- **Dentist** (doctor of medical dentistry or doctor of dental surgery) – This medical benefit covers treatment of accidental injury to natural teeth or fractured jaw rendered for an injury, or for surgery that does not involve repair, removal or replacement of teeth, gums or supporting tissue. The injury must be one that occurred while you were enrolled under this plan. Medical dental services require prior authorization. Please see **Dental Hospitalization** for more information.

- **Oregon-registered Clinical Social Worker** – This plan covers services rendered upon the written referral of a physician, a physician's assistant, or psychologist.
- **RN or LPN** – This plan covers services rendered upon the written referral of a physician if nurses customarily bill those services to patients.
- **Therapists** – This plan covers services of registered physical, occupational, speech, or audiological therapists for rehabilitative services. We require that a physician write a referral for all but the physical therapist. Any medically necessary follow up exams will be covered according to the general medical benefits of this plan and subject to any co-payment.

Professional provider visits in the hospital – Covered expenses include professional provider visits to you during a covered hospital or skilled nursing facility stay. We do not cover separately, visits relating to surgery performed during a hospital stay because these visits are ordinarily included in the surgeon's fee. Covered expenses also include physician consultations with written reports during each hospital stay. We do not cover staff consultations required by hospital rules. These benefits apply only if you are eligible for hospital or skilled nursing facility benefits.

Radiology – Services provided by a physician, or prescribed by a physician and provided by a lab or radiology facility are covered. 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 Benefits and 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.

Routine foot care – Such as treatment for corns and calluses, toenail conditions, hypertrophy or hyperplasia of the skin and nails is not covered unless the patient has diabetes, peripheral vascular disease, or recurrent infections.

Skilled nursing facility (SNF) – Services of a skilled nursing facility are covered for up to 60 days per calendar year of extended care. **The services must be prior authorized by Samaritan Health Plans.** Custodial care is not a covered benefit. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services)

Sleep lab – Services are covered when done in a home setting or a hospital setting.

Smoking cessation – Samaritan Health Plans offers ways to help you stop using tobacco, including Nicotine Replacement Therapy (NRT). If your doctor feels that you need a prescription to help you quit tobacco, Samaritan Health Plans will pay for Nicotine Replacement Therapy (NRT) at no cost to you for those medications, and including behavioral interventions (counseling, telephone counseling and self-help materials), drug treatments.

> **Tobacco use** – Defined as use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

Specialist provider – Services provided by any provider who is not defined as a primary care provider. A primary care provider visit is defined as services provided by a Pediatric, Family Medicine, Internal Medicine or OB-GYN provider.

Speech therapy – Services of a certified speech therapist are covered. Benefits are limited to speech delay in children, cleft palate, or to restore speech after brain trauma or stroke, or after injury to or removal of neoplasm from the larynx and for those with pervasive developmental disorders. Medically necessary therapeutic services for the treatment and care for brain trauma or stroke are covered.

A maximum of 30 days per calendar year, except in cases of neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problem, and other problems associated with pervasive developmental disorders for which rehabilitative services would be approved), can be considered for additional benefits, not to exceed 30 days per condition. (Limits do not apply for Mental Health and Chemical Dependency/Substance Abuse related services)

Surgery – This plan covers surgery (operative and cutting procedures), including treatment of fractures, dislocations and burns, and includes the services of the primary surgeon, assistant surgeon, the anesthesiologist or certified anesthesiologist. It also covers surgical supplies such as sutures and sterile setups when surgery is performed in the physician's office**. Some elective and planned procedures require a prior authorization; the plan's authorization list section for a complete list**. . **The following elective procedures require authorization (but are not limited to)**:

- All neck and back surgery
- Sclerotherapy
- Uvulopalatopharyngoplasty

Telemedicine – We cover certain telemedicine services. We cover face to face telemedicine services via two-way video communication. Services include two-way communication. These services are covered to allow health professionals to interact with a patient, parent or guardian of a patient in connection with medically necessary diagnosis. Services are covered equal to those described in this contract.

Therapeutic abortion – An abortion induced when pregnancy constitutes a threat to the physical or mental health of the mother and/or the fetus. Therapeutic abortions are done because pregnancy would cause the mother hardship, endanger their life or health, or because prenatal testing has shown that the fetus will be born with severe abnormalities. Terminations of pregnancy for other reasons outside of this are not a covered benefit.

Transplant services – This plan covers medically necessary organ and tissue transplants. It also covers the medical and hospital expenses of the donor if the transplant recipient is insured by Samaritan Health Plans. **Plan pays up to $8,000 for donor expenses.**

This plan covers the following medically necessary organ and tissue transplants:

- Kidney
- Kidney-Pancreas (under certain conditions)
- Pancreas
- Heart
- Heart-Lung
- Lung
- Liver
- Corneal (no authorization required)
- Bone marrow and peripheral blood stem cell
- Bone marrow for aplastic anemia
- Leukemia
- Lymphoma
- Severe combined immune-delivery disease or Wiskott-Aldrich Syndrome
- Pediatric bowel

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

For detailed transplant information, please contact Samaritan Health Plans at (541) 768-4550 or 1-800-832-4580.

Transplant payment – if a transplant is performed at an in-network provider facility, covered charges are paid in full less applicable co-pays, co-insurance and deductibles.

Transplant cost of facilities – if transplant services are available through a contractual agreement with an in-network facility but are performed at an out-of-network facility, this plan pays the lesser of 50% of the billed amount or $100,000. The balance is your responsibility and does not accumulate toward this plan's out-of-pocket maximum. Services provided by out-of-network providers are paid according to the percentages shown on the **Summary of benefits and Coverage** for out-of-network providers.

Corneal transplants are covered and do not require an authorization.

Tubal ligation and vasectomy p**rocedures** – Are covered.

Urgent care services – Are covered. See the **Definitions** for a description of urgent care services.

Urgent care is needed to prevent serious harm to your health from an unforeseen illness or an injury. **You can call your PCP's office 24 hours a day, seven days a week. Even if the office is closed, there is still someone available to help you.**

Your PCP can decide if you need to go to an urgent care or pediatric clinic. For current telephone numbers, hours and locations, please call our Member Services Department.

NOTE: Please see **Summary of Benefits and Coverage** for co-pay information. **NOTE**: Co-pays can be different based on the Plan you are enrolled in.

Wellness benefits – Non-standard plans include the following wellness benefits:

- **Individual wellness assessment** – This assessment is not done prior to enrollment and is only done after you have been enrolled and have chosen a plan and in no way will affect your coverage. This assessment is used to help you determine your health risks.
- **Health risk screening** – This screening is not done prior to enrollment and is only done after you have been enrolled and have chosen a plan and in no way will affect your coverage. The screening can include lab work for cholesterol and glucose levels, weight, height, BMI and other measurements.
- **Personal health coaching** – Is available for you for services such as dietician services and personal trainer services.

Services described (MRI, CT scans, back and/or neck surgeries, inpatient hospital stays and PET scans) and potentially related services may require prior authorization, where appropriate. This is not a complete list, see the **Prior Authorization list**

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:

- Gastric bypass and bariatric surgery
- Panniculectomies
- 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 medically necessary
- Temporomandibular joint (TMJ) or myofascial pain treatment, advice, or appliances
- Services for dental implants, or improving placement of dentures
- Sex transformations are excluded when not medically necessary or when not related to a mental health condition.
- Sexual Dysfunction is excluded when not medically necessary or when not related to a mental health condition.
- Eye surgeries to improve vision such as, Lasik, unless medically necessary
- Myeloablative high dose chemotherapy, except when the related transplant is covered
- Services, supplies, testing or treatment for sterility, infertility, impotency, frigidity, or sexual inadequacy, unless medically necessary or when not related to a mental health condition.
- 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. These medications covered by the Plan are considered OTC and require a written prescription from a physician to be covered under the plan.
- Immunizations or services in anticipation of exposure through travel, school 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 and sexual dysfunction (e.g., Viagra, MUSE, Yohimbine, Osphena, etc.), unless medically necessary or as a result of a mental health diagnosis
- Drugs or devices used for cosmetic reasons (e.g., 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, except as outlined for pediatric vision benefit.
- 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:
- Marital, family, career, or personal growth counseling, unless it is a part of an individual's treatment plan and billed specifically for the individual
- Educational programs, including some court-ordered programs that do not require coverage by the state of Oregon
- Voluntary mutual support groups like Alcoholics Anonymous, unless court ordered
- Counseling in the absence of illness
- Psychological testing that is not medically necessary
- 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:

- Massage or massage therapy
- Homeopathic treatment
- Biofeedback, for diagnosis other than migraine headaches and incontinence
- Hypnosis
- Experimental or investigational

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

- Any charge over the Usual and Customary or Reasonable charge for services or supplies;
- Hospital, Skilled nursing facility or other facility services that began before the covered person's coverage began, including services and supplies;

- Treatment incurred prior to enrollment and coverage under this Plan or after coverage terminates. The only exception is that if this plan is replaced by a group health policy while you are hospitalized, Samaritan Health Plans will continue paying covered hospital expenses until you are released or your benefits are exhausted, whichever occurs first;
- Services or supplies otherwise available (such services or supplies will be covered if otherwise required by law);
- Services provided by an immediate family member, including parents, grandparents, spouse/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 in order to determine eligibility for payment;
- Charges for travel or work related expenses, telephone consultations, missed appointments, get acquainted visits, completion of claim forms or completion of reports requested by the Claims Administrator in order to process claims;
- Care designed mainly to help with daily activities such as walking, getting out of bed, bathing, dressing, eating, and preparing meals;
- Services and supplies not specifically described as benefits under this Plan

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 $800 in rental or purchase fees or rentals over (3) months.
- Elective procedures or services (for the following):
    - Genetic testing, except standard prenatal testing, which includes Verifi®
    - Neck and back surgery (done as in-office procedures, outpatient, or inpatient)
    - Sclerotherapy
    - Uvulopalatopharyngoplasty
- Hospitalization for dental procedures
- Inpatient hospital care*, with an exception of maternity delivery services*
- Potentially cosmetic, reconstructive and/or experimental surgery and services, including clinical trials.
- Radiological services (for the following):
    - Computer Axial Tomography (CAT/CT) scans
    - Positron Emission Tomography (PET) scans
    - Magnetic Resonance Imaging (MRI)
    - Virtual Colonoscopy
    - Capsule endoscopy
- Residential services for mental health and substance abuse/detoxification
- Skilled nursing facility (SNF) services
- Therapeutic abortions
- Transplants, except corneal (including evaluation)

*Inpatient hospitalization admissions for the purpose of childbirth do not require a prior authorization in accordance with the Newborns' and Mothers' Protections (Newborns' Act). Services do not require prior authorization unless hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section.

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, and which are:

- Consistent with the symptoms of a health condition or treatment of a health condition
- Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective
- Not solely for the convenience of member or a provider of the service or medical supplies; and
- The most cost effective of the alternative levels of medical services or medical supplies, which can be safely provided to member in the PCP's judgment

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

Prior authorization determination timeframes

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

Type of claim	Authorization determination
Pre-service requests	Within 2 business days

Claims Involving Prior Authorization (Pre-Service Claims)

For services that do not involve urgent medical conditions: Samaritan Health Plan will notify your provider or you of its decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Samaritan Health Plan will notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Samaritan Health Plan will complete its review and notify your provider or you of its decision. If the information is not received within 45 days, the request will be denied.

For services that involve urgent medical conditions: Samaritan Health Plan will notify your provider or you of its decision within 72 hours after the Prior Authorization request is received. If Samaritan Health Plan needs additional information to complete its review, it will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Samaritan Health Plan will complete its review and notify the requesting provider or you of its decision by the earlier of (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.

Except in the case of misrepresentation, prior authorization determinations shall be subject to the following requirements:

- Prior authorization determinations relating to benefit coverage and medical necessity shall be binding on the insurer if obtained no more than 30 days prior to the date the service is provided.
- Prior authorization determinations relating to enrollee eligibility shall be binding on the insurer if obtained no more than five business days prior to the date the service is provided.

Notification of determination

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

Length of time determinations are valid

A preauthorization benefit determination relating to benefit coverage and medical necessity is valid for 90 calendar days. A preauthorization benefit determination relating to the member’s eligibility is valid for five working days, unless Samaritan states a shorter period because of specific knowledge that the member’s coverage will end within five days. These specified times are not binding on Samaritan Health Plans if there was misrepresentation on the part of the policyholder, member, or provider that was relevant to the preauthorization request.

Your pediatric vision benefits

The vision benefits described below are ONLY for those who are 19 and younger.

Pediatric vision benefits are **not subject to deductible** for certain covered vision services or supplies and the services are paid as listed in your **Summary of Benefits and Coverage**, for in-network vision providers. These vision care benefits are provided as shown below every benefit year.

Samaritan pays for vision exams and corrective lenses and frames, and contacts when prescribed by a licensed ophthalmologist or licensed optometrist, for you. The Plan allows you to choose any licensed ophthalmologist, optician, or optometrist.

Covered benefits

Lenses and frames, and contacts: Are covered as described in your Summary of Benefits by plan.

Eye examinations: One complete preventive eye exam, annually, are covered at 100% when provided by an in-network provider. Eye exams for medical purposes are paid as an office visit by a specialist provider.

Limitations

The vision care benefit will only pay for one pair of contact lenses or one pair of glasses (frames and lenses) per insured child, annually as described in your Summary of Benefits.

Exclusions

The following are not covered benefits under this Plan:

- Visual field charting
- Fitting charges
- Orthoptics or vision training
- Lenticular lenses
- Contact lenses, except as shown in the vision benefit plan provisions
- Subnormal vision aids
- Aniseikonic lenses
- High index lenses
- Photochromatic and transition lenses
- Hardware repairs
- Nonprescription lenses
- More than the allowance for a standard prescription when multi-focal hard resin lenses, coated lenses or no-line bifocals (blended type) are chosen;
- Extra charges for fashion eyewear features such as blended, coated, flintglass, oversize lenses or extra charges for special frames
- Medical or surgical treatment of the eyes; this can be covered under the medical provisions of the plan;
- Services and supplies that are payable under an occupational disease law;
- Any cost which is in excess of the maximum plan allowance;
- Replacement of lost, stolen, or broken lenses;
- Duplication or spare eyeglasses, lenses or frames;
- Any eye examination required as a condition of employment; and
- Any cost paid in whole or in part by any other provision of the Group Health Insurance Plan provided by the Policyholder;
- Experimental or investigational vision services are excluded under the same standards as the medical benefits described under **Experimental and investigational**. An experimental or investigational service is not made eligible for coverage even if your doctor considers that other services will be ineffective or not as effective as the service or that the service is the one most likely to prolong life.

Your premiums

What to do if you are having trouble paying your plan premium

At the time we end your membership, you can still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay these late premiums before you can enroll.

In order to reinstate you, you will be required to pay your premiums and complete the application meeting all eligibility requirements if necessary.

An insurer of a group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall notify the group policyholder when the policy is terminated and the coverage is not replaced by the group policyholder. Samaritan: (a) Must be given on a form prescribed by the Department of Consumer and Business Services; (b) Must explain the rights of the certificate holders regarding continuation of coverage provided by federal and state law and continuation coverage in accordance with applicable statutes; and (c) Must be given by mail and must be mailed not later than 10 working days of the termination determination according to the terms of the policy.

Your coverage will renew or continue in force at the decision of the plan sponsor. Samaritan can only non-renew in the event of nonpayment of premiums as described above, fraud, violation of participation or contribution rates, market exit, movement outside the services area, or cessation of association membership when applicable.

Any change in premium is subject to approval by the Oregon Department of Consumer and Business Services.

Monthly premium

The monthly premium amounts and the required employer contribution amount or percentage for each member as provided by your employer.

Premium modifications

In the case of a small employer (see Definitions – Small employer), premium rates will only be modified once in a 12-month period, unless there is a change in benefits mid-contract year that affects the cost of insurance. The contract renewal date is the first day of a contract year.

Samaritan may modify premium rates on any renewal date by giving the group a 30-day prior written notice. The group may reject the modification by giving written notice to Samaritan at least 15 days before the modification is to take place. Rejection of any modification terminates this policy. Payment of premium after receiving notice of modification constitutes the policyholder's acceptance of the change.

When premium is due

By the first day of each month, while the group policy continues in effect, the policyholder will pay Samaritan monthly, the full monthly premium for each member who is enrolled for all or any part of the month as set forth in the Group Agreement

Premium is not considered paid until Samaritan receives the full premium amount in cash or a form readily convertible to cash. The policyholder is not the agent of Samaritan for the purpose of collecting premiums.

Premium tax

In the event the State of Oregon imposes a tax on premium received from Oregon sited policyholders, Samaritan reserves the right to increase such policyholders' premium rates to include the amount of the premium tax. The increase in premium rates becomes effective on the date the tax is imposed on the premium of Oregon sited policyholders.

When premium is mistakenly paid

Samaritan will refund to the policyholder, premium that was paid in error, but only to a maximum of three months' premium and less any claims expense paid by Samaritan, on behalf of the individual for which a refund is requested. All refund requests must be made in writing and payroll records may be required to substantiate the request.

Member grievance and appeals process

Filing a grievance

Adverse Benefit Determination means**:**

- Denial of eligibility for or termination of enrollment in a health benefit plan
- Rescission or cancellation of a policy or certificate
- Source-of injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services
- Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or
- Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854

Grievance means a written complaint regarding:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the plan through a prior authorization; or
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between the member and the plan; or
- An internal appeal or an external review, or in writing or orally, for an expedited response described in ORS 743.804(2) (d) or an expedited external review

You or your **Authorized Representative** can file your grievance, in writing. Within five business days of receiving a grievance, we will send you or your Authorized Representative an acknowledgment letter. If the grievance cannot be resolved within five business days, we will notify you in writing that additional time is required. You or your Authorized Representative will then receive a written decision within 30 days from your initial letter.

Filing a level 1 appeal

Authorized Representative: An individual who by law or by the consent of a person can act on behalf of the person.

An appeal request must be: 1) in writing, 2) signed, 3) include the appeal reason; and 4) received by us within 180 days of the denial or other action giving rise to the grievance. You can use an Appeal Request Form to provide this information.

Within five business days of receiving the appeal, we will send you or your Authorized Representative an acknowledgment letter. You or your Authorized Representative has the right to appear in person to talk about your appeal. The Level 1 appeal decision will be determined by a healthcare professional not previously involved in your case. You or your Authorized Representative will receive a written decision within 30 days of our receiving your appeal request.

Please Note: If you, your Authorized Representative or your treating provider believes that the request to appeal is urgent; meaning, a review decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, your appeal will be processed in an expedited manner. For urgent appeals, your treating provider can act as your Authorized Representative.

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

External review

External Review decisions are made by Independent Review Organizations (IRO) that is not associated with Samaritan Health. Your appeal will be randomly assigned to an IRO by the Oregon Insurance Division (OID).

Your appeal can qualify for an External Review (at no cost to you) if:

- the Plan does not adhere to the rules and guidelines of the process defined for the internal review;

OR

- Internal appeal level 1 has been completed; and, the reason for the level 1 adverse decision was:
  - based on medical necessity; or
  - for treatment determined to be experimental or investigational; or
  - for the purpose of continuity of care (no interruption of an active course of treatment under ORS 743.854)
  - delivered in an appropriate health care setting and with the appropriate level of care **OR**
  - you and the Plan have mutually agreed to waive the internal appeals requirement

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

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

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

To apply for an External Review you must send your written request or the Appeal Request Form to us at the following address:

Samaritan Health Plans- Appeals Team
P.O. Box 1310
Corvallis, Oregon 97339

Once the OID has notified the Plan of the assigned IRO, we will submit your External Review request to the IRO within 2 business days. When you are notified by the IRO that your request for External Review has been received, you will have 5 business days to submit additional information about your appeal.

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

- Expedited External Review - 72 hours after receipt of the request
- Standard External Review - 30 days after receipt of the request

IRO decisions are final and we are bound by their decisions. If you want more information regarding External Review, please contact our Member Services Department at 541-768-4550; toll-free at 800-832-4580 or TTY 1-800-735-2900.

Expedited appeal process

If you believe your appeal is urgent, you, your Authorized Representative or your treating provider, can request an Expedited appeal. If the appeal request meets the definition of urgent under the law; which means, a decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, the appeal will be processed in an expedited manner (within 3 business days of our receiving the appeal request). If the appeal does not meet the definition of urgent, you will be notified immediately and the appeal will then be processed within the standard timeframe.

The Expedited appeal request must:

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

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

The internal Expedited review decision will be determined by a healthcare professional not previously involved in your case. A verbal notice of the decision will be provided to you, your Authorized Representative and your treating provider as soon as possible, but no later than 72 hours of our receiving the appeal. A written notice will be mailed within one working day following the verbal notification. If you have requested a simultaneous expedited External Review, the plan will also forward your appeal to the IRO.

To apply for an Expedited review:

Send your written request, or the Appeal Request Form, to:

Samaritan Health Plans- Appeals Team
P.O. Box 1310
Corvallis, Oregon 97339

Or call our Member Services Department:

(541) 768-4550, toll free 800-832-4580 or TTY 1-800-735-2900

Appeal timeframes

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

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

To obtain an Appeal Request Form or a waiver granting IRO access to your medical records visit www.samhealthplans.org or call our Member Services Department at (541) 768-4550, toll free 800-832-4580 or TTY 1-800-735-2900.

Your appeal rights

You have the right to:

- file a grievance about and/or appeal any decision we make regarding availability, delivery or quality of health care services, or an adverse determination based on the decision of the Plan through a prior authorization, claims payment, handling or reimbursement for healthcare services or matters pertaining to the contractual relationship between the member and the Plan.
- appoint someone to act as your Authorized Representative when filing a grievance or appeal, such as a relative, friend, treating physician, advocate, attorney, or someone else who has been legally appointed.
- contact us when you:
    - do not understand the reason for the denial.
    - do not understand why the health care service or treatment was not fully covered.
    - do not understand why a request for coverage of a health care service or treatment was not approved.
    - cannot find the applicable provision in your policy.
    - want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision.
- request within 180 days of the denial, or other action giving rise to the grievance or appeal, a 1st level of Internal Appeal
- a full and fair internal review of your appeal by healthcare professionals associated with us, but who were not involved in the action being appealed
- provide us with additional information that relates to your appeal.
- appear in person to talk about your internal levels of appeal.
- an internal review decision within 30 days for appeals and 3 business days for an expedited appeal

- request a copy of the information in your appeal (free of charge) regardless if it was used to make the decision.
- file an External Review (at no cost to you) within 120 days (180 days) if applicable.
- an External Review decision within 30 days of the IRO receiving your standard request and 3 business days for an expedited request.
- send additional information, in writing, directly to the IRO, no later than 5 business days after the appointment of the IRO or 24 hours in the case of an expedited review.
- an Expedited Review if you, your Authorized Representative or your treating provider believes that waiting the standard 30 day timeframe would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed
- a simultaneous Expedited Internal and External Review, if applicable.
- coverage while pending a decision
- information about our grievance and appeal processes. Contact our Member Services Department at 541-768-4550; toll-free at 1-800-832-4580; TTY 1-800-735-2900; or you can write to the following address:

Samaritan Health Plans Appeal Team
PO Box 1310
Corvallis, OR 97339

- To pursue civil action in accordance to 502(a) of the Employee Retirement Income Security Act of 1974 after you have exhausted your internal levels of appeal on an adverse benefit determination.
- The insurer is bound to follow the decision of the IRO, and can be penalized by DCBS if it fails to do so.
- The enrollee is financially responsible for benefits paid to or on behalf of an enrollee pursuant to ORS 743.804(2)(g) if the insurer's adverse benefit determination is upheld on appeal.
- The enrollee has the right to sue the insurer if the decision of the IRO is not implemented.
- Other dispute options, such as mediation. One way to find options that can be available is to contact your state Insurance Commissioner. To seek further assistance, contact any of the following:

Department of Consumer & Business Services

By calling (503) 947-7984 or the toll free message line at (888) 877-4894;
By electronic mail at: cp.ins@state.or.us;
By writing to the **Oregon Division of Financial Regulation; Advocacy Unit** at:
PO Box 14480
Salem, OR 97309-0405

Consumer Advocacy website:

http://www.oregon/gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx

You can, at any time, request a copy of these materials. If requested, we will send you a copy of those materials within 30 days of your request.

- Annual summary of grievance and appeals
- Annual summary of utilization review policies
- Annual summary of quality assessment activities
- The results of all publically available accreditation surveys
- An annual summary of our health promotion and disease prevention activities
- An annual summary of scope of network and accessibility of services

Claims information

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

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

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

If the covered person receives payment for a benefit that he or she is not eligible to receive, the plan has the right to recover the payment from the covered person (including by reducing future claim payments) or anyone else who benefits from it. The covered person has the right to appeal claims decisions that they do not agree with. **See Appeals and Grievances.**

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

Samaritan Small Group Plans
Samaritan Health Plans
P.O. Box 887
Corvallis, OR 97339-0336

Explanation of benefits (EOB)

We will report to you the action we take on a claim on a form called an Explanation of Benefits (EOB). If we deny all or part of a claim, the reason for our action will be stated on the EOB. The EOB will also include instructions to file an appeal or grievance if you disagree with the action we have taken on your claim; when benefits are available; the cost of a service is incurred on the day the service is rendered and the cost of a supply is incurred on the day the supply is delivered to the patient.

There are two exceptions to this rule. One is when you are in the hospital on the day coverage ends. In this case, we will continue to pay toward eligible charges for the hospitalization until discharge from the hospital or until your benefits have been exhausted, whichever comes first.

We have the sole right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly. If a person entitled to receive payment under the policy has died, is a minor or is incompetent, we can pay the benefits (up to $1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Samaritan Health Plans to the extent of the payment.

Claims involving concurrent care decisions

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

Member claim reimbursements

When the hospital bills you

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

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

If you have already paid for the services or supplies, please note that fact boldly on the form and include a receipt. Reimbursement forms are available online or by calling:

Member Services Department
541-768-4550,
toll-free at 1-800-832-4580;
TTY 1-800-735-2900;
Monday through Friday 8 a.m. to 8 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; and
- 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 form and include a receipt.

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

Physician reimbursement

You are entitled to ask if Samaritan Health Plans has special financial arrangements with our physicians that can affect the use of 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, the Plan will pay for certain other health care expenses. Bills should be forwarded to us as you receive them. You can also send them to us at regular intervals, for example, once a month. Again, if you have already paid for the services and supplies, please note that fact boldly on the form and include a copy of your receipt.

Prescription 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.

Claim determinations

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

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

Time Frames for Processing Claims

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

Timely Submission of Claims

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

Please send all claims to:

Samaritan Small Group Plans
Samaritan Health Plans
P.O. Box 887
Corvallis, OR 97339-0336

Claims Involving Concurrent Care Decisions

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

hours before the course of treatment is scheduled to end. Samaritan Health Plans will then notify you of its reconsideration decision within 24 hours after your request is received.

Motor vehicle coverage

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

Here are some rules, which apply with regard to motor vehicle insurance coverage:

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

Third-party liability and right of subrogation

This provision applies when you incur health care expenses in connection with an illness or injury for which one or more third parties can be responsible. In that situation, benefits for such expenses are excluded under this policy to the extent you receive 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 agree to hold, or directs your attorney or other representative to hold, the recovery against the other party in trust for us up to the amount of benefits we paid in connection with the illness or injury. We will require that you 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 receive from or on behalf of the third party and held in trust for payment to us.
- We are entitled to the amount of benefits we have paid in connection with the illness or injury, regardless of whether you have been made whole, from the proceeds of any settlement, arbitration award, or judgment that results in a recovery for you, 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.

- As long as you have signed a trust agreement, we will allow a deduction of a proportionate share of the reasonable expenses of getting a recovery, such as attorney fees and court expenses from the amount to be reimbursed to us.
- If you incur health care expenses for treatment of the illness or injury after recovery, we will exclude benefits for otherwise eligible charges until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount.

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

the amount of recovery; plus

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

Minus

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

Minus

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

Minus

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

shall equal the "net recovery amount."

This provision applies if you have 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 are 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 can advance benefits if you agree in writing to hold any recovery you obtain from the entity providing workers' compensation coverage in trust for us according to the Third-Party Liability provision.

Medicare

In the event your employer has 20 or more employees, then this plan is primary to Medicare per applicable federal laws. When someone has Medicare and this policy at the same time, we pay benefits for eligible charges first and Medicare pays second. Those situations are:

- When you or your spouse is age 65 or over and by law Medicare is secondary to your employer group health plan.
- When you incur eligible charges for kidney transplant or kidney dialysis and by law Medicare is secondary to your employer group health plan; and
- When you are 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.

In all other instances, we will not pay benefits toward any part of a covered cost to the extent the covered cost is actually paid under Medicare Part B had you or your covered dependent properly applied for benefits. Furthermore, when we are paying secondary to Medicare, we will not pay any part of expenses a Medicare Part B eligible covered member incurs from providers who have opted out of Medicare participation.

Coordination of benefits

Coordination of this group contract's benefits with other benefits

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

Definitions relating to coordination of benefits

Plan – Plan means any of the following that provides benefits or services for medical, care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

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

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

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

This plan – This plan means, as used in this COB section, the part of this contract to which this COB section applies and which can be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from this plan. A contract can apply one COB provision to certain benefits, such as medical benefits, coordinating only with similar benefits, and can apply another COB provision to coordinate other benefits. The order of benefit determination rules listed on page 56 determine whether this plan is a Primary plan or Secondary plan when a member has health care coverage under more than one plan.

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

Allowable cost – Allowable cost means a health care cost, including deductibles, co-insurance and co-payments, that is covered at least in part by any plan covering a member. When a plan provides benefits in the form of services, the reasonable cash value of each Service will be considered an Allowable cost and a benefit paid. A cost that is not covered by any plan covering a member is not an Allowable cost. In addition, any cost that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an Allowable cost.

The following are examples of expenses that are NOT Allowable expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable cost, unless one of the plans provides coverage for private hospital room expenses.
- If you are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable cost.
- If you are covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable cost.
- If you are covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable

cost for all plans. However, if the provider has contracted with the Secondary plan to provide the benefit or Service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable cost used by the Secondary plan to determine its benefits.

- The amount of any benefit reduction by the Primary plan because you have failed to comply with the plan provisions is not an Allowable cost. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and in-network provider arrangements.

Closed panel plan

A closed panel plan is a plan that provides health care benefits to members primarily in the form of services through a panel of providers that has contracted with or is employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a contracted provider. Samaritan Small Group Benefit Plan is not a closed panel provider plan.

Custodial parent

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

Order of benefit determination rules

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

- The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan. Except as provided in the bullet below, a plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both plans state that the complying plan is primary.
- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverage that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

Each plan determines its order of benefits using the first of the following rules that apply:

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

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

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

(i). the plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

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

(B) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that

parent's spouse does, that parent's spouse's plan is the Primary plan. This subparagraph does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph (A) of this subsection determines the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of paragraph (A) of this subsection determines the order of benefits; or

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

(I) The plan covering the custodial parent;

(II) The plan covering the custodial parent's spouse;

(III) The plan covering the non-custodial parent; and then

(IV) The plan covering the non-custodial parent's spouse C) For a dependent child covered under more than one plan of individuals who are not the parents of the dependent child, the provisions of subparagraph (A) or (B) above shall determine the order of benefits as if those individuals were the parents of the dependent child.

Active employee or retired or laid-off employee - The plan that covers a member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The plan covering that same member as a retired or laid-off employee is the Secondary plan. The same would hold true if a member is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled *Order of benefit determination rules* can determine the order of benefits.

COBRA or state continuation coverage - If a member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, subscriber or retiree or covering the member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled *Order of benefit determination rules* can determine the order of benefits.

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

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

Effect on the benefits of this plan

When this plan is secondary, we can reduce our benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable cost under its plan that is unpaid by the Primary plan. The Secondary plan can then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total Allowable cost for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under this plan and other plans. We can get the facts we need from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under this plan and other plans covering a member claiming benefits. We need not tell, or get the consent of, any person to do this. Each member claiming benefits under this plan must give us any facts we need to apply this section and determine benefits payable.

Facility of payment

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

Right of recovery

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

Workers' Compensation

As defined by House Bill 4104, we are required to provide coverage for claims for covered services denied or not yet adjudicated by the workers' compensation carrier.

Other claims recoveries

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

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

If you have questions please contact our Member Services Department by calling:

Member Services Department
541-768-4550,
toll-free at 1-800-832-4580;
TTY 1-800-735-2900;
Monday through Friday 8 a.m. to 8 p.m.

HIPAA privacy notice

Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the benefits manager.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, if you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, please contact:

Member Services Department
541-768-4550,
toll-free at 1-800-832-4580;
TTY 1-800-735-2900;
Monday through Friday 8 a.m. to 8 p.m.

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Patient Protection Act: Your rights and responsibilities

In accordance with Oregon law (Senate Bill 21, known as Patient Protection Act), the following Disclosure Statement includes questions and answers to fully inform you about the benefits and policies of this health insurance plan.

Your rights as a member

- You have a right to receive information about Samaritan Health Plans, our services, our providers, and your rights and responsibilities.
- You have a right to be treated with respect and recognition of your diversity and right to privacy.
- You have a right to participate with your healthcare provider in decision making regarding your care.
- You have a right to honest discussion of medically necessary treatment options.
- You are entitled to discuss those options regardless of how much the treatment expenses or if it is covered by this plan.
- You have a right to the confidential protection of your medical information and records.
- You have a right to voice complaints about Samaritan Health Plans or the care you receive, and to appeal decisions you believe are wrong.
- You have the right to continue care from an individual provider for a limited period of time after the medical services contract terminates.

Your responsibilities as a member

- You are responsible for providing Samaritan Health Plans and our providers with the information we need to care for you.
- You are responsible for following treatment plans or instructions agreed on by you and your healthcare providers.
- You are responsible for payment of co-pays at the time of service and be on time for that service.
- You are responsible for reading and understanding all materials about your health plan benefits.
- You are responsible for making sure services are prior authorized when required by this plan before receiving medical care.

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

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

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

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

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

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

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

When continuity of care applies

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

- you and the professional provider agree that continuity of care is desirable and you request continuity of care from us.
- the care is medically necessary and otherwise covered under the plan.
- you remain eligible for benefits and covered under the plan; and
- the plan has not terminated.

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

- retires
- dies
- no longer holds an active license
- has relocated outside of our service area
- has gone on sabbatical; or
- its prevented from continuing to care for patients because of other circumstances.

How long continuity of care lasts

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

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

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

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

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

Medical necessity of continuing care

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

Quality of medical care

The covered person always has the right to choose his or her own hospital or physician. The plan is not responsible for the quality of medical care the covered person receives. The plan cannot be held liable for any claims for damages connected with injuries suffered by the covered person while receiving medical services and supplies.

Complaint and appeals:

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

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

You also have the right to file a complaint and seek assistance from the director of the Department of Consumer and Business Services.

By calling (503) 947-7984 or the toll free message line at (888) 877-4894;
By electronic mail at: cp.ins@state.or.us
By writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit at:
PO Box 14480
Salem, OR 97309-0405

Consumer Advocacy website:
http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx

What are your pre-authorization and utilization review criteria?

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

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for you. And, pre-authorization is your assurance that medical services will not be denied because they are not medically necessary.

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

Let us know if you would like a written summary of information that we can consider in our utilization review of a particular condition or disease. Simply call the Member Services Department phone number on the back of your identification card.

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

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

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

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

What additional information can I get from you upon request?

The following documents are available by calling our Member Services Department:

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

- Information about our prior authorization and utilization review procedures.

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

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

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

To obtain the mentioned information, write to:

Oregon Insurance Division

By calling (503) 947-7984 or the toll free message line at (888) 877-4894;
By electronic mail at: cp.ins@state.or.us;
By writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit at:
PO Box 14480
Salem, OR 97309-0405

Consumer Advocacy website:

http://www.oregon.gov//DCBS/insurance/gethelp/Pages/fileacomplaint.aspx

Plan administration

Governing law

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

Compliance with state and federal mandates

To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the Policy, including Patient Protection and Affordable Care Act (PPACA, the Employee Retirement Income Security Act of 1974 (ERISA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), Civil rights and employment laws including Titles VI and VII of the Civil Rights Act of 1964, sections 503 and 504 of the Rehabilitation Act of 19767; The Americans with Disabilities Act of 1990; Executive Order 11246; the Age Discrimination in Employment Act of 196; and the Age Discrimination Act of 1975; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), and the Women's Health and Cancer Rights Act of 1998 (WHCRA). These laws have been amended from time to time. In the event of any conflict between these provisions and the current provisions of the law, the current provisions of the law shall govern.

Other authorities and responsibilities

SHP is not the named fiduciary or Plan Administrator of the Plan. SHP does not have discretionary authority with regards to administration of the Plan and does not make Group or Member eligibility determinations.

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

Changing this contract

This document is your contract with Samaritan Small Group Benefit Plan. This contract cannot be changed except by a written endorsement or notification to you issued by us that have been approved by an officer of Samaritan Health Plans. We can change this contract by giving you 30-days advance written notice, or 60 day written notice for preventive benefit changes; but we can do so only if we are changing all contracts of the same form and class. The client and Plan will determine and agree upon adjusted deductibles and other accumulators as it applies to their mid-year enrollment. All benefit plan years will be administered January 1 – December 31 following a mid-year enrollment.

Contract renewal and termination

The Contract will renew automatically from year to year unless terminated as otherwise provided in the Contract. Termination of the member under the Contract for any reason will completely end all obligations of the Company to provide the member with Benefits after the date of termination, except where required by ORS 743.529(1) 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.

Termination of group

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

enrolled in Samaritan through the employer group through the end of the first full month requested and agreed upon termination date.

Rescinding coverage

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

Legal action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 90 days after written proof of loss has been furnished in accordance with the policy. No action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. After two years from the date of issue of the policy no misstatements, except fraudulent misstatements, made by the applicant shall be used to void the policy or to deny a claim. We acknowledge that misstatements, misrepresentations, omissions, or concealments on the part of the insured are not fraudulent unless they are made with intent to knowingly defraud.

In order for Samaritan Health Plans to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on the part of the insured, 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.

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. 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.

HIPAA/ADA

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

Confidential communication

Effective Jan. 1, 2016, a new “Confidential Communication” law allows enrollees the right to have protected health information sent to you instead of the person who pays for your health insurance plan. Enrollees can request that they be contacted:

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

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

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

Your health plan must acknowledge the receipt of the request form and respond to your confidential communications request. If you have any questions, please contact Customer Service.

Certificate of creditable coverage

A covered person who ceases to be covered under the plan will be provided a certificate that evidences the covered person's creditable coverage and the period of that creditable coverage, upon request. The time as of which the certificate will be provided and the contents of the certificate are explained below. **Creditable Coverage** is defined as 180 days of continuous coverage with an applicable plan.

Provision of certificate upon request

A covered person, or someone on behalf of a covered person, can request a certificate of creditable coverage at any time within 24 months of the date that coverage under the plan ended. A request for a certificate can be made even if a certificate was previously provided, including upon a prior request. A certificate provided upon request will disclose each period of continuous coverage that ceased during the 24-month period ending on the date of the request, or which was continuing on the date of the request. A separate certificate can be provided for each period of continuous coverage.

Specification of benefits

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

Member services department

The Samaritan Health Plans home office in Corvallis is maintained to meet your servicing needs. Come see us at 2300 NW Walnut Boulevard or contact us at:

(541) 768-4550, toll free 800-832-4580 or TTY 1-800-735-2900. Our Member Services Department hours are 8 a.m. to 8 p.m., Monday through Friday. We look forward to serving you.

Statements made by applicants, policy holder or insured are representations and not warranties

Samaritan Small Group Benefit Plan

Samaritan Health Plans
2300 NW Walnut Boulevard
Corvallis, OR 97339
www.samhealthplans.org