Samaritan
Health Plans

Samaritan Health Plans

Group Certificate of Medical, Surgical, Pharmacy and Hospital Insurance

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

Bruce Butler
Chief Executive Officer

Introduction

Welcome to Samaritan Health Plans. We are proud to serve our neighbors of Oregon and contribute to the health and well-being of our communities! The following is a brief outline of several key aspects of your group health plan.

- Some capitalized terms have defined definitions. Please refer to the Definitions section for more information.
- In this Group Certificate, Samaritan Health Plans is referred to as "we", "us" or "our". Members enrolled in this Plan are referred to as "you" or "your".
- A group entity must be physically located in the state of Oregon in order to qualify as an Employer and recipient of the Group Policy.
- Coverage provided under this employer group plan is provided through:
    - Samaritan Health Plan In-Network Providers located in our Service Area;
    - Our national In-Network Providers; and
    - Out-of-Network Providers
- A printable directory of In-Network Providers in our Service Area and our national In-Network Providers is available at samhealthplans.org/groupfindcare. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- The Group Contract for this employer group plan consists of this Group Certificate plus the Employer Group Addendum, Rates, Schedule of Benefits, any Endorsements and amendments that accompany these documents, and those policies maintained by Samaritan Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Employer Group Addendum, (3) Group Certificate, (4) Schedule of Benefits, (5) Rates, and (6) applicable Samaritan Health Plan policies.

Samaritan Health Plans guarantees 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, the Affordable Care Act (ACA) and any applicable Oregon Revised Statute.

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

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

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

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

We look forward to serving you!

Sincerely,

Samaritan Health Plans

Table of Contents

1. Becoming a Samaritan Member

1.1 Your Group Plan

Your Plan allows you to receive Covered Services from In-Network Providers through your In-Network benefit. In-Network Providers will work with us to get Prior Authorization for your treatment. If you are wishing to seek Services from Out-of-Network Providers, it is your responsibility to make sure the Services get Prior Authorization by Samaritan Health Plans before treatment is received. **It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is an In-Network Provider and whether or not a service is a Covered Service even if you have been directed or referred for care by an In-Network Provider.**

Whenever you visit a Provider:

- Bring your Member ID Card with you.
- Be prepared to make a Copayment at the time of visit if the office visit is subject to a Copayment.
- If your office visit is subject to a Coinsurance (a percentage of the amount billed for Services), you will most likely not be able to pay for what you owe at the time of your visit. Your provider's office will send you a bill for what you owe later. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive Services, and bill or credit you for the balance.

Please Keep These Materials for Future Reference:

- Schedule of Benefits
- Group Certificate (this document)
- Group Certificates for additional Plans or Coverage Riders (if purchased)
- Prior Authorization List
- Summary of Benefits & Coverage

Your Health Plan ID Card

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

Provider Directory

If you are unsure about a physician/provider's, Hospital's, or other facility's participation with Samaritan Health Plan, visit our Provider Directory, available online at www.samhealthplans.org/groupfindcare. Additionally, you can contact our Customer Service

Department to get information about a provider's participation with Samaritan Health Plan and your benefits. You can also request a hard copy of the Provider Directory, which we will provide at no cost to you.

Interpreter Services

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

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

Please contact our Customer Service Department with all of the necessary information at least 72 hours before your appointment.

Member Portal

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

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

2. General Terms Under Which Benefits Are Provided

Throughout this Group Certificate of Medical, Surgical, Pharmacy and Hospital Insurance, the terms "we," "our" and "us" refer to Samaritan Health Plans and the terms "you" and "your" refer to the Eligible Employee and to each Enrolled Dependent, unless otherwise specified. Special terms used in the Plan Benefits section and Group Certificate to explain your plan have their first letter capitalized and appear in the "Definitions" section of this Group Certificate. You are entitled to receive the benefits set forth in the Plan Benefits section subject to the following conditions:

- All benefits are subject to the terms, conditions and definitions in this Group Certificate and the exclusions and limitations in the Benefit Exclusions section, including payment of any applicable Deductible, Coinsurance, and Copayments identified in the attached Schedule of Benefits.
- All services other than the limited preventive care services outlined in this Certificate are covered only if Medically Necessary as defined in the "Definitions" section of this Group Certificate.
- The fact that a Provider may provide, prescribe, order, recommend, approve, refer, or direct a service or supply does not, in and of itself, make the service or supply a covered benefit.
- To qualify as covered Services and Supplies, all Services and Supplies must be expressly set forth as benefits in this Plan Benefits section.
- When Services are performed by or received from an Out-of-Network Provider, your expenses include a Calendar Year Deductible (if any), fixed dollar amounts for certain services, and the amount by which billed charges exceed the Maximum Plan Allowable (MPA) for other services. The definition of MPA is set forth in the "Definitions" section of this Group Certificate. The MPA for covered Services and Supplies may not be the same as what an Out-of-Network Provider bills.
- Even though a Hospital or other Provider may be In-Network, during your visit or stay you may receive Covered Services or Supplies that are performed by or received from Out-of-Network Providers. If you receive Covered Services at an In-Network facility (including, but not limited to, a licensed hospital, an ambulatory surgical center or other outpatient setting, a laboratory, or a radiology or imaging center), at which you receive Covered Services by an Out-of-Network Provider, the services provided by the Out-of-Network Provider will be payable at the In-Network level of cost benefits and Deductible, if applicable, and without balance billing (the difference between a Provider's billed

charge and the MPA) by the Out-of-Network Provider. Such other types of Providers may include, but are not limited to, those who provide anesthesia services, emergency room Physician services, radiology (x-ray), pathology and laboratory services.

- For Covered Services, Samaritan Health Plans uses available guidelines for Medicare, including billing and coding requirements, to assist in its determination as to which Services and procedures are eligible for reimbursement, and in determiningMPA.
- A medical service or supply not expressly included in the Plan Benefits section is not a covered benefit, even if it is not specifically listed as an exclusion in the Benefit Exclusions section.
- Medical Services received by Specialty Care Providers for certain conditions or treatment procedures are covered only if such Services are provided at In-Network Providers that are designated as Specialty Care Providers. Services which require use of a Specialty Care Provider include but are not limited to: 1) birthing center services; 2) home health care; 3) infusion services that can be safely administered in the home or in a home infusion suite; 4) organ and tissue transplant services; 5) durable medical equipment; 6) prosthetic devices/orthotic devices; and 7) wigs. We have the right to require a Member to use a designated Specialty Care Provider as a condition to receive coverage under this Agreement. Specialty Care Providers may be located anywhere in the United States. Members may be required to travel out of the Service Area to receive care. If a Member is required by us to use a Specialty Care Provider outside the Service Area, we will pay reasonable transportation, board and lodging expenses for the Member, to be determined by us based upon individual circumstances, including without limitation the distance between the Member's home and the Specialty Care Provider, and the Member's medical condition.
- Outside of renewal or as required by Oregon state or federal mandate, no material modification will be made to benefits, including preventive benefits, without providing notice to Members 60 days in advance of the effective date.
- The coverage described in the Plan Benefits section shall be consistent with the Essential Health Benefits coverage requirements in accordance with the Affordable Care Act (ACA). The Essential Health Benefits are not subject to any annual or lifetime dollarlimits. f both a state law and federal law require coverage of the same or similar service, the insurer must assure that all elements of both laws are met and provide the coverage in the manner most beneficial to the consumer
- The benefits described under this Agreement do not discriminate on the basis of race, ethnicity, nationality, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, or religion, and are not subject to any pre-existing condition exclusion period. Please refer to the Notice of Nondiscrimination section in this Group Certificate.
- A printable directory of In-Network Providers in our Service Area and our national In-Network Providers is available at www.samhealthplans.org/groupfindcare. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- The Group Contract for this employer group plan consists of this Group Certificate plus the Employer Group Policy, Rates, Schedule of Benefits, any Endorsements and

amendments that accompany these documents, and those policies maintained by Samaritan Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Employer Group Policy, (3) Group Certificate, (4) Schedule of Benefits, (5) Rates, and (6) applicable Samaritan Health Plan policies.

2.1 Protection Against Surprise Medical Bills

When you get emergency care or get treated by an Out-of-Network Provider at an In-Network Hospital, Independent Freestanding Emergency Department or Ambulatory Surgical Center, you are protected by federal law from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-Network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-Network Providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than In- Network costs for the same service and might not count toward your annual Out-of-Pocket Maximum.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider.

You are protected from balance billing for:

Emergency Services
If you have an emergency medical condition and get Emergency Services from an Out-of-Network Provider or facility, the most the Provider or facility may bill you is your plan's In-Network cost-sharing amount (such as Deductibles, Copayments and Coinsurance). You cannot be balance billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post stabilization services.

Certain services at an In-Network hospital, independent freestanding emergency department or Ambulatory Surgical Center
When you get services from an In-Network hospital, independent freestanding emergency department or Ambulatory Surgical Center, certain Providers there may be Out-of-Network. In these cases, the most those Providers may bill you is your plan's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology,

laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these In-Network facilities, Out-of-Network Providers cannot balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care Out-of-Network. You can choose a Provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the Copayments, Coinsurance, and Deductibles that you would pay if the provider or facility was In-Network). Your health plan will pay Out-of-Network Providers and facilities directly. Your health plan generally must:

1. Cover Emergency Services without requiring you to get approval for services in advance (Prior Authorization).
2. Cover Emergency Services by Out-of-Network Providers.
3. Base what you owe the Provider or facility (cost-sharing) on what it would pay an In Network Provider or facility and show that amount in your explanation of benefits.
4. Count any amount you pay for Emergency Services or Out-of-Network services toward your Deductible and Out-of-Pocket Maximum.

If you believe you've been wrongly billed, you may contact our Customer Service Department at 541- 768-4550 or toll-free at 800-832-4580 (TTY 800-735- 2900)

For assistance outside of Samaritan Health Plans:

State of Oregon

You may contact the Oregon Division of Financial Regulation at: Oregon Division of Financial Regulation, Consumer Protection Unit at 503-947-7984 or 1-888-877- 4894, or visit https://dfr.oregon.gov.

Federal

You may contact the U.S. Department of Health and Human Services and file a complaint by calling 800-985-3059 (toll-free) or going to https://www.cms.gov/nosurprises/consumers

3. Plan Benefits

3.1 Covered Benefits

**May require Prior Authorization, please see Prior Authorization or visit website (*2022 Prior Authorization List - For Large Group Everyday Choice Plans (samhealthplans.org)) for complete list

Physician Services

Benefits are subject to payment of any applicable Copayments or Coinsurance and will vary depending on whether the procedure is performed in a physician's office, hospital, outpatient office, or an ambulatory surgery center. Applicable Copayments and Coinsurance can be found in your Schedule of Benefits.

Certain exclusions and limitations may apply. Before obtaining care, be sure to read the "Benefit Exclusions" and the "Prior Authorization" sections of this Group Certificate and your Schedule of Benefits for additional benefit limitation information.

Medically Necessary Physician services are covered as follows:

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

Diagnostic Services – Diagnostic services, including radiology (X-ray), pathology, laboratory tests, sleep studies, cardiac catheterization, and other imaging, are covered. Imaging services including, but not limited to, MRA, MRI, CT, PET, echocardiography, and nuclear cardiac imaging, require Prior Authorization. Hearing tests in support of a diagnosis are covered.
Office Visits with Primary Care Providers – Your office visits to a Primary Care Provider, including Medical Services for illness or injury, are covered. Office procedures may require Prior Authorization. Refer to your Prior Authorization list for more information.

Physician Services While Hospitalized – The services of Physicians during a covered hospitalization, including services of primary care providers, specialist surgeons, assistant surgeons, anesthesiologists, pediatrician visits for an Enrolled newborn child, and other appropriate medical personnel, are covered.

Specialty Physician Services – Services of specialty Physicians and other specialty Providers are covered when they are In-Network Providers.

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

Primary Care Provider Designation – Samaritan Health Plans allows the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider or any Women's Health Care Provider who participates in our network and who is available to accept you or other members. Until you make this designation, we will designate one for you. For children, you may designate a pediatrician as the Primary Care Provider or any willing in-network pediatrician. For information on how to select a Primary Care Provider, and for a list of In-Network Primary Care Providers or any Women's Health Care Provider, you may contact our Customer Service Department.

Obstetrical and Gynecological Care – You do not need Prior Authorization from us or from any

other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain

procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan. For a list of In-Network health care professionals who specialize in obstetrics or gynecology, you may contact our Customer Service Department.

Hospital Inpatient Services

Certain exclusions and limitations may apply. Before obtaining care, be sure to read the "Benefit Exclusions" and the "Prior Authorization" sections of this Group Certificate and your Schedule of Benefits for additional benefit limitation information.

Medically Necessary Hospital inpatient services are covered as follows:

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

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

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

Charges for rental of telephones, radios or televisions, guest meals, or other personal items, are not covered.

Maternity Care* – Covered Services of a physician or certified nurse midwife are covered. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for Illness. We cover care necessary to support a healthy pregnancy and labor and delivery. We cover Members whose mothers have taken medication containing diethylstilbestrol (DES) prior to the insured's birth.
Inpatient Hospitalization admissions for childbirth do not require a Prior Authorization in accordance with the Newborns' and Mothers' Health Protection Act. Services do not require Prior Authorization unless the Hospital stay exceeds 48 hours for a vaginal delivery, or 96 hours for a cesarean section.

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

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

State-Approved Programs - Services performed by a state Hospital or state-approved program are not excluded if such services would otherwise be covered by this plan.

***Exclusions and Limitations**:*

- A private room or services of private or special duty nurses other than as Medically Necessary when you are an inpatient in a Hospital.
- Personal comfort items, such as television, telephone, lotions, shampoos, meals in the home, guest meals in inpatient facilities, housekeeping services, etc.
- Outpatient prescription or other drugs and medications.
  Prescriptions relating to an inpatient/outpatient confinement filled at a Hospital pharmacy prior to discharge for use at home (take-home medications) except for prescriptions for a 24-hour supply or less, following an emergency room visit.

Outpatient Services

Benefits are subject to payment of any applicable Copayments or Coinsurance and will vary depending on whether the procedure is performed in a physician's office, hospital, outpatient office, or an ambulatory surgery center. Applicable Copayments and Coinsurance can be found in your Schedule of benefits.

Certain exclusions and limitations may apply. Before obtaining care, be sure you read the "Benefit Exclusions" and the "Prior Authorization" sections of this Group Certificate and your Schedule of Benefits for additional benefit limitation information.

Medically Necessary outpatient services are covered as follows:

Diagnostic Services – Diagnostic services include our radiology, laboratory, and High-tech imaging benefit categories. Outpatient services may be provided in a non-hospital based health care facility or at a Hospital.

- **High-Tech Imaging*** – Imaging services such as MRI, CT scans, PET scans and/or SPECT scans are considered high-tech imaging. Refer to your Schedule of Benefits for Cost Share information.
- **Laboratory Services*** – Covered Services are paid according to the plan when provided by or prescribed by a Provider. Services are paid based on place of service, Provider type, and Provider billing. Refer to your Schedule of Benefits for Cost Share information.
- **Radiology** – Covered Services provided by or prescribed by a Provider are paid according to the plan. Covered Services include, but are not limited to, x-rays, diagnostic and therapeutic services, electrocardiograms, fluoroscopy, and ultrasounds. Refer to High-Tech Imaging and Preventive Care services within this section for additional information. Refer to your Schedule of Benefits for Cost Share information.

Proton Beam Therapy – This Plan covers proton beam therapy for the treatment of cancer on a basis no less favorable than the coverage of radiation therapy.

Radiation Therapy – Radiation therapy is covered.

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

Outpatient Surgery – Certain services may be covered only when prior authorized or as Emergency Medical Care. Prior Authorization requirements can be verified by contacting us or as outlined in the "Prior Authorization" section of this Group Certificate.

Emergency Care Services

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

Emergency Care and Urgent Care Services are covered inside or outside our Service Area without Prior Authorization, including emergency eye care. Benefits for these Services are described below and paid according to the plan. Refer to your Schedule of Benefits for Cost Share information.

Emergency Room – Services of a Hospital emergency room are limited to treatment of an Emergency Medical Condition and are not covered if merely for your convenience.

Notification – If you are hospitalized for an Emergency Medical Condition, notice of the admission sufficient to establish your identity and the institution to which you were admitted must be given to us no later than 24 hours or by the next business day after admission or as soon as medically possible.

Follow-up and Continued Care – After Stabilization of an Emergency Medical Condition, all follow-up care must be provided by an In-Network Provider in accordance with the terms and conditions of the Group Medical and Hospital Service Agreement and this Group Plan Benefits section. If you are hospitalized in an Out-of-Network Provider Hospital and require continuous care, you shall be transferred by us to an In-Network Provider as soon as Stabilization has occurred. We must approve in advance any expenses incurred after Stabilization and transfer to an In-Network Provider is medically feasible. All other services provided by an Out-of-Network Provider if you have refused a transfer after Stabilization are excluded.

Ambulance Transport – Licensed ground or air ambulance services are covered in the event of an Emergency Medical Condition. Air ambulance service is covered only when ground transportation is medically or physically inappropriate. Medically Necessary ambulance transport for facility to facility transfers is covered only when Prior Authorized. Prior Authorization requirements can be verified by contacting us or as outlined in the "Prior Authorization" section of this Group Certificate. Applicable Copayments and Coinsurance can be found on the Schedule of Benefits.

***Exclusions and Limitations**:* Ambulance transport that is not Emergency Medical Care or

Medically Necessary is not covered.

Claims – All claims for Emergency Medical Care must contain sufficient information to establish the emergency nature of the care.

Urgent Care Services

Medically Necessary Urgent Care Services are covered under this Certificate.

Autism Spectrum and Pervasive Developmental Disorder

Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations:

- Services must be Medically Necessary.
- The initial screening and an individualized treatment plan must be provided by a licensed Neurologist, Pediatric Neurologist, Developmental Pediatrician, Psychiatrist or Psychologist who has experience or training in the diagnosis of autism spectrum disorder.
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualized treatment plan.
- Treatment must be provided by a health care professional licensed to provide ABA services.
- Treatment may be provided in the Member's home or in a licensed health care facility.
- The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Autism Service Provider for the specific patient being treated and must be reviewed by the Autism Service Provider no less than every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
- The Autism Service Provider must submit updated treatment plans to Samaritan Health Plans for continued behavioral health and at ongoing intervals of no less than six-months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.
- Samaritan Health Plans may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

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

Biofeedback

Covered for Mental Health and Substance Use Disorder, migraine headaches and urinary incontinence. Refer to your Schedule of Benefits for Cost Share information. This benefit is limited to ten (10) lifetime visits for migraine headaches and urinary incontinence. (Limits do not apply for Mental Health and Substance Use Disorder services.)

Blood Transfusion

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

Child Abuse Medical Assessments

Covered Services provided by a children's advocacy center in conducting a child abuse assessment of a child enrolled in the Plan, and that are related to the child abuse assessment including a forensic interview and mental health treatment.

Approved Clinical Trial*

Benefits are provided for Covered Services directly related to a Member's participation in an Approved Clinical Trial. Covered Services include the routine patient costs for items and Services received in connection with the Approved Clinical Trial, to the extent that the items and Services are otherwise Covered Services under the Plan.
The following costs are excluded:

- The cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The Plan does not discriminate against a Member who participates in a clinical trial, whether or not the trial is an Approved Clinical Trial. The Plan provides benefits for Services unrelated to a clinical trial to the extent that the Services are otherwise Covered Services under the Plan.

Craniofacial Anomalies*

The Plan covers dental and orthodontic services for the treatment of Craniofacial Anomalies if the Services are Medically Necessary to restore function. Covered Services are paid based on place of service, Provider type, and Provider billing
Exclusions and Limitations*:* Craniofacial Anomalies does not include developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or temporomandibular joint disorder (TMJ).

Dental Anesthesia

General anesthesia services and related facility charges will be covered in relation to a dental procedure if such services and related facility charges are Medically Necessary because the Member:

- Has a medical condition that the Member's Physician determines would place the Member at an undue risk if performed in a dental office. The dental procedure must be approved by the Member's Physician.

The services must be performed in a Hospital or in an Ambulatory Surgery Center. Inpatient anesthesia services are covered only when prior authorized. The dental procedures performed are only covered as specifically outlined in this Agreement.

Dental Injury*

Covered Services provided by a dentist or physician, to treat an injury of the jaw or natural teeth are covered under the Plan as a medical benefit.

Refer to your Schedule of Benefits for Cost Share information. Covered Services are paid based on place of service, provider type, and provider billing.
Only the following major dental procedures are eligible for reimbursement:

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

Diabetes Management

The following is covered in relation to the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes:

- **Diabetes self-management Programs** – Benefits covered in full including:: (a) one program of assessment and training; and (b) up to three hours annually, of assessment and training

following a material change in the condition, medication, or treatment in an existing treatment of diabetes.

- **Diabetes Education** – Covered Services of a Certified Diabetes Educator (CDE) for diabetes self-management education programs are covered. This means outpatient instruction for diabetics about the Disease and its control, taught by a CDE. Refer to your Schedule of Benefits for Cost Share information
- **Diabetes Management for Pregnant Women** – Benefits are covered in full for drugs, and Supplies that are Medically Necessary for a woman to manage her diabetes during each pregnancy, beginning with conception and ending six weeks postpartum, are covered. Covered Services are paid based on place of service, Provider type, and Provider billing.
- **Screening for Gestational Diabetes** - as supported by Health Resources and Services Administration (HRSA) guidelines, is covered as preventive care in the "Preventive Care" portion of this Plan Benefits section.
- **Diabetic Supplies*** – Eligible Supplies defined as gauzes, syringes, needles, lancets, alcohol and alcohol swabs, and betadine swabs. Some items can be purchased at a Pharmacy. When diabetic supplies are purchased at a Pharmacy, refer to the Prescription Drug Benefits section. Refer to your Schedule of Benefits for Cost Share information
- **Diabetic Equipment** – Eligible equipment is covered and is covered under Medical Supplies. The following are considered diabetic equipment: diabetic pumps, glucose monitors, test strips, diabetic shoes and inserts, and diabetic shoe fitting. Refer to your Schedule of Benefits for Cost Share information
- **Routine Foot Care** – Treatment for corns and calluses, toenail conditions, hypertrophy or hyperplasia of the skin and nails for Member that has diabetes mellitus is covered. Refer to your Schedule of Benefits Cost Share information.

Dialysis Services

Dialysis Services are covered in an office or at a facility. Coverage includes, but is not limited to, professional services, facility charges, and any supplies, drugs or solutions used for dialysis. If you receive dialysis services due to a diagnosis of end stage renal disease, you may be eligible to enroll in Medicare. If you enroll in Medicare, this plan will coordinate benefits per Medicare rules.

Durable Medical Equipment (DME), Prosthetics, Orthotics and Medical Supplies*

Durable Medical Equipment, including your initial rental or purchase, is covered provided it is prescribed by your Physician, and is the least costly alternative that achieves a medically acceptable result. Coverage includes, but is not limited to, crutches, wheelchairs, orthopedic

braces, prosthetics, glucometers, and equipment for administering oxygen are covered. Refer to the Benefit Exclusions section for additional information.
In assessing Medical Necessity for Durable Medical Equipment coverage, we apply nationally recognized Durable Medical Equipment coverage guidelines, such as those defined by InterQual (McKesson) and the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prosthetics – Eligible devices are covered if Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. Power-assisted Prosthetics are not covered. Repairs to existing Prosthetics (even if acquired before the Member's coverage under the Plan) are also covered, up to the cost of replacement. Coverage is determined by Medicare standards of care.
Vision Hardware – Eligible items after cataract surgery or due to medical needs are covered. Hardware needed after cataract surgery is a one-time per eye benefit.

Essential Health Benefits

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

Habilitative Services

Coverage is provided for habilitative services and/or therapy that assist an individual in partially or fully acquiring, maintaining, or improving age appropriate skills and functioning and that are necessary to address a health condition, to the maximum extent practical, when

provided by an In-Network Provider, licensed physical, speech or occupational therapist or other contracted Provider, acting within the scope of his or her license, to treat physical and Mental Health Conditions, subject to any required Prior Authorization from us. The services must be based on a treatment plan authorized, as required by us or the Member's Physician.

***Exclusions and Limitations**:*

- Habilitative services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment plan goals.
- Speech therapy is not covered for occupational or recreational voice strain that could be needed by professional or amateur voice users, including, but not limited to, public speakers, singers, and cheerleaders.
- Health care services that are not habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, and custodial care.

Inpatient habilitative services are limited to:

- A maximum of thirty (30) days per calendar year.
- We may also approve an additional thirty (30) days per condition when Medical Necessity criteria are met, not to exceed sixty (60) days total.
- The maximum benefits for inpatient and outpatient treatment are shown on the Copayment and
- Coinsurance Schedule. Prior Authorization is required for Inpatient services.
- Inpatient habilitative services to treat Mental Health Conditions are not subject to day limits/maximums.
-

Outpatient habilitative services are limited to:

- A maximum of thirty (30) visits per calendar year. We may approve an additional benefit of up to thirty (30) visits per condition when Medical Necessity criteria are met, not to exceed sixty (60) visits total.
- The maximum benefits for inpatient and outpatient treatment are shown on the Copayment and
- Coinsurance Schedule. Prior Authorization is required for Inpatient services.
- Outpatient habilitative services to treat Mental Health Conditions are not subject to day limits/maximums.

Health Education Services

Instruction in the appropriate use of health services and the contribution you can make to the maintenance of your own health is covered. Health education services shall include instruction in personal health care measures and information about services, including recommendations on generally accepted medical standards for use and frequency of such service. Qualifying classes include: prenatal/child birthing, exercise, healthy heart, first aid/CPR, weight

management, stress management, and smoking cessation. Qualifying classes must be taken at a Hospital or Clinic.

Hearing Aids and/or Hearing Assistive Technology Systems*

Covered if Medically Necessary and prescribed, fitted, and dispensed by a licensed Audiologist or Hearing Aid Specialist. The maximum benefit for hearing aids and/or hearing assistive technology systems is every 36 months. Services include those required and defined by ORS 743A.141. Examples of this may include:

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

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

For hearing aids, more frequently than every 36 months if modifications to an existing hearing aid will not meet the needs of an enrollee who is:

- Under 19 years of age; or
- 19-25 years of age and enrolled in a secondary school or an accredited educational institution.

Refer to your Schedule of Benefits for Cost Share information. Contact our Customer Service Department for specific coverage requirements.

Home Health **Care**

Home Health Care for Skilled Nursing Services is covered in your home or place of residence, which is not a Skilled Nursing Facility. Daily coverage is limited to what we would pay an In-Network Skilled Nursing Facility for 24-hour Skilled Nursing Services. Prior Authorization is not required.

***Exclusions and Limitations**:*
We may utilize a Specialty Care Provider of home health services if you live in Oregon. Prior Authorization is required for physical, occupational and speech therapy performed in the home. We do not cover Custodial Care.

Hospice Care

Hospice Care is covered if you are terminally ill. Covered Services are paid according to the plan. Respite care is covered with a maximum of five (5) consecutive days and thirty (30) days lifetime.

Infusion*

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

Maternity Benefits

Certain exclusions and limitations may apply. Before obtaining care, be sure to read the "Benefit Exclusions" portion of this Plan Benefits section and your Schedule of Benefits for additional benefit limitation information.

Medically Necessary maternity care is covered as follows:

- **Availability** – Maternity benefits are available for all Members (Subscriber, Subscriber's Enrolled spouse or Domestic Partner, and a Subscriber's enrolled Dependent child).
- **Prenatal and Postnatal Care** – Prenatal and postnatal care are covered. This benefit is subject to the maternity delivery care (professional services only) Copayment or Coinsurance amount shown on the Schedule of Benefits.
- **Universal Newborn Nurse Home Visits** – This Plan covers universal newborn nurse home visiting services for a newborn child up to the age of six months.
- **Hospital Room and Board** – Hospital room and board for the mother are covered the same as for any other covered illness or injury. This benefit is subject to the inpatient services Copayment or Coinsurance amount shown on the Schedule of Benefits.
- **Delivery and Nursing Care** – Delivery services and facilities and nursing care are covered. Birthing Center services will be directed to a designated Specialty Care Provider in accordance with the "General Terms Under Which Benefits Are Provided" portion of this Group Certificate. Services provided by other than the designated Specialty Care Provider will not be covered.
- **Notification Required** – Please notify us at the time of the first prenatal visit.
- **Abortion services** – Abortions are covered as required by state law.

Surrogacy Arrangements

Members who are a surrogate at the time of Enrollment or Members who agree to a surrogacy arrangement during the Contract Year must, within thirty (30) days of Enrollment or agreement to participate in a surrogacy arrangement, send us written notice of the surrogacy arrangement in accordance with the notice requirements as outlined in this Group Certificate. A Member

who enters into a surrogacy agreement must reimburse Samaritan Health Plans for Covered Services related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement. Member reimbursements to Samaritan Health Plans are limited to the compensation amounts specified in the surrogacy agreement, amounts not specific in such agreement would be covered under maternity services and not subject to reimbusrment to Samaritan Health Plans.

Note: This provision does not amend the contract to restrict any terms, limits, or conditions that may otherwise apply to surrogates and children born from surrogates. Please see the "Exclusions and Limitations (What's not covered)" section.

***Exclusions and Limitations**:*
Services of a lay midwife are not covered.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act:
Under federal law, health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48-hours following a vaginal delivery, or less than 96-hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending Provider (e.g., your Physician, nurse midwife, or Physician's assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48-hours (or 96-hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Medical Supplies

Medical supplies are covered as follows:

- Diabetic supplies dispensed in accordance with any formulary adopted by us are covered, including syringes, blood glucose monitors and test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and pump accessories, insulin infusion devices, and foot care appliances for prevention of complications associated with diabetes. Insulin, glucagon emergency kits and prescriptive oral agents are covered under the "Prescription Drug Benefits" subsection of this Group Plan Benefits section.
- Ostomy supplies are covered, including flanges, pouches, irrigators, irrigator sleeves and drains, closed-end pouches, stoma caps, ostomy deodorant, belts, convexinserts,

drain tube adapters, drainable pouch clamps, medical adhesive, replacement filters, security tape, and skin barriers.

- Non-durable supplies required for the function of Durable Medical Equipment are covered.
- Allergy serums, treatment compounds, solutions, and medications are covered. Substances administered by therapeutic injection in a Provider's office are covered.

Non-durable medical supplies provided in the In-Network Provider's office are covered.

***Exclusions and Limitations**:*

Wound care products, incontinence products, generic multi-use products, reusables and all other nondurable medical supplies are not covered.

Mental Health Conditions

Benefits for treatment of Mental Health Conditions are provided. Inpatient, residential, partial hospitalization and intensive outpatient services and some outpatient services require Prior Authorization. To obtain Prior Authorization please contact our Customer Service Department.

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

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

- Assessment and evaluation in order to diagnose or determine if a Mental Health condition or Substance Use Disorder exists;
- Treatment of Mental Health conditions or Substance Use Disorders which are subject to significant improvement through evidence-based therapeutics;
- Treatment provided in healthcare facilities, Residential programs or facilities, day or Partial Hospitalization programs, or Intensive 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 will not deny benefits for a Medically Necessary treatment or service for a Mental Health Condition based solely upon:

- An Enrollee's interruption of or failure to complete a prior course or treatment;
- Samaritan Health Plans categorical exclusion of such treatment or service when applied to a class of Mental Health Conditions; or
- The fact that a court ordered the Enrollee to receive or obtain the treatment or service for a Mental Health Condition, unless otherwise allowed by law.

Samaritan Health Plans covers Services and treatment for those Mental Health and Substance Use Disorder diagnoses covered under the Mental Health and Addiction Equity Act of 2008. Samaritan Health Plans is compliant with state and federal Mental Health parity.
For purposes of this section:
"Facility" means a corporate or governmental entity or other provider of services, licensed for the treatment of Mental Health Conditions.

"Program" means a particular type or level of service that is organizationally distinct within a Facility. A program that provides services for persons with both a Substance Use Disorder diagnosis and a Mental Health Condition shall be considered to be a distinct and specialized type of program for both Substance Use Disorder and Mental Health Conditions.

"Provider" means a person that has met our credentialing requirements, is otherwise licensed and eligible to receive reimbursement for coverage under the contract and is:

- A health care Facility;
- A residential Program or Facility;
- A day or partial hospitalization Program;
- An outpatient service; or
- An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

Exclusions and Limitations*:*
No coverage is provided for the following services:

- The coverage of a treatment or service that is or may be excluded from coverage under state law;
- Educational or correctional services or sheltered living provided by a school or halfway house; however, a Member may receive covered outpatient services while in custody or living temporarily in a sheltered living situation or receive treatment or services related to a Member's education that are included in a Medically Necessary treatment plan provided by a Provider;
- Psychoanalysis or psychotherapy received as part of an educational or training program and not otherwise covered, regardless of diagnosis or symptoms that may bepresent;

Nutritional Therapy and/or Counseling

Covered Services of a Licensed Dietician for the treatment of celiac sprue, hyperlipidemia, eating disorders, obesity, or otherwise stated as Medically Necessary by a Provider are covered and paid based on place of service, provider type, and provider billing. Licensed Dieticians are considered Specialists.

Organ and Tissue Transplant Services*

Services including organ and tissue transplants are covered.

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

- Bone marrow and peripheral blood stem cell
- Bone marrow for aplastic anemia
- Corneal
- Heart
- Heart-Lung
- Kidney
- Kidney-Pancreas (under certain conditions)
- Leukemia
- Liver
- Lung
- Lymphoma
- Pancreas
- Pediatric bowel
- Severe combined immune-delivery disease or Wiskott-Aldrich Syndrome

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

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

Transplants, In-Network – If a Transplant is performed at an In-Network Provider facility, covered charges are paid in full less applicable Copays, Coinsurance and Deductibles.
Transplants, Out-of-Network – If a Transplant is performed at an Out-of-Network Provider facility, services will not be covered.

Outpatient Drugs

Drugs that are administered on an outpatient basis in a Hospital, alternate facility, physician's office, or in the Member's home. Benefits under this section are provided only for outpatient drugs which, due to their characteristics (as determined by the Plan), must typically be administered or directly supervised by a qualified, licensed/certified health professional. Benefits under this section do not include drugs that are typically available by Prescription Order or refill at a Pharmacy. Covered Services are paid according to the plan based on place of service, Provider type, and Provider billing.
Prior Authorization is not required for prescription drugs and over-the-counter medications that are determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations.

Prescription Drug Benefits

The level of Prescription Drug Coverage is determined by our Formulary. To find out which tier a specific drug is covered in or if there are any specific limits or authorization requirements, see the Formulary at www.samhealthplans.org/groupbenefits**.**

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

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

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

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

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

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

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

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

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

Afforable Care Act Preventive Drugs - In accordance with the Affordable Care Act (ACA) your Plan covers, at no cost to you, certain preventive medications, including contraceptives, both prescription and over-the-counter, when these medications are purchased from Participating Pharmacies. ACA preventive drugs that your Plan covers are listed on your Formulary. Over-the-counter ACA preventive drugs received from Participating Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner. Over-the-counter contraceptives do not require a written prescription, as required by ORS 743A.067(2(j)(C) or 743A.067(4)

IMPORTANT NOTES:

- Your most cost-effective option is to use Generic Drugs whenever available. Brand Name Drugs 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.
- Covered Prescription Drugs must be Medically Necessary for diagnosis and/or treatment of an Illness or Injury. We will only cover medications up to a 90-day supply, even when medications are needed for vacations, school, or work for long periods of time. The exception is FDA-approved contraceptives, which are covered for an initial 3-month supply and then a 12-month supply of the same contraceptive, regardless if the initial 3-month supply was covered under this Plan.
- Some plan options can have a combined (or integrated) Deductible with medical expenses. You can find this information in your Schedule of Benefits.
- Over-the-Counter (OTC) drugs will not be covered without a prescription, unless required by law. Reference the Formulary for more specific drug coverage. Some preventive OTC drugs are covered without a prescription. (see Affordable Care Act Preventive Drugs and Reproductive Health sections).
- All drugs are approved to be on the Formulary by Samaritan Health Plans' Pharmacy & Therapeutics Committee. Reference the Formulary for more specific drug coverage information.
- Compound Drugs are only covered with an approved authorization.
- We will provide coverage of a drug, even if it is not FDA-approved for a prescribed medical condition, only if the Oregon Health Resources Commission determines the use is effective.
- We will cover Prescription Drugs that are dispensed by a licensed practitioner at a rural

health clinic for an urgent medical condition if there is not a Pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any Pharmacy within 15 miles of the clinic.

- We will allow for a 90-day transition period on selected non-formulary Mental Health and behavioral drugs. Please refer to the Resource Guide on page 1 to contact our Customer Service Department.

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 Drugs. Samaritan Health Plans offers a Closed Formulary to their Members. A Closed Formulary is a method used by Samaritan Health Plans to provide Prescription Drug benefits in which only specified FDA-approved Prescription Drug products are covered, as determined by Samaritan Health Plans, 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.

Preventive Care Services

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

If you have questions as to whether a service is preventive, please contact our Customer Service Department.
The schedules provided for the preventive benefits below are only recommendations and do not represent a full list:

A and B list for Preventive Services:
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Women's Preventive Services:
http://www.hrsa.gov/womensguidelines/

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

Colorectal Screenings – We cover Services for colorectal cancer screening that have been assigned either a grade A or grade B by the USPSTF for any individual at high risk, and as a part of the individual's routine Preventive Care. Screenings are provided at no Cost Share to the Member for preventive screenings.

The USPSTF recommends screening for adults age 45 and older using:

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

We cover preventive colorectal screenings for individuals who are younger than age 45 or require a screening any time prior to a 10-year interval and have been diagnosed by their Provider as high risk for colorectal cancer. An individual is considered high risk if the individual has:

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

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

Lung Cancer Screening – The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

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

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

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

> **Infant Care** – Well baby care covers physical examinations, including the standard in-hospital examination at birth, diagnostic X-rays, and Laboratory Services for an enrolled baby up to age 24 months.

Children/Adolescent Care – We cover routine periodic health appraisals, routine physical examinations, and physical examinations required for school and/or to participate in athletics. Handling fees are not covered.

We cover physical examinations and any related laboratory tests and X-ray examinations up to the following amounts:

- Age 2-6, one examination every Calendar Year.
- Age 7-17, one examination every two Calendar Years.

Reconstructive Services/Surgery

Covered Services are paid according to the plan, under the following circumstances, when Medically Necessary:

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

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

Reproductive Health Care Services

We cover Reproductive Health Care Services as required under the Oregon Insurance Code. Reproductive Health Care Services do not require Copays or cost sharing when received by an In-Network Provider. Out-of-network Services will have cost sharing applied unless:

- There is no In-network provider to furnish the service, drug, device, product or procedure that is geographically accessible or accessible in a reasonable amount of time, as defined by the Department of Consumer and Business Services by rule consistent with the requirements for provider networks in ORS 743B.505 (Provider networks); or
- An in-network provider is unable or unwilling to provide the service in a timely manner.

Refer to your Schedule of Benefits for Cost Share Information.

If you have questions as to whether a service is a reproductive health care service, please contact our Customer Service Department.

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

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

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

We also cover:

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

Abortions – Abortions are covered as required by state law.

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

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

We also cover:

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

Rehabilitation Therapy

For the purposes of this section:
Rehabilitation Services are health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech language pathology and psychiatric rehabilitation services in a variety of inpatient and or outpatient settings. Prior Authorization is required for Inpatient services.

Rehabilitation therapy is covered as follows:
Medically Necessary therapy and services for the treatment of traumatic brain injury are covered.

Rehabilitation therapy for physical impairments in Members diagnosed with Pervasive

Developmental Disorder or Autism that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered Medically Necessary when criteria for rehabilitation therapy are met.
The following services are covered in connection with other conditions when Medically Necessary:
Hospital-based or outpatient physical, occupational and speech therapy, manipulations, cardiac rehabilitation, rehabilitation therapy following a covered mastectomy. The services must be based on a treatment plan authorized, as required by the plan or the Member's Physician. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment plan goals.

Coverage for an osteopathic manipulative treatment provided by an osteopathic physician shall include the cost of the evaluation conducted by the osteopathic physician that resulted in the osteopathic manipulative treatment.

***Exclusions and Limitations**:*

- Speech therapy is not covered for occupational or recreational voice strain that could be needed by professional or amateur voice users including, but not limited to, public speakers, singers, and cheerleaders.
- Health care services that are not rehabilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, and custodial care.
- Inpatient rehabilitation services are limited to:
    - A maximum of 30 days per Calendar Year.
    - We may also approve an additional 30 days per condition when Medical Necessity criteria are met, not to exceed 60 days total.
- The maximum benefits for inpatient and outpatient treatment are shown on the Schedule of Benefits.
- Rehabilitative services to treat Mental Health Conditions are not subject to the day/visit limit maximums.

Skilled Nursing Facility (SNF)*

Covered Services of a Skilled Nursing Facility are covered for up to 60 days per Calendar Year of extended care. The maximum benefit is shown on the Schedule of Benefits. Prior Authorization is required.

Sleep Lab

Sleep study services are covered when ordered by a pulmonologist, neurologist, psychiatrist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory.

Telemedical Services

Telemedicine is the mode of delivering health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a patient's health care. The plan will cover Services as medically necessary, if the Service is determined to be safely and effectively provided, and the application and technology used to provide the Service meets all standards required by state and federal laws governing the privacy and security of protected health information. Refer to your Schedule of Benefits for Cost Share Information.

Covered Telemedical Services may include the following:

- Landlines, wireless communications, the Internet and telephonenetworks;
- Synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices; and
- Communications between providers or between one or more providers and one or more patients, family members, caregivers or guardians."

The Plan does not require a Member to have an established patient-provider relationship with a provider to receive Telemedicine Services from the provider or require a Member to consent to Telemedicine Services in person.

Voluntary Sterilization

Male and female sterilization services are covered. Services are covered in full when received from In-Network Providers.
Exclusions and Limitations*:*
Reversal of voluntary infertility (sterilization) is not covered.

Wigs*

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

Women's Preventive Care Services

We cover Women's Preventive Care Services. This includes annual women's exams, although it is recognized that several visits can be needed to obtain all necessary recommended Preventive Services, depending on a woman's health status, health needs, and other risk factors. Women's exams include the following:

- **Clinical Breast Exam** – An annual breast exam for women 18 years of age or older or at any time when the women's healthcare provider recommends for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer.

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

We also cover screening and appropriate counseling or interventions for:

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

If you have questions as to whether a women's care service is preventive, please contact our Customer Service Department.

Women's Preventive Care Services do not require Copays or cost sharing when received by an In-Network Provider. Out-of-network Services will have cost sharing applied unless there is no In-Network Provider to furnish the service, drug, device, product, or procedure that is geographically accessible or accessible in a reasonable amount of time as defined by the Department of Consumer and Business Services by rule.

Refer to your Schedule of Benefits for Cost Share information.

Women's Preventive Services requirements are developed through the guidelines provided by the HRSA and the Women's Preventive Services Initiative (WPSI). Prior Authorizations are not required for Women's Preventive Care benefits.
The schedules provided for the preventive benefits below are only recommendations and do not represent a full list:

> Women's Preventive Services:
> http://www.hrsa.gov/womensguidelines/

4. 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.

5. Prior Authorization

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

Coverage of certain Services, procedures, Supplies, and equipment require written Prior Authorization by Samaritan Health Plans before being performed or supplied. Your Provider can request Prior Authorization by phone, fax, or mail. If for any reason your Provider will not or does not request Prior Authorization for you, you must contact Samaritan Health Plans yourself. In some cases, additional information or a second opinion can be required before authorizing coverage. Samaritan Health Plans continually reviews new technologies and standards of medical practice. The Prior Authorization list is not intended to suggest that all the items included are necessarily covered by the benefits of this plan. If a service or items are not listed, the Prior Authorization list does not necessarily exclude the item from being covered. This list is updated periodically, and members should ask their provider to check to see if a service or supply requires authorization. For a full list of medical benefits that require Prior Authorization, visit our website 2022 Prior Authorization List - For Large Group Everyday Choice Plans (samhealthplans.org) (Drafter note: year will be updated to include 2023 when available)

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

5.1 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

5.1.1 Claims Involving Prior Authorization (Pre-Service Claims)

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

For Services that involve urgent medical conditions – Samaritan Health Plans will notify your

Provider or you of its decision within 72 hours after the Prior Authorization request is received. If Samaritan Health Plans needs additional information to complete its review, it will notify the requesting Provider or you within 24 hours after the request is received. The requesting Provider or you will then have 48 hours to submit the additional information. Samaritan Health Plans will complete its review and notify the requesting Provider or you of its decision by the earlier of:

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

5.1.2 Notification of Determination

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

5.1.3 Length of Time Determinations are Valid

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

6. Benefit Exclusions

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

6.1 Least Costly Setting for Services

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

6.2 Excluded Services

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

6.2.1 This Plan Does Not Cover the Following Surgeries and Procedures:

- Any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for Injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or Mental Health condition);
- Bariatric surgery;
- Panniculectomies;
- Cosmetic services and surgery, except those Services and surgery that fall under the "reconstructive services/surgery" benefit;
- Abdominoplasty;
- Treatment for infertility, including artificial insemination, in vitro fertilization, or Gamete Intrafallopian Transfer (GIFT) procedures;
- Surgery to reverse voluntary sterilization;
- Routine foot care such as treatment for corns and calluses, toenail conditions, hypertrophy or hyperplasia of the skin and nails unless the patient has diabetes mellitus;
- Surgical procedures that alter the refractive character of the eye, unless Medically Necessary;
- Treatment to augment or reduce the upper or lower jaw, except when Medically Necessary;
- Temporomandibular joint (TMJ) or myofascial pain treatment, advice, or appliances;
- Services for dental implants, or improving placement of dentures;
- Sex transformations are excluded when not Medically Necessary or when not related to a Mental Health condition;
- Sexual dysfunction is excluded when not Medically Necessary or when not related to a Mental Health condition;
- Eye surgeries to improve vision, such as Lasik, unless Medically Necessary;
- Myeloablative high dose chemotherapy, except when the related Transplant is covered;
- Services, Supplies, testing or treatment for sterility, infertility, impotency, frigidity, or sexual inadequacy, unless Medically Necessary or when not related to a Mental Health condition; and
- Custodial Care, including routine nursing care, and rest cures, and Hospitalization for environmental change.

6.2.2 This Plan Does Not Cover the Following Drugs and Medications:

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

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

- Eyeglass or contact lens fitting fees, vision therapy, orthoptics and visual appliances (colored lenses, prisms and special glasses) for reading, learning or behavioral disabilities or dyslexia; and
- Routine Supplies and equipment used for comfort, convenience, Cosmetic purposes, or environmental control. This includes appliances like air conditioners, air filters, whirlpools, hot tubs, heat lamps, or tanning lights. It also includes personal items like telephones and televisions, and maintenance Supplies or equipment commonly used for purposes other than medical care.

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

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

- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a schoolor halfway house or received as part of an educational or training program;
- Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, neurofeedback, chelation or hyperbaric chambers;
- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act;
- Services provided through community or social programs; and
- Services provided by the Department of Human Services or the Oregon Health Authority, other than employee benefit plans offered by the department and the authority.

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

- Massage Therapy
- Homeopathic treatment;
- Biofeedback, except as outlined in your Schedule of Benefits and in Section 3.1; Covered Services; Biofeedback;
- Hypnosis; and
- Experimental or Investigational.

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

- Non-emergency services without Prior Authorization, if Prior Authorization is required pursuant to the "Prior Authorization" portion of this certificate;
- Expenses, other than for Emergency Medical Care, for any condition or complication caused by any procedure, treatment, service, drug, device, product, or supply excluded from coverage.
- A private room or services of private or special duty nurses other than as Medically Necessary when you are an inpatient in a Hospital.
- 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 person's coverage, including Services and Supplies;
- Treatment incurred prior to enrollment and coverage under the Plan or after coverage terminates. The only exception is that if this Group Policy is replaced by a group health policy while you are hospitalized, Samaritan Health Plans will continue paying covered Hospital expenses until you are released, or your benefits are exhausted, whichever occurs first;
- Services provided by an immediate family member, including parents, grandparents, Spouse, siblings, children and grandchildren;

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

7. Plan Administration

7.1 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 laws rules, and by applicable federal law. If there is conflict between the provisions of this Plan and Oregon State or federal laws, Oregon State or federal laws will take precedence over the provisions of this Plan.

7.2 Compliance with State and Federal Mandates

The Plan will provide benefits in accordance with the requirements of all applicable state and federal laws. These laws may be amended from time to time. Upon contract issuance or renewal, any insurer offering a health benefit plan must update the plans of the insurer as necessary to comply with stateand federal law

7.3 Other Authorities and Responsibilities

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

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

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

7.4 Changing this Certificate

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

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

7.5 Group Contract Renewal and Termination

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

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

If the Group has not paid the premium by the due date, SHP will issue a notice to the Group advising that if the premium is not received by the end of the grace period, the policy will be terminated. The notice will be issued at least ten (10) days prior to the end of the grace period and will explain the subscriber's rights to continuation coverage under federal and/or state law. If the policy is subsequently terminated due to nonpayment of premium, it is the duty of the Group to send the subscriber notice of termination.

In the event this policy is terminated for the Group for a reason other than nonpayment of premium, and the insurance is not replaced by the Group, SHP will mail a notice of termination to the Group. It is the duty of the Group to send the subscriber notice of termination. The notice will explain the subscriber's rights to continuation coverage under federal and/or state law. SHP's notice to the Group will be mailed within ten (10) working days of termination.

7.6 Rescinding Coverage

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

Samaritan Health Plans may not rescind the Plan unless:

A. The Employer:
    a. Performs an act, practice or omission that constitutes fraud

b. Makes an intentional misrepresentation of a material fact as prohibited by the terms of the Plan;

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

C. Samaritan Health Plans provides notice of the rescission to the Oregon Division of Financial Regulation in the form, manner and time frame prescribed by the Oregon Division of Financial Regulation by rule.

7.7 Legal Action

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

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

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

7.8 Relationship to Samaritan Health Services

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

7.9 Inmates and Juveniles in Detention Centers

We will not deny reimbursement for any service or supply covered by the Plan or cancel the

coverage of a Member under the Plan on the basis that:

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

7.10 Privacy of Member Information

Keeping a Member's protected health information confidential is very important to Samaritan Health Plans. Protected health information includes enrollment, claims, and medical and dental information. Samaritan Health Plans uses such information internally for claims payment, authorization of services, and business operations such as case management and quality management programs. Samaritan Health Plans does not sell this information. The Notice of Privacy Practices provides more detail about how Samaritan Health Plans uses Members' information. A copy of the notice is available on the Samaritan Health Plans website at www.samhealthplans.org/notice-of-privacy-practices or by calling our Customer Service Department.

7.11 Confidential Communication

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

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

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

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

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

8. Eligibility and Enrollment

Eligibility and enrollment criteria are determined and processed through your employer group

as provided on the Group Contract, which is part of this agreement. We encourage you to contact your employer group to determine whether you meet the eligibility criteria to be enrolled in the Plan.

8.1 Employees

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

8.2 Family Members

If you are enrolled in the Plan, the following family members may also be eligible for enrollment as your Dependent if criteria are met according to the Group Contract:

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

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

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

8.3 How and When to Enroll

8.3.1 When You First Become Eligible

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

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

To enroll, you must complete and sign a Member Enrollment Application & Change Form, which is available from your Employer. The application must include complete information on you and your enrolling family members. Return the application to your Employer, and your Employer will send it to Samaritan Health Plans.

8.3.2 Open Enrollment

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

8.3.3 Mid-Year Special Enrollment – Newborns

A newborn baby of you or your Spouse is eligible for enrollment under the Plan during the 30-day period after birth. To add the child to your coverage, you must submit a Member Enrollment Application & Change Form listing the child as your Dependent. A Claim for maternity care is not considered notification for the purpose of enrolling a newborn child.

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

If no additional premium is required, then the baby's Eligibility continues if you are covered. However, Samaritan Health Plans cannot enroll the child and pay benefits until we receive a Member Enrollment Application & Change Form listing the child as your Dependent.

8.3.4 Mid-Year Special Enrollment – Adopted Children

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

support and care of the child in anticipation of adoption of the child. To add the child to your coverage, you must complete and submit a Member Enrollment Application & Change Form listing the child as your Dependent. You can be required to submit a copy of the certificate of adoption or other legal documentation from a court or a child placement agency to complete enrollment.

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

If no additional premium is required, then the child's Eligibility continues as long as you are covered. However, Samaritan Health Plans cannot enroll the child and pay benefits until we receive a Member Enrollment Application & Change Form listing the child as your Dependent.

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

If you marry, you can enroll yourself in the Plan (if you are not already enrolled) or you can add your new Spouse and any newly eligible Dependent children to your coverage. The enrollment must be made during the 30-day period from the date of the marriage. Samaritan Health Plans must receive your Member Enrollment Application & Change Form and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the date of marriage.

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

If you are enrolled in the Plan, you may enroll a new Domestic Partner and any eligible Dependent children of the Domestic Partner. The enrollment must be made during the 30-day period from the date of the domestic partnership. Samaritan Health Plans must receive your Member Enrollment Application & Change Form and additional premium during the initial enrollment period. Coverage for your new Domestic Partner and any eligible Dependent children of the Domestic Partner will then begin on the first day of the month after the beginning of the partnership.

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

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

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

Samaritan Health Plans must receive your Member Enrollment Application & Change Form and additional premium during the 30-day initial enrollment period beginning on the date of the court appointment. Coverage will then begin on the first day of the month following the

date of the court order. You may be required to submit a copy of the court order to complete enrollment.

8.3.8 Returning to Work After a Leave of Absence (LOA) or 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 Dependents were covered before your layoff, they can resume coverage at that time as well.

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

8.4 Other Special Enrollment Events

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

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

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

8.4.1 Special Enrollment – Loss of Eligibility for Other Coverage

If the employee declined enrollment for themselves or Dependents because of other health insurance coverage, the employee or Dependents can enroll in the Plan later if the other coverage ends involuntarily. Dependents may enroll, if the employee enrolls in coverage. "Involuntarily" means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below an Employer's minimum requirement, the other insurance plan was discontinued, the other employer's premium contributions toward the other insurance plan ended, or because of death of a Spouse, divorce, or legal separation. To do so, the employee must request enrollment within 30 days after the other health insurance coverage ends (or within 60 days after the other health insurance

coverage ends, if the other coverage is through Medicaid or a state Children's Health Insurance Program (CHIP)). Coverage on this Plan will begin on the first day of the month after the other coverage ends.

8.4.2 Special Enrollment – Premium Assistance Subsidy

If the employee or the employee's Dependents were eligible to enroll under this Plan but did not enroll during a previous enrollment period, and the employee or the employee's Dependents become entitled to group health plan premium assistance under a Medicaid-sponsored or Children's Health Insurance Program (CHIP)-sponsored arrangement, we will provide a "special enrollment period" for the employee and their Dependents if the employee requests enrollment within 60 days after the date of entitlement. Coverage will begin on the first day of the month after becoming eligible for such assistance.

8.4.3 Qualified Medical Child Support Orders (QMCSO)

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

8.5 Termination of Coverage

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

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

8.5.1 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 within 30 days of the divorce or legal separation. Continuation coverage may be available for your Spouse. Refer to Federal and State Continuation Coverage for more information.

8.5.2 Dependent Children

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

8.5.3 If You Die

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

9. State and Federal Continuation Coverage

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

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

9.1 State Mandated Continuation of Coverage

Under this Plan, you (and your Dependents, if applicable) may have continuation coverage rights under Oregon state law.

9.1.1 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 Dependents 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 Dependents 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 the Plan for at least three months before the date of the qualifying event. If your Employer recentlyswitched

to this Group Policy from another group health plan without a break in coverage, you will receive credit for time under the previous plan.

- Dependents who were not enrolled in the 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 to your Employer 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 its regular monthly payment. Samaritan Health Plans cannot accept the premium directly from you.
- The Plan must still be insured by Samaritan Health Plans. If the Group Policy is discontinued by your Employer or is otherwise terminated, you will no longer qualify for continuation through this Group Policy.

9.1.2 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; or
- If you and a covered Dependent become eligible for another group health plan (such as a Spouse's employer's plan or a plan at your new job), the coverage will end on the date you become eligible for that plan.

9.1.3 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 Plan will also apply to everyone enrolled in continuation coverage. We can provide you uninterrupted coverage when the existing Group Policy is replaced.

9.1.4 Continuation for Spouses over Age 55

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

- Failure to pay premiums when due;

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

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

- Thirty days of the date of the employee's death;
- Sixty days of the date of legal separation; or
- Sixty days of the date of entry of the divorce decree.

9.2 Federal COBRA Continuation

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

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

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

Individuals entitled to COBRA continuation coverage have the same rights afforded similarly-situated plan Members who are not enrolled in COBRA. COBRA Participants may add newborns, a new Spouse, and adopted children (or children placed for adoption) as covered Dependents in accordance with the Plan's Eligibility and enrollment rules, including the Plan's special enrollment rules.

9.2.1 Qualifying Events

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

- Your hours of employment are reduced; or

- Your employment ends for any reason other than your gross misconduct.

Your Spouse will become a qualified beneficiary if they lose coverage under the Plan because any of the following qualifying events happens:

- Your death;
- Your hours of employment are reduced;
- Your employment ends for any reason other than for gross misconduct; or
- You become divorced or legally separated.

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

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

9.2.2 Notification of Qualifying Event – Your Responsibility

When your Employer receives notification of one of the above "qualifying" events, you will be notified that you or your Family Member, as applicable, have 60 days from the date coverage is lost or the date you receive the notice, whichever is later, to elect continuation coverage. If this election is not made within this 60-day period, your right to elect continuation coverage under this Plan will be lost.

9.2.3 Length of COBRA Continuation Coverage

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

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

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

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

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

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

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

9.2.4 Disability Extension of 18-month Period of Continuation Coverage

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

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

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

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

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

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

9.2.6 Once Notification Is Given

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

9.2.7 Cost of COBRA Continuation Coverage

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

9.2.8 When COBRA Continuation Coverage Ends

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

- Failure to timely pay the full required continuation premium;
- The Employer no longer offers group health coverage;
- The person later becomes covered under any other group health plan. However, coverage under another plan will not cause continuation to end if the other plan excludes or limits coverage for a pre-existing condition of the person;
- The person later becomes entitled to Medicare benefits under Part A, Part B, orboth;

- In the case of a person who qualified for an extra 11 months continuation coverage based on the disability and persons receiving continuation coverage by reference to such disabled person, the date of a final determination by the Social Security Administration that the person is no longer disabled;
- The applicable period of continuation ends; or
- Coverage is terminated for cause (e.g., a Member submits a fraudulentClaim).

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

9.3 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 Dependents can continue this Plan's coverage if you, the employee, no longer qualify for coverage under the Plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your Eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility. The following requirements apply to USERRA continuation:

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

9.4 Continuation After Injury or Illness Covered by Workers' Compensation

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

- You take full-time employment with another Employer; or

- Six months from the date you first pay your health insurance premium under this provision.

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

9.5 Work Stoppage

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

10. In-Network Providers

- Upon Enrollment, each Member will be issued a plan identification card. It is the Member's responsibility to notify us if the card is not received within a reasonable time after the Member's Effective Date of coverage. In addition, it is the Member's responsibility to present the card to each health care Provider at the time ofservice.
- To ensure the maximum available benefits under this Agreement, Members mustobtain all Medical Services from In-Network Providers and in accordance with any Prior Authorization requirements, even when a Member expects payment to be made by another plan or a third-party. Members should consult our Provider Directory for a list of In-Network Providers, including Women's Health Care Providers, authorized to act as Primary Care Providers.
- For personal reasons, a Member may refuse to accept a procedure or treatment recommended by the treating Physician.
- The relationship between us and In-Network Providers is that of independent contractors. In-Network Providers are independent professionals who operate their own offices and business, make their own medical decisions, and provide services to entities and patients other than us and our Members. In-Network Providers agree to methods and rates of payment from us, concurrent and retrospective review by us of Medical Services provided to Members, and our medical management procedures. To be covered by us, non-emergency Medical Services provided to Members must be obtained from In-Network Providers.
- The fact that Members and In-Network Providers each have contractual relationships with us does not prevent a Member from obtaining nor an In-Network Provider from providing services that are not covered by us. We have no direct control over the examination, diagnosis, or treatment of a Member. We do perform medical management, including, but not limited to, case review for purposes of determining coverage, consultation with Providers regarding Prior Authorization and Referrals, and concurrent and retrospective review of Medical Services provided to Members. The purpose of our medical management procedures is to encourage the lowest cost method of treating a Member, which, meets the needs of the Member. These procedures are not

intended to ration care or limit care to methods not appropriate to treat a Member's condition. These procedures are not intended to create a Physician/patient relationship or to replace the relationship between a Member and his or her Physician. A Member is always entitled to obtain, at his or her own expense, services not covered under the terms of this Agreement.

- We shall use ordinary care in the exercise of our power and in the performance of our obligations under this Agreement.
- An Out-of-Network Provider must cooperate with our requirements for review of treatment and to the same extent as an In-Network Provider in order to be eligible for reimbursement.

11. Important Notices

11.1 Notice of Special Enrollment

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

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

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

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

11.2 Women's Health and Cancer Rights Act

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

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

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

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

11.3 Protection of Genetic Information

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

12. Your Rights and Responsibilities

As a Member of Samaritan Health Plans, you should know what to expect from us, as well as what we ask from you. Nobody knows more about your health than you and your doctor. We take responsibility for providing the very best health care services and benefits possible; your responsibility is to know how to use them well. Please take time to read and understand your benefits. We want you to have a positive experience with Samaritan Health Plans, and we are ready to help in any way.

12.1 Members Rights

- Be cared for by people who respect your privacy and dignity.
- Be informed about Samaritan Health Plans, our providers, and the benefits and Services you have available to you as a Member.

- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Samaritan Health Plans.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Samaritan Health Plans' Member rights and responsibilities policy.
- Refuse care from specific providers.

12.2 Members Responsibilities

- Read and understand the information in and the terms of your Plan. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions, and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact us. We will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Samaritan Health Plans and your physicians or providers need to provide care.
- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let us know if you have concerns or if you feel that any of your rights are being compromised, so that we can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Samaritan Health Plans decision.
- Notify Customer Service if your address changes.

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

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

12.4 When Continuity of Care Applies

If you are undergoing an active course of treatment by an In-Network Provider and the benefits for that Provider are denied (or paid at a level below the benefits for an Out-of-Network Provider)because 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 as long as:

- You and the 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 Provider and us ends in accordance with quality of care provisions of the contract between the Provider and us or because the Provider:

- Retires;
- Dies;
- No longer holds an active license;
- Has relocated outside of our Service Area;
- Has gone on sabbatical;
- Is prevented from continuing to care for patients because of other circumstances; or The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the individual provider have been exhausted.

12.5 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 the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider.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; or

As long as the enrollee continues under an active course of treatment, but not later than the 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider 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.

12.6 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.

12.7 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.

12.8 What additional information can I get from you upon request?

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

- Rules related to our medication Formulary, including information on whether a particular medication is included or excluded from the Formulary and informationon what medications require Prior Authorization from Samaritan Health Plans;
- Provisions for behavioral health services, and Hospital services, and how you can obtain the care or Services;

- A copy of our annual report on complaints and appeals;
- A description of our risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the Health Care Financing Administration;
- A description of our efforts to monitor and improve the quality of health Services;
- Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for your care;and
- Information about our Prior Authorization and utilization review procedures.

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

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

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

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

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

By electronic mail at DFR.InsuranceHelp@oregon.gov

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

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

13. Member Grievance and Appeals Review

Samaritan Health Plans understands that you may have questions or concerns about your benefits, eligibility, the quality of care you receive, how we reached a claim determination or handled a claim. We try to answer your questions promptly and give you clear, accurate answers.

If you have a question, concern, or complaint about your coverage, please contact our Customer Service Department. Many times, our Customer Service Department can answer your question or resolve an issue to your satisfaction right away. If you feel your issues have not been addressed, you have the right to submit a Grievance and/or Appeal in accordance with this section.

13.1 Filing a Grievance

If you are dissatisfied with the availability, delivery, or the quality of healthcare services; or claims payment, handling or reimbursement for healthcare services, you or your Authorized Representative can file your Grievance in writing. We will attempt to address your grievance generally ~~w~~within 30 days of receipt.

You may receive information about our Grievance and Appeal processes by contacting our Customer Service Department.

13.2 Filing a Level 1 Appeal

If you disagree with our decision about your medical bills or healthcare services, you or your Authorized Representative may submit an Appeal of an Adverse Benefit Determination. The Appeal request must be:

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

You can use an Appeal Request Form available from Customer Service to provide this information. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances. In filing a Grievance or Appeal:

- You can submit for consideration any written comments, documents, records, and other materials relating to the Adverse Benefit Determination; and

- You can, upon request and free of charge, have reasonable access to and copies of the documents, records, and other information relevant to the Adverse Benefit Determination.

Within 7 days of receiving the Appeal, we will send you or your Authorized Representative an acknowledgment letter. You or your Authorized Representative has the right to appear in person to talk about your Appeal. The Level 1 Appeal decision will be determined by a healthcare professional not previously involved in your initial Adverse Benefit Determination. You or your Authorized Representative will receive a written decision within 30 days of our receiving your Appeal request.

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

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

13.3 External Review

External Review decisions are made by Independent Review Organizations (IRO) that are not associated with Samaritan Health Plans. When an Appeal is upheld by the Plan, a letter notifying you of the decision is sent along with a waiver form within 30 days. **If you are dissatisfied with the Plan's adverse decision, you or your Authorized Representative may have the right to request an external review. To be eligible for external review, the Member must (i) have exhausted the Internal Appeals process shown above; and (ii) provide us a signed Authorization to Use and Disclose Health Information (waiver) to release medical records to the IRO.** The waiver with instructions and a return address and fax number is provided directly to the member with an adverse appeal determination. If a signed waiver was not included with the member's external review request, several attempts to obtain the waiver will be made. Attempts will be made to reach the member by phone, mail and/or email within 5 business days of the request for external review. Members can obtain a copy of the waiver on the Samaritan Health Plans website at www.samhealthplans.org or call our Customer Service Department at the phone number listed on the back of membership card to request a copy of the waiver. If we do not receive the signed waiver from the Member within 5 business days of the request for external review, the external review request is deemed ineligible and we will be unable to proceed with the external review process at that time. However, if the Member supplies the signed waiver after the end of the 5 business days but before the end of the 180-day eligibility period for external review, we will accept the submitted document and proceedwith

the external review process. For the purposes of any internal recordkeeping or communication with the Member about the external review process that is not specifically required by law or rule, the Plan may treat a late waiver submission as part of the original request for external review. However, for the purposes of the external review timeline, insurers must treat a late submission of a signed waiver as the initiation of a new external review request.

Additionally, your appeal can qualify for an external review (at no cost to you) if:

- The Plan does not adhere to the rules and guidelines of the process defined for the internal review
- The Level 1 appeal has been completed; and, the reason for the Level 1 adverse decision was:
    - based on medical necessity
    - for treatment determined to be Experimental or Investigational
    - for the purpose of continuity of care (no interruption of an active course of treatment); or
- You and the Plan have mutually agreed to waive the internal appeals requirement

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

Please note: 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.

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

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

- Expedited External Review – 3 days after receipt of the request
- Standard External Review – 30 days after receipt of the request

IRO decisions are final and we are bound by their decisions. We pay for all costs for the handling of external review cases and administer these provisions in accordance with the law. If we do not comply with the IRO decision, we may be penalized by the Oregon Division of Financial Regulation, and you have the right to sue us under applicable Oregon law.

13.4 Expedited Review Process

If you believe your Appeal is urgent, you, your Authorized Representative, or your treating Provider, can request an expedited review. If the Appeal request meets the definition of urgent under the law; which means, a decision made within the standard timeframe of 30 days could

seriously jeopardize your life or health or your ability to regain maximum function, the Appeal will be processed in an expedited manner (within 3 days of our receiving the Appeal request). If the Appeal does not meet the definition of urgent, you will be notified immediately, and the Appeal will then be processed within the standard timeframe.

The expedited review request must:

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

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

The internal expedited review decision will be determined by a healthcare professional not previously involved in your case. A verbal notice of the decision will be provided to you, your Authorized Representative, and your treating Provider as soon as possible, but no later than 3 days of our receiving the Appeal. A written notice will be mailed within one working day following the verbal notification.

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

To apply for an Expedited Review, you must send your written request or the Appeal Request Form to us.

13.5 Appeal Timeframes

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

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

To obtain an Appeal Request Form or a waiver granting IRO access to your medical records, please contact our Customer Service Department for more information.

13.6 Submit a Grievance or Appeal

To submit your Grievance or Appeal, please contact our Customer Service Department at 541-768-4550 or toll-free at 800-832-4580 (TTY 800-735-2900). They can be faxed to 541-768-9765. Written Grievances or Appeals should be sent to:

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

13.7 Assistance with your Grievance or Appeal

You also have the right to file a complaint and seek assistance from the Division of Financial Regulation.

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

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

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

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

14. 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 received the service or supply to be eligible for payment.

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

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

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

Samaritan Health Plans
PO Box 887
Corvallis, OR 97339

14.1. Out-of-Network Provider Claims

Written notice of claim for treatment outside our Service Area must be given to us within 90 days from the date of service or as soon as reasonably possible, but not later than one year from the date of service provided, unless the Member is legally incapacitated throughout that year. If a Member is hospitalized at a Hospital that is an Out-of-Network Provider, the Member shall, or shall cause the Hospital or the Subscriber to notify us by telephone of the hospitalization on the first business day after the admission or as soon as reasonably possible. If a Member is unable to personally contact us or is unable to instruct some other person to do so, the notification period will not begin until such time as the Member is again able to notify us. If a Member is conscious and able to communicate with others, he or she shall be deemed capable of notifying us. We will not reimburse the cost of treatment received at a Hospital that is an Out-of-Network Provider if the required notice is not provided. The claim will be paid or denied within 30 days following receipt of the claim. If additional information is needed to make the determination, we will notify the Member and Provider in writing within 30 days following receipt of the claim and provide an explanation of the information needed to process the claim. Written claims must include a statement describing the services rendered, date of services, charges, and should be addressed to:

Samaritan Health Plans
P.O. Box 887
Corvallis, OR 97339

Samaritan Health Plans at PO Box 887 Corvallis, OR 97339, with information sufficient to identify the Member, shall be deemed notice to the insurer.

14.2 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 an 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 isneeded.

- 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.

14.2.1 Time Frames for Processing Claims

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

14.2.2 Timely Submission of Claims

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

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

14.2.3 Claims Involving Concurrent Care Decisions

If an ongoing course of treatment for you has been approved by Samaritan Health Plans, you will be provided advance notice of any decision made by medical cost management procedures to reduce or terminate that course of treatment. 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.

14.3 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.

14.3.1 Rules that Apply 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 the Claim, we may advance benefits as long as you agree in writing:

    - to give information about any motor vehicle insurance coverage which can be available to you; and
    - to hold the proceeds of any recovery from motor vehicle insurance in trust for us and reimburse us as provided in the following paragraphs;
- If we have paid benefits before motor vehicle insurance has paid, we are entitled to have the amount of the benefit we have paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of you. This amount must be 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;
- An insurer may not receive a reimbursement or subrogation for personal injury protection benefits or health benefits the insurer provided to a person injured in a motor vehicle accident from any recovery the injured person obtains in an action for damages except to the extent that:
    - The injured person first receives full compensation for the injured person's injuries; and
    - The reimbursement or subrogation is paid only from the total amount of the recovery in excess of the amount that fully compensates for the injured person's injuries
- If you are involved in a motor vehicle accident, can have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the Accident. In that case, this provision and the "Third Party Liability" provision both apply.

14.4 Third-Party Liability and Right of Subrogation

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

14.4.1 Rules that Apply to Third-Party Liability Situations:

- If a Claim for health care cost is filed with us and you have not yet received recovery from the responsible person, we can advance benefits for covered expenses if you or your covered Dependent agrees to hold, or directs your attorney or other representative to hold, the recovery against the other party in trust for us up to the amount of benefits we paid in connection with the Illness or Injury.
- If we pay benefits, we will be entitled to have the amount of the benefits we have paid separated from the proceeds of any recovery you receive from or on behalf of the third party and held in trust for payment to us.
- We are entitled to the amount of benefits we have paid in connection with the Illness or Injury from the proceeds of any settlement, arbitration award, or judgment that results in a recovery for you or your covered Dependent, the third party's insurer, or any other

insurance recovery. This is so regardless of whether: the third party or the third party's insurer admits liability; the health care expenses are itemized or expressly excluded in the third-party recovery; or the recovery includes any amount (in whole or in part) for Services, Supplies, or accommodations covered under the policy. The amount to be in trust shall be calculated based upon Claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.

- If you make a recovery and fail to hold in trust for us the amount of paid benefits, and fail to pay us that amount as required by this Third-Party Liability (TPL) provision, we can limit future treatment or future medical benefits for any care up to the amount of benefits we paid for the Illness or Injury caused by the third party. Not all TPL Claims will go to subrogation. Samaritan Health Plans follows rules on Third Party Liability and subrogation to the full extent of the law.
- We expect full reimbursement before any amounts are deducted from the Plan, proceeds, award, judgement, settlement, or other arrangement. This obligation to reimburse the Plan shall be equally binding upon you regardless of whether or not the third party or its insurer has admitted liability, or the medical charges are itemized in the third-party payment.
- If you or your Dependent Incur health care expenses for treatment of the Illness or Injury after recovery, we will exclude benefits for otherwise Eligible Charges until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount.

14.4.2 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."

14.5 Workers' Compensation

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

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

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

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

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

14.5.1 Rules that Apply to Workers' Compensation Claims that Have Been Filed:

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

14.6 Medicare Secondary Payer

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

- When you or your Spouse are age 65 or over and by law Medicare is secondary to the Plan;

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

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

14.7 Coordination of Benefits

14.7.1 Coordination of this Group Contract's Benefits with Other Benefits

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

14.7.2 Definitions Relating to Coordination of Benefits

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

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

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

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

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

Coordination – When this Plan is primary, we determine payment for our benefits first before those of any other plan without considering any other plan's benefits. When this Plan is

secondary, we determine our benefits after those of another plan and can reduce the benefits we pay so that all plan benefits do not exceed 100% of the total Allowable Charges.

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

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

- The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Charge, unless one of the plans provides coverage for private Hospital room expenses.
- If you are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Charge.
- If you are covered by two or more plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Charge.
- If you are covered by one plan that calculates its benefits or Services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or Services on the basis of negotiated fees, the primary plan's payment arrangement shall be the Allowable Charge for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Charge used by the secondary plan to determine its benefits.
- The amount of any benefit reduction by the primary plan because you have failed to comply with the Plan provisions is not an Allowable Charge. Examples of these types of Plan provisions include second surgical opinions, Prior Authorization of admissions, and In-Network Provider arrangements.

14.7.3 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.

14.7.4 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.

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

Non-Dependent or Dependent

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

Dependent Child Covered Under More than One Plan

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

A. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    i. the plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
    ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
B. For a Dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
    i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the Dependent child's health care expenses, but that parent's Spouse does, that parent's Spouse's plan is the primary plan. This subparagraph does not apply with respect to any plan year

during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

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

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

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

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

C. For a Dependent child covered under more than one plan of individuals who are not the parents of the Dependent child, the provisions of subparagraph A or B above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

Active Employee or Retired or Laid-Off Employee

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

COBRA or State Continuation Coverage

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

Longer or Shorter Length of Coverage

The plan that covered the Member as an employee, subscriber or retiree longer is the primary plan and the plan that covered the Member the shorter period of time is the secondary plan.

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

Effect on the Benefits of this Plan

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Other Claims Recoveries

If we mistakenly make a payment for you or your covered Dependent to which you or your covered Dependent are not entitled to, 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.

15. Definitions

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

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

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

Alternative Care Provider – A chiropractor, acupuncturist or massage therapist who is professionally licensed by the appropriate governmental agency to treat an Injury or Illness.

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

Appeal – A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Approved Clinical Trial – Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

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

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

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

Behavioral Health Clinician – Includes the following types of Providers:

- Licensed Psychiatrist;
- Licensed Psychologist;
- Certified Nurse Practitioner with a specialty in psychiatric Mental Health;
- Licensed Clinical Social Worker;
- Licensed Professional Counselor or licensed Marriage and Family Therapist;
- Certified Clinical Social Work Associate;
- Intern or resident who is working under a board-approved supervisory contract in a clinical Mental Health field; and
- Any other clinician whose authorized scope of practice includes Mental Health diagnosis and treatment.

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

Brand Name Drugs (Medication) – 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Emergency Medical Condition– is a medical condition or behavioral health condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical or behavioral health attention would:

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part;
- Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;
- 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 transfer may pose a threat to the health or safety of the woman or the unborn child; or
- That is a behavioral health crisis

Emergency Services – with respect to an Emergency Medical Condition:

- A medical screening exam or behavioral health assessment that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition;
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital or Independent Freestanding Emergency Department, and

- Covered Services provided by staff or facilities of a Hospital or Independent Freestanding Emergency Department after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay, including poststabilization services for medical or behavioral health conditions that is Medically Necessary to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

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

Essential Health Benefits (EHB) –Essential Health Benefits (EHB) must include items and Services within at least the following categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;

- Pregnancy, maternity, and newborn care;
- Mental Health and Substance Use Disorder services, including behavioral health treatment;
- Prescription Drugs;
- Rehabilitative and Habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management;
- Pediatric services, including oral and vision care;
- Coverage for up to 20 spinal manipulation visits per year;
- Coverage for up to 12 acupuncture visits per year;
- Removal of barriers to prescribing Buprenorphine for medication-assisted treatment of opioid use disorder; and
- Coverage of at least one intranasal spray opioid reversal agent for opioid prescriptions of 50 MME or higher.

The Plan covers all required Essential Health Benefits. There are no annual or lifetime dollar limits imposed on these benefits.

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

- If a drug or device, the health intervention must have final approval from the United States Food and Drug Administration (FDA) as being safe and efficacious for general marketing. However, if a drug is prescribed for other than its FDA-approved use and is recognized as "effective" for the use for which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a drug must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant peer-reviewed medical literature or by the United States Secretary of Health and Human Services.
- The scientific evidence must permit conclusions concerning the effect of the service, supply, or drug on health outcomes, which include the disease process, Injury or Illness, length of life, ability to function, and quality of life.
- The service, supply, or drug must improve net health outcome.
- The scientific evidence must show that the service, supply, or drug is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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

necessary documentation, contact our Customer Service Department.

Formulary – A list of drugs your Plan covers.

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

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

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

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

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

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

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

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

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

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

outpatient settings.

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

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

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

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

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

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

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

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

In-Network Copayment (Copay) – A fixed amount (for example, $35) you pay for covered health care services provided by an In-Network Provider. In-Network Copayments usually are less than Out-of-Network Copayments. Refer to your Schedule of Benefits for Cost Share information.

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

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

Intensive Outpatient Services – Services targeted to individuals who require more intensive services than outpatient counseling services. These Services are provided in a concentrated

manner and generally involve multiple outpatient visits per week, over a period of time. They include both individual and group therapy, for individuals requiring stabilization.

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

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

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

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

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

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

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate or medically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury, or Disease;
- Not primarily for the convenience of the patient, physician, or other healthcare Provider, and not more costly than an alternative service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, or Disease;
- In Samaritan Health Plan's determination as based on available information and documentation, and in accordance with the terms of the Plan; and
- The least costly of the alternative Supplies or levels of service which can be safely provided to the patient. This means, for example, that care rendered in a Hospital inpatient setting is not Medically Necessary if it could have been provided in a less expensive setting, such as a Skilled Nursing Facility or by a nurse in the patient's home, without harm to the patient.
- Services and Supplies intended to diagnose or screen for a medical condition are not considered Medically Necessary in the absence of signs or symptoms of the condition, or abnormalities on prior testing. Medically Necessary care does not include Custodial Care. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

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

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

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

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

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

further information.

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

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

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

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

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

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

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

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

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

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

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

Prescription Drug Coverage – Coverage under a plan that helps pay for Prescription Drugs. If the plan's Formulary uses "tiers" (levels), Prescription Drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered Prescription Drugs.

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

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

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

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

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

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

- Acupuncturist, Massage Therapist, Chiropractor
- Certified Nurse Practitioner
- Clinical Social Worker and Counselors
- Dentist (Doctor of Medical Dentistry, Doctor of Dental Surgery, or denturist) and expanded practice Dental Hygienist
- Naturopathic Doctor or Physician
- Optometrist
- Pediatrician
- Pharmacist
- Physician (Doctor of Medicine or Osteopathy)
- Physician Assistant (to be paid as if submitted by the supervising physician)
- Podiatrist
- Professional Counselor or Marriage and Family Therapist

- Psychologist
- Registered Nurse or Licensed Practical Nurse, but only for those Services for which nurses customarily bill a patient
- Registered Physical, Occupational, Speech, or Audiological Therapist
- Women's healthcare provider

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

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

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

Domestic Partner – is a person of either the same sex or opposite sex as the employee who is not a statutory domestic partner, but who lives with an employee in a long-term, committed relationship. The same rights and benefits provided to Spouses under the Plan will be provided on the same terms to covered domestic partners.

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

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

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

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

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

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

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

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

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

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

Spouse – The person to whom you are legally married.

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

Supplies – Consumable goods to support health care services.

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

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

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

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

16. Discrimination is Against the Law

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

Samaritan Health Plans provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Samaritan Health Plans provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact 541-768-4550, TTY: 800-735-2900.

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

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

You can file a Grievance in person or by mail, fax, or email. If you need help filing a Grievance, the Compliance Manager/Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building

Washington, DC 20201
800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

17. Multi-Language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800- 832-4580 (TTY: 1-800-735-2900).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-832-4580 (TTY: 1-800-735-2900).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-832-4580 (TTY : 1-800-735-2900) 。

Tagalog (Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-832-4580 (TTY: 1-800-735-2900).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-832-4580 (ATS: 1-800-735-2900).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-832-4580 (TTY: 1-800-735-2900).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-832-4580 (TTY: 1-800-735-2900).

한 한 한 (Korean): 한 한 : 한 한 한 한 한 한 한 한 한 한 한 한 , 한 한 한 한한한 한한한한 한 한 한 한 한 한 한 한 한 한 . 1-800-832-4580 (TTY: 1-800-735-2900) 한 한 한 한 한 한 한 한 한 한 .

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-832-4580 (телетайп: 1-800-735-2900).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-832-4580（TTY:1-800-735-2900）まで、お電話にてご連絡ください。

ℓ Ĕā Ĕ◦ ĔĀ (Lao): ħ′ ♦♣Ĕn : ♪Ø ĔĀæ Ĕ Iæ Ĕij ĥâØ Ĕℓ Ĕā Ĕ ◦ ĔĀ, ☻Ĕij ẁ Ŵ ☻Ĕij ♣æ Ā♥ ĥÿ ŒĔ ĉ ♦Ø Ĕij ℓ Ĕā Ĕ, ħ♦ ♥ẁ ĥāų Ẃæ Ĕ, Ħ▪ǽ ij ŵ ℓØ ĉ ▪ ĨĈØ Iæ Ĕij . ħIJ● 1-800-832-4580 (TTY: 1-800-735-2900).

¡ ‘À‘%∏√ **(Thai):** ‡ƒÕ∫ :

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,∏ƒ1-800-832-4580
(TTY: 1-800-735-2900).

í×**(Cambodian)** ♣╝ ◄ĩ ╫ ή╝ ᴂ ′╘Ń Ĵ ₩ ╘◙ ◄ ▒ Ġ í×♠ŕė □ľ θ╞P◄í╥₩▒ Ġ
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Українська (Ukranian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-832-4580 (телетайп:
1-800-735-2900).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-832-4580 (TTY: 1-800-735-2900).

Oroomiffa (Oromo/Cushite): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-832-4580 (TTY: 1-800-735-2900).

:(Farsi/Persian)افریس

توجه :ارگ به زابن افریس گفتگو می دینک، لایهستت زیناب بصوتر راالگین یابر شمارفاهم می باشد. با

امتس بگیرید.(1-800-832-4580 (TTY: 1-800-735-2900

:(Arabic) اعلرةيب

حلموظة: إذا نكت حتتدث اذكر اةغلل، إفن خدامت اعاسملدة اغللوةي تتوافر لك . اصتل برقم اجملابن

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Samaritan Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.