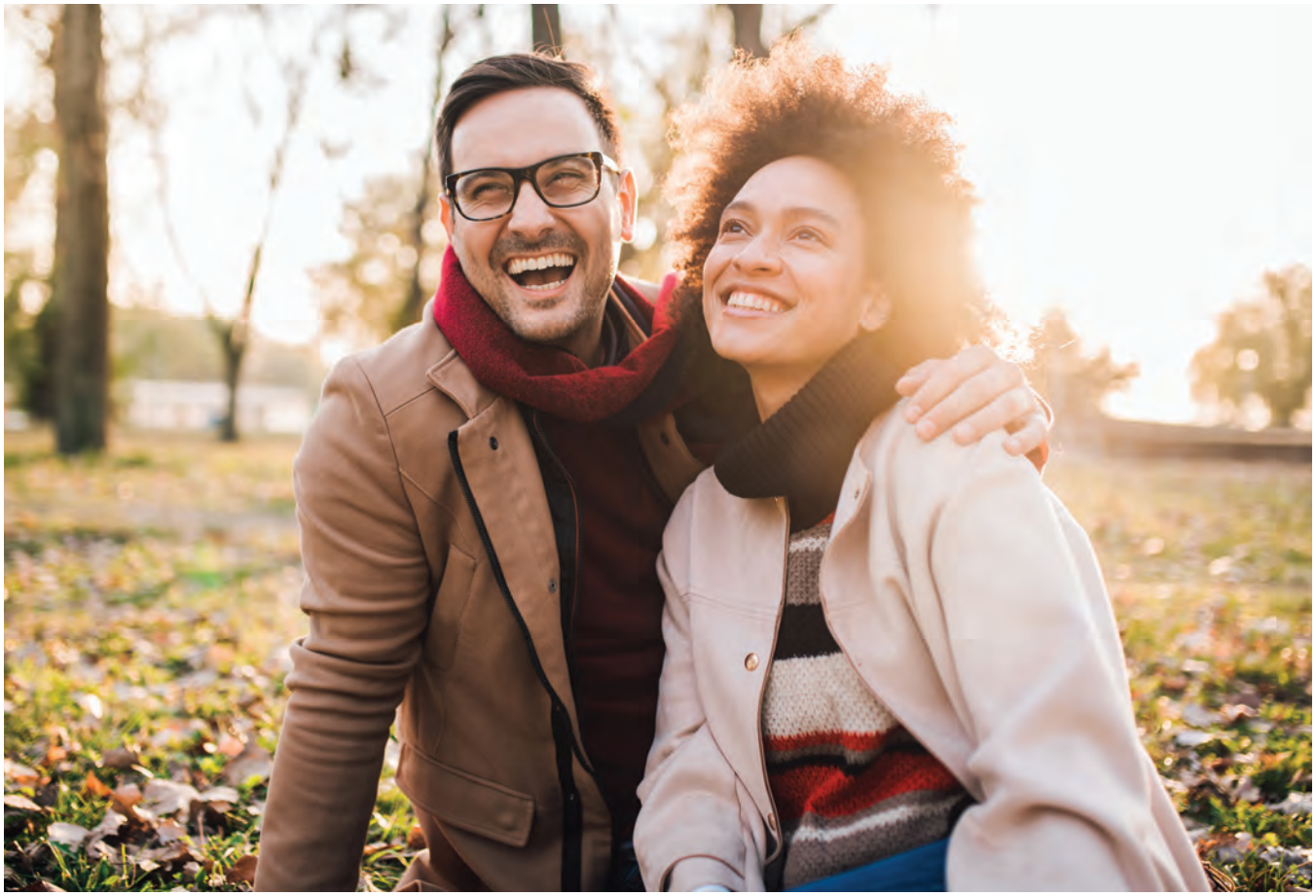
Samaritan Health Plans



Samaritan Choice Plans

Vision benefits

Your Samaritan employee health plan vision benefits handbook.

2024

Introduction

This document describes the vison benefits for Samaritan Health Services' employees and affiliated adopting employers. It serves as both the plan document and the summary plan description and is designed to explain your plan as of Jan. 1, 2024.

Every effort has been made to make these explanations as accurate as possible. For more information, contact Customer Service:

Monday through Friday, 8 a.m. to 8 p.m.
541-768-4550, toll free **800-832-4580** (TTY **800-735-2900**)

Samaritan Health Plans
PO Box 1310
Corvallis, OR 97339

This document is available on the Samaritan Choice Plans' website at **samhealthplans.org/Choice**.

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Member resources

The Samaritan Health Plans office in Corvallis, Oregon is maintained to meet your needs. We look forward to serving you!

Contact us

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

By phone: **541-768-4550** or toll free at **800-832-4580** (TTY **800-735-2900**), 8 a.m. to 8 p.m.

By email: SHSChoicePlansTeam@samhealth.org, 8 a.m. to 5 p.m.

By mail: PO Box 1310, Corvallis, OR 97339

Member website offers 24/7 access to plan details

Go to **samhealthplans.org/Choice-Benefits** to take advantage of your online tools:

- **Find care:** search in-network for doctors and specialties near you.
- **Member materials:** look at the plan materials.

Member portal offers 24/7 access to claims information

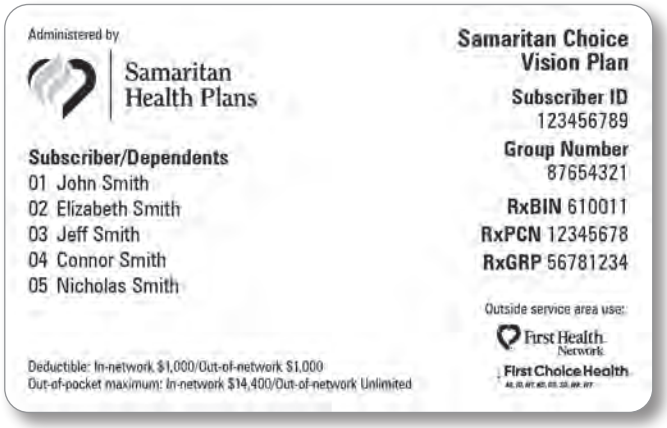
Go to **MyHealthPlan.samhealth.org** to take advantage of the following online tools:

- View claims processed by your health plan.
- View details about your eligibility with the health plan, including the amount you have met toward your deductibles and your plan limits.

Member ID card

Your new member ID card(s) will be mailed to you within 14 days of your enrollment onto the plan. In the meantime, you may contact Customer Service to inquire about your member ID number when receiving services. If you need additional member ID card(s) for additional members in the household, please contact Customer Service to request additional cards.

Here's an example of your ID card:



2024 Samaritan Choice vision plan benefits

This plan pays for vision exams, corrective lenses and frames when prescribed by a licensed ophthalmologist or licensed optometrist for you and your insured dependents. The plan allows you to choose any licensed provider practicing within the scope of their license to provide vision benefits. However, for eye examinations, there is a difference in reimbursement for in-network vision providers and out-of-network vision providers.

There is no deductible for covered vision services or supplies. The benefits are paid at 100% of the allowed amount, up to the limits listed below, for services with in-network vision providers and 70% of the allowed amount, up to the limits listed below, for services with out-of-network vision providers. These vision benefits are provided on a calendar year basis.

Covered benefits

Eye examinations: One comprehensive eye exam (including eye refraction) per calendar year is covered 100% after a $25 copay for in-network vision providers and 70% after a $25 copay for out-of-network vision providers. In addition, visual acuity screening in children (ages zero to 21 years) is covered and the copay does not apply. The U.S. Preventive Services Task Force recommends screening to detect amblyopia, strabismus and defects in visual acuity in children in accordance with Bright Futures. Frequency per benefit period is covered in compliance with Bright Futures recommendations.

Vision hardware and/or lenses: The following hardware and/or lenses are covered on a calendar year basis at a **combined benefit maximum limit of $300 per calendar year:**

- Prescription lenses.
- Prescription contact lenses.
- Frames.

Limitations

The vision benefit will only pay for the items listed above, up to the allowed amount per individual and per calendar year.

Exclusions

The following are not covered benefits under this plan:

- Hardware repairs.
- Fitting fees for contact lenses or eyeglasses.
- Medical or surgical treatment of the eyes.
- Visual fields testing.
- Non-prescription lenses.
- Extra charges for fashion eyewear features such as blended, coated, glass, oversize lenses or extra charges for special frames.
- Subnormal vision aids.
- Orthoptics or vision training.
- Any expense which is in excess of the maximum plan allowance.
- Any eye examination required as a condition of employment.
- Any expenses which result from an act of declared or undeclared war or armed aggression.
- Any expense paid in whole or in part by any other provision of the Group Health Insurance plan provided by the policyholder.
- Services and supplies that are payable under a workers' compensation or occupational disease law.

Service area and out-of-area services

The Samaritan Choice Plans' service area is defined as Benton, Lincoln, Linn and Tillamook counties. Services done within the country, out of our service area, will be paid based on whether the billing provider is contracted with SCP. All plan provisions will apply.

Out-of-the-country coverage

SCP covers all **urgent** and **emergent** services received outside of the country at the in-network benefit level. Any other services besides urgent and emergent services provided out of the country will not be covered. Most providers in other countries will not bill SHP directly, so members may need to pay for services out-of-pocket at the time of service. Please fill out the Member Reimbursement form and submit with all receipts and pertinent documentation of the covered health care expenditures to SCP. All member reimbursement requests must be submitted to SCP within 365 days from the date services were obtained.

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

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

Samaritan Choice vision plan does not cover services for the sole purpose of travel, school, work or occupation (for example, immunizations, routine physicals or laboratory services).

Please note:

Not all providers in our service area are considered in-network providers. Not all providers outside our service area are considered out-of-network providers. Please refer to the “Member resources” section and call Customer Service to verify the network status of your provider before obtaining services.

Who is eligible

Employees: All non-temporary employees of Samaritan Health Services who are assigned as .50 full-time equivalent, also known as FTE, or greater are eligible under the plan.

Workers classified by the employer as independent contractors are not eligible to participate in the plan during the period they are classified as independent contractors, even if those workers are later retroactively reclassified as employees.

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

- Your lawful spouse as defined by the state of Oregon (except for legal separation).
- Any children over age 26 who are disabled. SCP will require proof of disability and periodic verification of the dependent's status.
- Domestic partners of employees who have this benefit available through their place of employment and who meet all of the following criteria (Contact Human Resources for more information or to see if you qualify):
    - The partner is 18 years of age or older.
    - The employee and the partner share a close personal relationship.
    - The employee and the partner are responsible for each other's common welfare.
    - The employee and the partner share a permanent residence with the intent to continue doing so indefinitely.
    - The employee and the partner are jointly financially responsible for basic living expenses including, but not limited to, food, shelter and medical expenses.
    - Neither the employee nor the partner is legally married to anyone else.
    - The employee and the partner have lived together as a domestic partnership and met all other criteria set forth in this section for at least six months.
    - The employee and the partner are not related to each other by blood closer than marriage in Oregon or the state where they have a permanent residence and are domiciled.

The Internal Revenue Services does not recognize a domestic partner as being a qualified dependent except in very limited circumstances. Thus, under the IRS rules, coverage of a domestic partner under the plan is a taxable benefit to the employee. Accordingly, employees must pay income taxes on the fair market value of the plan coverage provided to their domestic partners and the dependents of domestic partners. The value of the domestic partner coverage is considered wages, is included in the employee's gross income and is subject to state and federal income tax and Federal Insurance Contributions Act, also known as FICA withholding. However, any benefits paid for the domestic partner that are attributable to coverage included in the employee's income are taxable neither to the employee nor to the partner.

Dependent children under age 26: For purposes of coverage under the plan, the term, child, includes:

- A biological child of you or your spouse.
- An adopted child of you or your spouse.
- A child 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.
- A child for whom you are legal guardian.
- A child of a qualified domestic partner of an employee (see applicable IRS information above).

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

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

Qualified Medical Child Support Order (QMCSO): SCP will extend benefits to an employee's non-custodial child, as required by any QMCSO, under the Employee Retirement Income Security Act. SCP has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from Customer Service.

How and when to enroll

When you first become eligible: For most SHS employees, coverage begins the first day of the month following or coinciding with the employee's first date of employment or transfer to an eligible status.

During this waiting period, you should complete the online enrollment process for yourself and any eligible dependents you wish to have enrolled in the plan. Human Resources must receive your elections within 30 days after the date you become eligible for coverage, in order for you and your eligible dependents to become covered as of the initial eligibility date. By enrolling, you are agreeing to participate and you are authorizing compensation reduction contributions to cover your share of the cost of your elected coverage under the plan. Your employer will announce your required contribution each year.

Enrolling new dependents: If you become married while you are covered under the plan, your new spouse and their children become eligible for coverage on the date of the marriage. Your new stepchildren must meet the dependency or other eligibility requirements applicable to children as discussed earlier in this document.

You may enroll your qualified domestic partner by completing the online enrollment process and Affidavit of Domestic Partnership form, at the time of your initial enrollment or within 30 days of the partnership first becoming eligible, according to the criteria stated in the "Who is eligible" section. All other domestic partner applications will be subject to late enrollment provisions.

Please note: A newborn child or a child placed with a member for the purpose of adoption will be covered from the moment of birth, the date of adoption or placement for adoption if the child is enrolled as a member within the first 60 days. If additional premium is required, coverage shall not take effect unless application and premium required are received within 61 days after birth or placement. Additional premium is required if enrollment of the additional dependent places the family in a higher premium bracket.

Waiver of coverage: You may waive coverage under the plan for yourself. You may also waive coverage for any of your eligible dependents. If you waive coverage for yourself, your dependents are not eligible for coverage. Coverage can be waived by completing the online enrollment process.

Subsequent enrollment: If you do not enroll yourself and/or your eligible dependents within 30 days of first becoming eligible or your newborn or adopted child within 60 days of birth or adoption, you may be considered a late enrollee. If so, you must wait until the next annual enrollment period (in the fall) to enroll. If you enroll during the annual enrollment period (open enrollment), coverage will become effective as of the following Jan. 1.

Please note: You and/or your eligible dependents will **not** be considered a late enrollee in the following circumstances:

- You did not enroll because you and/or your eligible dependents were covered under another health benefit plan. If you subsequently lose that other coverage, you or your eligible dependents may enroll in the plan within 30 days. In this situation, your effective date of coverage will be the first day following your loss of coverage under the other health benefit plan.
- A court has ordered that coverage be provided for your child under your health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

HIPAA special enrollment notice

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 toward you or your dependent's other coverage). However, you must request enrollment within 30 days after you or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent due to marriage, birth, adoption, court-appointed guardianship 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 or guardianship and within 60 days of birth, adoption or placement for adoption.

To request special enrollment or to obtain more information, contact Human Resources for more information.

What happens if eligibility changes

A number of events, such as changes in your employment or marital status, may affect your eligibility for coverage under the plan. This section explains what happens in these situations.

Termination of employment: If your employment with the employer ends, coverage for you and your covered dependents will ordinarily stop on the last day of the month your employment ends. However, you and your covered dependents may then be able to continue coverage on a self-pay basis. Please refer to the "Continuation coverage" section for details.

Transfer to non-benefited position: If you cease to be an eligible employee, then the coverage for you and your dependents will ordinarily end on the last day of the month in which your change of status occurs. However, you and your covered dependents may then be able to continue coverage on a self-pay basis. Please refer to the "Continuation coverage" section for details.

Legal annulment of marriage, legal separation or divorce: Coverage for your spouse and any children who cease to meet the definition of eligible family members (for example, former stepchildren), normally ends on the last day of the month in which the final decree is entered. Your spouse and/or other former family members may be able to continue coverage on a self-pay basis. The definition of spouse in this document includes same-sex and opposite-sex marriages that have been validly entered into. Please refer to the "Continuation coverage" section for details.

If your domestic partnership ends: Coverage for your domestic partner and any children of a domestic partner (not related to the enrolled employee by birth or adoption) will terminate upon the termination of the domestic partnership or death of the employee, whichever comes first. The employee and partner are required, by the Affidavit of Domestic Partnership, to give written notice to the employer within 30 days of any change in qualifying criteria. Domestic partners, as beneficiaries, may continue this policy's coverage under a COBRA-like coverage for no more than 18 months. Children of the domestic partner, as qualified beneficiaries, may continue this policy's coverage under COBRA for up to 36 months.

If you die: Coverage for your dependents will end on the last day of the month in which your death occurs. However, your dependents may continue their coverage on a self-pay basis. Please refer to the "Continuation coverage" section for details.

If your children are no longer eligible: Coverage normally ends on the last day of the month after your child reaches age 26. (**Your qualified dependent children may continue their coverage on a self-pay basis. Please refer to the "Continuation coverage" section for details.**)

Your enrollment responsibilities

As a SCP member, you are responsible for doing the following actions **within the specified timeframe** as described below:

- Within 30 days of eligibility, **you should complete the online enrollment process** for yourself and any eligible dependents you wish to have enrolled in the plan.
- **You must notify** Human Resources within 30 days of the date of marriage of your new spouse and their children, once they become eligible for coverage on the date of the marriage.
- You may enroll your qualified domestic partner by completing the online enrollment process and Affidavit of Domestic Partnership form, at the time of your initial enrollment or within 30 days of the partnership first becoming eligible according to the criteria stated in the "Who is eligible" section. All other domestic partner applications will be subject to late enrollment provisions.
- If you intend to have your newborn or adopted child covered under the plan, it is imperative that you **enroll your child** within 60 days of birth or placement.
    - Adding the newborn to the plan will cover claims retroactively to the date of birth, if reported within the first 60 days.
    - The subscriber will be charged the premium for the additional dependent the pay period containing the birth date.
- If you do not enroll yourself and/or your eligible dependents within 30 days of **first becoming eligible** or your newborn or adopted child within 60 days of birth or adoption, you may be considered a late enrollee.

Continuation coverage

Consolidated Omnibus Budget Reconciliation Act of 1985

Federal law requires that most employers sponsoring group health plans offer employees and their family members the opportunity to continue their group health coverage (called continuation coverage) at group rates in certain instances where coverage under the plan would otherwise end. This section is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

Both you and your spouse should take the time to read this section carefully. Please contact Human Resources for more information.

The plan will provide no greater rights than what is provided with the Consolidated Omnibus Budget Reconciliation Act of 1985, also known as COBRA, or applicable law. The law(s) have been amended from time to time. In the event of any conflict between this continuation of coverage provision and the current provision of the law, the current provisions of the law shall govern. Your rights are described below.

As an employee of SHS, you may have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment, or the termination of your employment.

If you are the spouse of an employee covered by the plan, you may have the right to choose continuation coverage for yourself if you lose coverage under this plan for any of the following reasons:

- The termination of your spouse's employment.
- Reduction in your spouse's hours of employment.
- The divorce or legal separation from your spouse.
- Your spouse becomes entitled to Medicare.
- The death of your spouse.

In the case of a dependent child of an employee covered by this plan, he or she may have the right to continuation coverage if group health coverage is lost for any of the following reasons:

- The termination of the parent's employment with the employer.
- Reduction in the parent's hours of employment.
- The parent's divorce or legal separation.
- The parent who is a covered employee becomes entitled to Medicare.
- The death of a parent who is a covered employee.
- The dependent ceases to be a dependent child under this plan.

The employee or a family member has the responsibility to inform the employer of a divorce, legal separation or a child losing dependent status under the plan, within 60 days of the date of one of these events. Despite the 60-day COBRA deadline, if the employee fails to give notice to SHS Human Resources within 30 days, it could complicate the employee's tax reporting and withholding.

When SHS Human Resources is notified that one of these qualifying events has happened, the COBRA plan administrator will notify you that you may have the right to choose continuation coverage. Under the law, you must inform the COBRA plan administrator that you want continuation coverage within 60 days of the later of:

- The date you would lose coverage because of one of the events described earlier.
- The date on the notice you are sent informing you of your right to elect continuation coverage.

Coverage must be offered to each person losing plan coverage, who was covered the day before the qualifying event. Each person is a qualified beneficiary and has the individual right to elect COBRA continuation coverage. A qualified beneficiary can add a new spouse during the continuation period on the same terms as an active employee. The newly added spouse is a beneficiary. A beneficiary cannot elect coverage that is different from that elected by the qualified beneficiary. The beneficiary's continuation period shall end on the same date that the qualified beneficiary's continuation period ends.

If you do not choose continuation coverage, your group health insurance coverage will end as of the last day of the month in which the event occurred; the event that gave rise to your continuation coverage rights (the qualifying event).

If you choose continuation coverage, SHS is required to allow you to elect the health coverage you were receiving immediately prior to the COBRA qualifying event. You may choose to elect: (i) medical/pharmacy and dental/vision coverage, (ii) dental/vision coverage or (iii) medical/pharmacy coverage only. If you have a flexible spending account (or FSA), and are under-spent at the time you lose coverage, you may have the option of FSA continuation coverage under COBRA.

Qualifying event	**Maximum coverage period**	**Qualified beneficiaries** (only members covered by the plan the day before the event occurred, or a child born to or placed for adoption with a covered employee during continuation coverage)
Covered employee's termination of employment	18 months	Employee, spouse, dependents
Covered employee's reduction in work hours (for any reason) below those required to maintain normal coverage	18 months	Employee, spouse, dependents
Covered employee's divorce or legal separation	36 months	Spouse, dependents
Covered employee's death	36 months	Spouse, dependents
Covered employee's entitlement to Medicare benefits	Up to 36 months	Spouse, dependents
Loss of status as a dependent child of the covered employee, under the plan rules	36 months	Dependent

Extension of maximum coverage period (not applicable to health FSA component)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Plan Administrator of a disability or a second qualifying event to extend the period of COBRA coverage. Failure to provide notice of a disability or a second qualifying event will eliminate the right to extend the period of COBRA continuation coverage. However, the period of COBRA continuation coverage for the Health Flexible Spending Account (FSA) cannot be extended under any circumstances. These extension opportunities also do not apply to a period of COBRA continuation coverage resulting from a covered employee's death, divorce, legal separation or a dependent child's loss of eligibility, since they already qualify for the maximum 36 months of coverage. There are other situations that may not allow coverage periods to be extended. Please check with the COBRA plan administrator for more details.

Disability extension of COBRA continuation coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Plan Administrator within the required timeframe, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started sometime before the 60th day of COBRA continuation coverage and must last until the end of the COBRA coverage available without the disability extension (18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

You must notify the COBRA plan administrator of a qualified beneficiary's disability by this deadline.

The disability extension is available only if you notify the plan in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination.
- The date of the covered employee's termination of employment or reduction of hours.
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan due to the covered employee's termination of employment or reduction of hours.
- The date the qualified beneficiary receives the member handbook or COBRA general notice informing him/her of the responsibility to notify the plan and the procedures for doing so.

In providing this notice, you must follow the notice procedures specified in the "Notice procedures" section below. If these procedures are not followed or if the notice is not provided to the COBRA plan administrator during the 60-day notice period, then the disability extension of COBRA coverage will be denied.

Second qualifying event extension of COBRA continuation coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA continuation coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the divorce or legal separation from the covered employee, a dependent child's ceasing to be eligible for coverage as a dependent under the plan, death of a covered employee or a covered employee becoming entitled to Medicare. These events can be a second qualifying event, only if they would have caused the beneficiary to lose coverage under the plan if the first qualifying event had not occurred. (This extension is not available under the plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

However, the law also provides that a person's continuation coverage will end earlier than above on the occurrence of the earliest of the following reasons:

- SHS no longer provides group health coverage to any of its employees.
- The person fails to pay their premium for continuation coverage on time.
- The person becomes covered under another group health plan (but see "Preexisting condition limitation" discussed below).
- The person becomes entitled to Medicare after electing continuation coverage under this plan.
- The person is no longer determined to be disabled, if coverage is continued beyond the eighteenth month due to the person's disability.

Preexisting condition limitation: COBRA continuation coverage may terminate when you become covered under another group health plan, but only if the other plan does not contain an exclusion or limitation that affects a preexisting condition you have. However, most health plans are required to credit time covered under a prior plan toward any preexisting condition coverage-waiting period. If you become covered under another group health plan having a preexisting condition coverage-waiting period that is satisfied due to this crediting of prior coverage, your COBRA continuation coverage may be terminated.

If the covered employee becomes entitled to Medicare within 18 months before his or her termination of employment or reduction of hours

When plan coverage is lost due to 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 coverage under the plan's medical, pharmacy and vision components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event, can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which employment terminates, COBRA coverage for the spouse and children who lost the coverage as a result of the termination can last up to 36 months after the date of the Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months **before** termination or reduction of hours.

Newborn and adopted children: If you are entitled to COBRA because you are a current or former employee of SHS and a child is born or placed for adoption while you are on COBRA continuation coverage, you can enroll your new child for COBRA continuation coverage immediately. You must notify the COBRA plan administrator within 30 days of the event and submit the appropriate documentation. Your newborn and adopted child will obtain qualified beneficiary status. In other words, the child will have independent election rights and second qualifying event rights (i.e. same rules that apply to a covered employee).

Premium payments: If you are eligible for continuation coverage, you do not have to show that you are insurable (proof of good health) to choose continuation coverage. However, under the law, you must pay 102% of the premium rate for your continuation coverage. A third party may pay your premium for you, but you remain responsible for ensuring the payment is made by the due date or within the 30-day grace period. These rules apply to your spouse and dependents who are eligible for continuation coverage. Individuals receiving a disability extension may be charged 150% of the premium during the extension.

Premiums must be mailed or delivered to the COBRA plan administrator. Your first payment is due no later than 45 days after the date you elect continued coverage, retroactive to the date coverage ceased. Payment for each subsequent month's coverage is due on the first day of the month and must be received within 30 days of the due date. Required monthly premiums may change during the continuation period in the manner allowed by the law. The COBRA continuation coverage member will be notified of any changes in the benefits and/or rates during the continuation period.

If you have any questions about the law, please contact Human Resources. Also, if you have changed marital status or you or your spouse have changed addresses, please notify Human Resources immediately. If any member changes their address while on COBRA continuation coverage, please notify the COBRA plan administrator.

Your COBRA rights are subject to change. Coverage will be provided only as required by law. Should the law change, your rights will change accordingly. In the event that more than one continuation provision under the plan applies, the periods of continuous coverage will run concurrently to the extent permitted by law.

Early retiree coverage: The plan provides that if a covered employee's employment with the employer ends, coverage for the employee and the employee's covered dependents will ordinarily stop on the last day of the month the employee's employment ends, subject to those individuals' COBRA continuation rights. Certain employees who retire from employment with the employer before becoming eligible for Medicare may continue coverage under the plan or selected components of the plan, designated by the employer's chief executive officer (the CEO) or the SHS board of directors (the board), subject to the following rules.

a. Early retirees eligible for continued coverage shall be those designated by the CEO or board in writing, subject to the following principles:

    i. In general, only senior executives with a significant period of service, who terminate employment with the employer at an age that is commonly viewed as an early retirement age, will be considered for designation.

    ii. A designation may be revoked by the CEO or board at any time upon notice to the retiree, whether for competition with the employer, actions the CEO or board concludes are contrary to the employer's interests or other factors.

    iii. Coverage shall be available to the early retiree and the spouse or domestic partner and dependents of the early retiree as of the date of early retirement, and pursuant to the plan's special enrollment provisions, any later-acquired spouse, domestic partner or dependent.

    iv. Subject to (a)(ii) above, an early retiree's coverage shall end when the early retiree becomes eligible for Medicare, regardless of whether the early retiree enrolls in Medicare upon first becoming eligible to do so.

    v. Subject to (c) below, a spouse's, domestic partner's or dependent's coverage shall end on the earlier of the date the early retiree's coverage ends for any reason, or the date the spouse's, domestic partner's or dependent's coverage would end if the early retiree were an active employee, unless the CEO or board, in writing, specifically authorizes a longer coverage period for the spouse, domestic partner or dependent.

    vi. The term and conditions for continued coverage shall be established by the CEO or board and shall be subject to amendment or termination by the CEO or board during the period of COBRA continuation coverage.

vii. Ordinarily, the provision of continued coverage shall be conditioned upon the early retiree's execution and non-revocation of a release of claims against the employer and its directors, employees, agents and affiliates, in a form acceptable to the CEO or board.

b. The CEO or board shall determine each year the amount, if any, of the employer's subsidy for early retiree coverage and announce the amount to the affected persons. The employer may establish different subsidy amounts for different early retirees, spouses, domestic partners and dependents. Ordinarily, no subsidy will be provided for spouses, domestic partners or dependents acquired after retirement, even if a subsidy is provided for spouses, domestic partners or dependents as of the date of retirement.

c. Ordinarily, COBRA continuation coverage triggered by the early retiree's retirement will not begin until after the end of any early retiree coverage provided pursuant to this provision. In addition, if an early retiree, spouse, domestic partner or dependent loses early retiree coverage due to a COBRA qualifying event, the administrator will permit the qualified beneficiary to elect continuation of the early retiree coverage pursuant to COBRA.

d. Ordinarily, the employer will report any subsidy it provides for early retiree coverage, for an early retiree who was a highly compensated individual at or shortly before retirement, as taxable income to the early retiree and reportable on IRS form W-2.

COBRA continuation coverage regarding health flexible spending accounts

COBRA continuation coverage under the health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the amount of their submitted claims is less than their year-to-date contributions.

COBRA coverage will consist of the health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by the reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it-rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year and health FSA COBRA continuation coverage will terminate at the end of the plan year.

Unless otherwise elected, all qualified beneficiaries who were covered under the health FSA will be covered together for health FSA COBRA continuation coverage. However, each qualified beneficiary could alternatively elect separate COBRA continuation coverage to cover that beneficiary only with a separate health FSA annual limit and a separate premium.

Qualified beneficiaries may not enroll in the health FSA at open enrollment.

How to elect COBRA continuation coverage

To elect COBRA continuation coverage, you must complete the election form that is part of the plan's COBRA Election Notice. The election form is provided by the COBRA plan administrator, Total Administrative Services Corporation (TASC) and must be returned to TASC. Contact information can be found under the "Notice Procedures" section below.

Deadline for electing COBRA continuation coverage

If mailed, your election must be postmarked or if hand-delivered, emailed, faxed or submitted through online enrollment your election must be received by the individual at the address specified on the election form, no later than 60 days after the date of the COBRA Election Notice provided to you at the time of your qualifying event or if later, 60 days after the date that plan coverage is lost. **If you do not submit a completed election form by this due date, you will lose your right to elect COBRA continuation coverage.**

Independent election rights

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Any qualified beneficiary for whom COBRA continuation coverage is not elected within the 60-day election period, specified in the COBRA Election Notice, will lose his or her right to elect COBRA continuation coverage.

Special considerations in deciding whether to elect COBRA continuation coverage

In considering whether to elect COBRA continuation coverage, you should take into account that failure to elect COBRA continuation coverage will affect your future rights under federal law. First, you can lose the right not to have preexisting conditions applied to you by other group health plans, if you have more than a 63-day gap in health coverage. Electing COBRA may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions, if you do not get COBRA continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan, for which you are otherwise eligible (such as a plan sponsored by your spouse's employer), within 30 days after your group health coverage ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

How to change your COBRA continuation coverage election

If you want to change your initial election and are still within your 60-day election period, please complete a new COBRA Continuation Coverage Election form and submit to the plan within the required timeframe.

To drop a portion of your coverage or covered members, or terminate your coverage early, you must contact the COBRA plan administrator. Contact information is provided in the "Notice procedures" section below.

To add dependents or change coverage options during open enrollment periods, please contact the COBRA plan administrator for current forms.

Termination of COBRA coverage before the end of the maximum coverage period

COBRA continuation coverage will automatically terminate before the end of the maximum period if:

- Any of the required premiums are not paid in full on time.
- A qualified beneficiary becomes covered after electing COBRA under another group health plan (but only after any exclusions of that plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied).
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA.
- The employer ceases to provide any group health plan for its employees.
- During a disability extension period, the disabled qualified beneficiary is determined to no longer be disabled. (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate.) For more information about the disability extension period, please refer to the "Disability extension of COBRA continuation coverage" section above.

COBRA continuation coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

Notification of other coverage

After electing COBRA, you must notify the COBRA plan administrator in writing, within the required timeframe, when a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both). The required timeframe is 60 days from the latest of:

1. The date of the Medicare entitlement.
2. The date of loss of coverage.
3. The date the qualified beneficiary receives the member handbook or COBRA General Notice, informing them of the responsibility to notify the plan and the procedures for doing so.

You must also notify the COBRA plan administrator in writing within 30 days, if after electing COBRA, a qualified beneficiary becomes covered under other group health plan coverage. Refer to the "Notice procedures" section below. In addition, if you were already entitled to Medicare before electing COBRA, notify the plan of the date of your Medicare entitlement at the address shown in the "Notice procedures" section below.

Payment for COBRA continuation coverage

All COBRA premiums must be paid by cash, check, money order or recurring credit card. Your first payment and all monthly payments for COBRA continuation coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice, provided to you at the time of your qualifying event. However, if the plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA plan continuation coverage to the address specified in the notice of new address.

If mailed, your payment is considered to have been made on the date it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified for the COBRA administrator.

If you elect COBRA, you do not have to send any payment with the election form. However, you must make your first payment for COBRA continuation coverage no later than 45 days after the date of your election. (This is the date your election form is postmarked, if mailed, or the date your election form is received by the individual at the address specified for delivery of the election form, if delivered electronically or by hand.) Please refer to the "How to elect COBRA continuation coverage" section.

If you do not send your initial payment with your election notice, but pay within the 45 days after you elect, your initial premium payment may need to be adjusted to include more than the first month's premium. The following example assumes your loss of coverage date is April 30 and you elect coverage June 29. If you send in your payment on Aug. 8 (40 days after your election date), at a minimum, your payment should cover the months of May, June and July. And your August payment (due Aug. 1) must be paid within the 30-day grace period, by Aug. 31.

Claims will be denied until you have elected COBRA and made the first payment. After the first payment is made in full within the required timeframe, claims will be reprocessed for payment.

After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments for each subsequent month of COBRA continuation coverage. The amount due for each month will be disclosed in the election notice packet provided to you at the time of your qualifying event. Under the plan, each of these monthly payments for COBRA continuation coverage is due on the first day of the month for that month's COBRA continuation coverage. **Neither the COBRA Plan Administrator nor the plan will send a monthly bill to you for your COBRA continuation coverage. It is your responsibility to pay your COBRA premiums on time.**

Although monthly payments are due on the first day of each month of COBRA continuation coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA continuation coverage will continue each month, as long as the payment for that month is made before the end of the grace period.

However, if you do not make a monthly payment within the grace period for the month, your COBRA continuation coverage will be retroactively terminated (going back to the last month when a full timely payment was received).

If you fail to make a monthly payment before the end of the grace period for that month, you lose all rights to COBRA continuation coverage under the plan.

Eligibility during election and initial payment period

During the initial 60-day election period, until an election form is received, providers verifying eligibility will be told members are not benefit-eligible and not payment-eligible. If you receive medical services prior to electing your continuation coverage, keep any medical payment receipts and submit for reimbursement under the plan provisions, once you have elected and paid your initial premium payment.

Once an election form has been received, you will be considered benefit-eligible under the plan. If you submit a full premium payment with your election form, claims will be processed following the usual procedure. Providers verifying eligibility will be told members are benefit-eligible and payment-eligible. If a full premium payment is not sent with the election form, claims will be denied until a full premium payment has been received. Providers verifying eligibility will be told members are benefit-eligible, but not payment-eligible, as requirements have not been met. They will also be informed that no claims, including prescription drug charges, will be paid until the initial premium payment is received in full. Once the full initial premium payment has been received within the required timeframe, the claims will be reprocessed. If premiums are not paid in full by the required deadline, coverage will be terminated retroactively. Additional information may be provided following HIPAA guidance. A third party is allowed to make premium payments for a COBRA member but must do so within the required timeframe.

Notice procedures

Warning: If you miss a required due date or if you do not follow these notice procedures, you will lose the right to elect COBRA (or will lose the right to an extension of COBRA continuation coverage, as applicable). This applies to all related qualified beneficiaries as well, unless they contact the COBRA plan administrator independently.

Notices must be written and submitted on plan forms

Any notice that you provide related to COBRA continuation coverage elections must be in writing, signed and submitted on the COBRA plan administrator's required forms. This includes the initial election when choosing to be covered under COBRA continuation coverage, any changes made to your original or subsequent elections and all reportable events. You may request forms by contacting the COBRA plan administrator. Submit address changes of any COBRA enrolled member to the COBRA plan administrator. If you are not able to submit this form timely, an address change may be reported to the plan by contacting SHP Customer Service.

How, when and where to send notices

SHS's COBRA plan administrator is Total Administrative Services Corporation (TASC).

You must mail, email, fax or hand-deliver your notice to TASC:

By mail:	**TASC** **PO Box 14015** **Madison, WI 53708-0015**
By email:	**COBRAService@tasconline.com**
By fax:	608-663-2753
Hand-deliver:	Contact TASC customer service for instructions at **800-422-4661**.

However, if a different address, email or fax is listed for notices to the COBRA plan administrator appears in their most recent documents, you must mail, hand-deliver, email or fax your notice to that address.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, emailed or faxed, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. The applicable notice periods are described throughout this document in the appropriate sections.

You may contact TASC Customer Care by phone at 800-422-4661 or by e-mail at COBRAService@tasconline.com if you have questions or wish to confirm you are complying with all required procedures for COBRA enrollment. Customer service hours are 8 a.m. to 5 p.m., Monday through Friday, Central Time.

Additional information required for notice of qualifying event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the COBRA plan administrator that coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the COBRA plan administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional information required for notice of disability

Any notice of disability that you provide must include all the following:

1. The name and address of the disabled qualified beneficiary.
2. The date that the qualified beneficiary became disabled.
3. The names and addresses of all qualified beneficiaries who are still receiving COBRA continuation coverage.
4. The date that the Social Security Administration made its determination.
5. A copy of the Social Security Administration's determination.

Requirements if you are no longer disabled

If the member is no longer disabled, the plan must be notified of this change in writing. The law requires this notification within 30 days of the change in status. Contact the COBRA plan administrator for instructions and forms pertaining to this notice procedure.

Additional information required for notice of second qualifying event

Any notice of a second qualifying event that you provide must include the following:

1. The names and addresses of those who are receiving COBRA continuation coverage.
2. The second qualifying event and the date that it happened.
3. If the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Other second-qualifying events may require documented proof.

Additional information required for notice of special Medicare extending rule

Any notice of Medicare entitlement that you provide must include the following:

1. The name and address of the Medicare-entitled member.
2. The effective date of Medicare entitlement.
3. The names and addresses of all qualified beneficiaries who are receiving COBRA continuation coverage.
4. A copy of the Medicare card.

Who may provide notice(s)

The covered employee (i.e., the employee or former employee who is or was covered under the plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage, due to the qualifying event described in this notice.

When notices must be provided

Action needed	Timeline to report
Report the following second qualifying events to the COBRA plan administrator, TASC: ● Employee divorce. ● Legal separation. ● A child's loss of dependent status (for example, child turns 26).	Within 60 days of the later of: ● Date of the qualifying event. ● Date of loss of coverage due to qualifying event. ● Date member receives member handbook.
Once you receive the COBRA Coverage Election Notice, if you choose to elect, you must submit a completed COBRA Coverage Election form to TASC.	Within 60 days of the later of: ● Date on the notice. ● Date you lose group health coverage.
If you elect COBRA continuation coverage, you must remit your initial payment to TASC (if you did not send your initial payment with the COBRA Coverage Election form).	Within 45 days of the date you elect COBRA continuation coverage.
Your monthly premium payments are due on the first of each month. You must remit your monthly premium payments to TASC.	By the end of the 30-day grace period.

Action needed	Timeline to report
Qualified beneficiaries may request special enrollment. (for example, in a spouse's health plan).	It must be within 30 days of the loss of other coverage (including at the end of the COBRA continuation coverage maximum period).
Disability: If you are reporting the disability of a qualified beneficiary, you must send TASC a copy of the Social Security Administration ruling letter.	Within 60 days from the later of: ● The date Social Security Administration issues the disability determination. ● The date of the qualifying event. ● The date of loss of coverage. ● The date the qualified beneficiary receives the member handbook.
No longer disabled: You must report to TASC a Social Security Administration determination that the disabled qualified beneficiary is no longer disabled.	Within 30 days after the Social Security Administration determination was made.

General provisions

Medical necessity of continuing care

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

Quality of medical care

The plan is not responsible for the quality of medical care the covered person receives. The plan cannot be held liable for any claims or damages connected with injuries suffered by the covered person while receiving medical services and supplies. The covered person has the right to choose his or her own hospital or physician; however selecting an in-network provider will maximize benefits while minimizing out-of-pocket expenses. Whenever the covered person receives services of an out-of-network provider, it will likely result in greater out-of-pocket expense in the form of higher deductibles, copayments and/or additional coinsurance. Payments to out-of-network providers are based on the maximum plan allowable, as determined by the plan, which may be significantly less than the out-of-network provider's actual billed amount. The covered person may be responsible for any difference between the maximum plan allowable and the actual billed amount. We are here to help you maximize your benefits and encourage you to call or e-mail us, so we may help you find an in-network provider whenever possible.

Third-party liability and right of subrogation

If a covered person receives any benefits arising out of an injury or illness for which the covered person (or his or her guardian or estate) may have or asserts any claim or right to recovery against a third-party or parties, then any payment or payments under the plan for such benefits shall be made on the condition and with the understanding that the plan will be reimbursed. Such reimbursement will be made by the covered person (or his or her guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the covered person (or his or her guardian or estate) from any policy or contract from any insurance company or carrier, including the covered person's insurer or any third-party plan or fund as a result of a judgement, settlement, arbitration, award or other arrangement. The covered person on behalf of his or herself (or his or her guardian or estate) acknowledges and agrees that the plan will be reimbursed in full before any amounts are deducted from the policy, proceeds, award, judgment, settlement or other arrangement. This obligation to reimburse the plan shall be equally binding upon the covered person regardless of whether or not the third-party or its insurer has admitted liability or the medical charges are itemized in the third-party payment.

The plan will not pay or be responsible, without its prior written consent, for any fees or costs associated with a covered person pursuing a claim against any coverage. Neither the make-whole rule nor the common-fund doctrine of insurance law applies under the plan.

Any reimbursement required by this provision shall also apply when a covered person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

The plan will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third-parties and insurance companies and carriers, including the covered person's insurer. The amount of such subrogation will be equal to the total amount paid under the plan arising out of the injury or illness for which the covered person (or his or her guardian estate) has, may have, or asserts a cause of action. In addition, the plan will be subrogated for attorney fees incurred in enforcing its subrogation rights under this provision.

By reason of such subrogation, the plan or the claims administrator on behalf of the plan, has the right to sue and assert rights against any such third-party in a covered person's name.

If a covered person incurs expenses for treatment of the injury or illness after receiving a recovery, the plan will not pay benefits for covered expenses until the total amount of the covered expenses incurred after the recovery exceeds the net recovery amount (i.e., the amount of the recovery minus the amount previously reimbursed to the plan).

The covered person on behalf of himself or herself (or his or her guardian or estate) specifically agrees to do nothing to prejudice the plan's rights to reimbursement or subrogation. In addition, the covered person on behalf of himself or herself (or his or her guardian or estate) agrees to cooperate fully with the plan and claims administrator in asserting and protecting the plan's subrogation rights. The covered person on behalf of himself or herself (or his or her guardian or estate) agrees to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect the plan's subrogation rights.

The covered person specifically agrees on behalf of himself or herself (or his or her guardian or estate) to notify the claims administrator in writing of whatever benefits are paid under the plan that arise out of any injury or illness that provides or may provide the plan subrogation rights under this provision.

Failure to comply with the requirements of this provision by the covered person (or his or her guardian estate) may result in a forfeiture of benefits under the plan.

Plan administration: In order to make clear the extent of the administrator's authority, the administration has absolute discretion to carry out its duties pursuant to the plan.

Motor vehicle accidents

If you have been diagnosed with any diagnoses that have potentially been caused by a motor vehicle accident, SCP automatically sends a letter with a form requesting any supporting information related to a motor vehicle accident. If your diagnosis is **not** related to a motor vehicle accident, please return the form indicating that you are receiving treatment for a diagnosis not related to a motor vehicle accident.

Most motor vehicle liability policies are required to provide a full range of liability insurance that includes medical care. The plan will not pay medical costs if the covered person is entitled to health care under motor vehicle insurance. It will pay benefits toward eligible expenses over the amount covered by the motor vehicle insurance. If the covered person is paid benefits before motor vehicle insurance payments are made, then the plan is entitled to reimbursement from any subsequent motor vehicle insurance payments made to the covered person. The plan may recover expenses directly from the motor vehicle insurer or from any settlement or judgment that the covered person obtained from a third-party.

Before the plan pays a benefit, the covered person must provide information about any motor vehicle payments that may be available. Also, at the request of the claims administrator, the covered person must sign an agreement to hold the income of any recovery in trust for the plan.

Anti-assignment

You 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 assignment by you 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 document to any other person, corporation or other organization or entity.

Coordination of benefits

1. **Coordination of this group contract's benefits with other benefits**

   This "Coordination of Benefits" section applies when a covered person 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 governs the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms, without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

2. **Definitions relating to coordination of benefits**

   Plan: Plan means any of the following that provide benefits or services for medical, pharmacy or routine vision services. 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.

   2.1. **Plan includes**: Group insurance contracts, health maintenance organization 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.

2.2. **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 under 2.1 and 2.2 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.

The plan: The plan means, as used in this COB section, the part of this contract to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from the plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules listed in section 3 determines whether the plan is a primary plan or secondary plan when a covered person has health care coverage under more than one plan.

When primary, SCP determines payment for our benefits first before those of any other plan, without considering any other plan's benefits. When secondary, SCP determines our benefits after those of another plan and may reduce the benefits SCP pays so that all plan benefits do not exceed 100% of the total allowable expense.

Allowable expense: A health care expense, including deductibles, coinsurance and copayments, which are covered at least in part by any plan covering a covered person.

SCP members are expected to pay for their cost shares (copays, coinsurances and deductibles) and SCP will only pay for benefits after satisfaction of member deductibles and other eligibility requirements, even when SCP is in the secondary position. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering a covered person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person, is not an allowable expense.

The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense 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 expense.

Allowable expense regarding Medicare: When this plan pays secondary to Medicare, the Medicare approved amount will be the allowable expense for this plan, as long as the provider accepts Medicare. When the provider does not accept Medicare, the Medicare limiting charge (the most that the provider can charge you for the service when they do not accept Medicare), will be the allowable expense. The Medicare payment combined with the payment from this plan will not exceed 100% of the total allowable expense.

If you are covered by two or more plans that provide benefits or services based on negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

If you are covered by one plan that calculates its benefits or services on the basis of maximum plan allowable 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 expense 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 expense used by the secondary plan to determine its benefits.

The amount of any benefit reduction by the primary plan because the covered person has failed to comply with the provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, pre-certification of admissions and in-network provider arrangements.

Closed panel plan: A closed panel plan is a plan that provides health care benefits to covered persons, primarily in the form of service through a panel of providers that has contracted with or is employed by the plan and that excludes coverage for services provided by other providers, except in case of emergency or referral by a panel member. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

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

3. Order of benefit determination rules

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

a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan.

b. Except as provided in paragraph one (1) 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.

    1. 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 coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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

d. Each plan determines its order of benefits using the first of the following rules that apply. Rules are applied in a sequential order:

    1. **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.

    2. **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.

   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 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 rule applies to plan years commencing after the plan is given notice of the court decree.

   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 subparagraph (a) above shall determine 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 subparagraph (a) above shall determine the order of benefits.

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

   - First, the plan covering the custodial parent.
   - Second, the plan covering the spouse of the custodial parent.
   - Third, the plan covering the non-custodial parent.
   - Lastly, the plan covering the dependent spouse of the non-custodial parent.

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 covered person 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 D (1) 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 D (1) can determine the order of benefits.

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

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

4. **Effect on the benefits of this plan**

When the plan is secondary, SCP may reduce our benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may 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 expense 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 covered person 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.

5. **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 the plan and other plans. SCP may 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 the plan and other plans covering a member claiming benefits. SCP need not tell or get the consent of any person to do this. Each covered person claiming benefits under this plan must give SCP any facts we need to apply this section and determine benefits payable.

6. **Facility of payment**

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

7. **Right of recovery**

If the amount of the payments made by SCP is more than we should have paid under this COB section, Samaritan Choice Plans may 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 may be responsible for the benefits or services provided for the covered person. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

Right to receive or release information

In order to give full effect to this COB provision, the plan may give or obtain necessary information from another insurer, organization or person. Each and every covered person under this plan, hereby gives consent and fully authorizes the plan to obtain any reasonably necessary information to apply this COB provision. A covered person will fully cooperate with all reasonable requests from the plan to obtain any such information.

Coordination with Medicare

If you and/or your spouse are enrolled in Medicare and this plan at the same time, this plan will pay benefits first when any of the following apply:

- You or your covered spouse are age 65 or over and by law Medicare is secondary to this plan.
- You or your covered spouse incur expenses for kidney transplant or kidney dialysis, and by law Medicare is secondary to the plan.
- You are entitled to benefits under section 226(b) of the Social Security Act (Medicare disability) and by law Medicare is secondary to the plan.

Medicare is the primary payer for non-working persons and spouses of non-working persons who first become entitled to Medicare on the basis of age or disability prior to acquiring end stage renal disease, as specified by law.

Allowable expenses regarding Medicare: When this plan pays secondary to Medicare, the Medicare approved amount will be the allowable expense for this plan as long as the provider accepts Medicare. When the provider does not accept Medicare, the Medicare limiting charge (the most that the provider can charge you for the service when they do not accept Medicare), will be the allowable expense. The Medicare payment combined with the payment from this plan will not exceed 100% of the total allowable expense.

Plan administration: In order to make clear the extent of the administrator's authority, the administrator has absolute discretion to carry out its duties pursuant to the plan.

Circumstances causing ineligibility or loss of benefits

The plan contains numerous conditions and limitations that may affect you or your family's right to participate or receive benefits. This section will highlight just a few such conditions and limitations. You or your family's rights may be affected by any of the following:

- Not being or remaining an eligible employee (please refer to the "Who is eligible" section).
- Not timely submitting an election to participate (please refer to the "How and when to enroll" section).
- Failing to timely pay for continuation coverage (please refer to the "Continuation coverage" section) or regular coverage while on FMLA leave (please refer to the "What happens if your eligibility changes" section).
- Changing your employment status or family status (please refer to the "What happens if your eligibility changes" section).
- Failing to timely submit claims for reimbursement (please refer to the "Claims information" and "Member grievances and appeals process" sections).
- Being called to active duty by any of Armed Forces of the United States (please refer to the "What happens if your eligibility changes" section).
- Reaching a benefit maximum, including the plan's lifetime maximum benefit (please refer to the "Benefit exclusions" section and elsewhere for other maximum limits).
- Failing to reimburse the plan under its right of subrogation (please refer to the "General provisions" section).
- Being subject to a plan amendment (please refer to the "Summary plan description" section).

Member grievances and appeals process

Authorized representative

You or someone you name to act on your behalf (authorized representative) may file a written grievance and/or written appeal with Samaritan Choice Plan. An expedited appeal may be filed verbally or in writing.

Your authorized representative can be a relative, friend, advocate, attorney, doctor or someone else who is already authorized under state law.

NOTE: In order for SCP to process a request received from your authorized representative, we must have proof of such designation. Proof can include a signed representative form, other appropriate legal papers supporting an authorized representative's status or durable power of attorney document.

SCP has an authorized representative form that you can request by calling Customer Service. Please refer to the "Member resources" section to contact Customer Service.

Filing a grievance

Grievance means a written complaint regarding:

- Availability, delivery or quality of health care services.
- Claims payment, handling or reimbursement for health care services.

You or your authorized representative may file a grievance:

By mail: Samaritan Choice Plans Grievance Team
PO Box 1310
Corvallis, OR 97339

By fax: 541-768-9765

By email: SHPOgrvcteam@samhealth.org

You have the option to file a grievance (complaint) through SCP's Grievance Team or you may choose to move straight to the appeal process without submitting a grievance.

We will attempt to address your grievance generally within 30 days of receipt. You may receive information about our grievance and appeal processes by contacting Customer Service.

If you remain dissatisfied with the outcome of your grievance, you or your authorized representative may file a written appeal within 180 days of the denial or other action giving rise to the grievance.

Filing an internal appeal

If you remain dissatisfied after the initial adverse benefit decision or grievance decision, you or your authorized representative have the right to file an appeal. The appeal request must be:

1. In writing.
2. Signed.
3. Include the appeal reason.
4. Received by SCP within 180 days of the denial or other action giving rise to the grievance. You may **submit your appeal in writing with a brief explanation as to why you would like to appeal**. You or your authorized representative have the right to appear in person to talk about your appeal.

Within seven business days of receiving the appeal, we will send you or your authorized representative an acknowledgment letter. You or your authorized representative has the right to appear in person to talk about your appeal. The Level 1 appeal decision will be determined by a healthcare professional not previously involved in your initial adverse benefit determination.

During the internal review, we may require an extension for processing your pre-service appeal. If so, a letter will be sent to you explaining the circumstances requiring the extension and a description of any additional information needed from you or your providers. In no event will this extension exceed the time frames explained in the "Appeal timelines" section. If you do not agree with our decision to extend the timeframe to process your appeal, you may file a grievance.

You or your authorized representative will receive a written decision within 30 days (pre-service, plus extension if needed) or 60 days (post-service) of our receiving your appeal request.

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, health or your ability to regain maximum function, your appeal will be processed in an expedited manner (three days after receipt of the request). Only pre-service requests qualify for expedited processing.

Urgent is determined when the member's life or health would be in serious jeopardy, or the member's ability to regain maximum function would be impaired or the member would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

You, your authorized representative or your treating provider may request a simultaneous expedited external review.

For more information, please refer to the "Expedited appeals" section.

External review

If you are still dissatisfied with our final adverse determination, your appeal may qualify for an external review (at no cost to you) if any of the following apply:

- The plan does not adhere to the rules and guidelines of the process defined for the internal review.
- The internal review has been completed and the reason for the adverse decision was for any of the following:
    - Based on medical necessity.
    - For treatment determined to be experimental or investigational.
    - For the purpose of continuity of care.
- You and the plan have mutually agreed to waive the internal appeal requirement.

Your request for an external review must be received in writing to us within 120 days of our final adverse determination. Within five business days of receiving your request for external review, we will send you or your authorized representative a confirmation letter that your request is eligible for external review. (If your request is not eligible for external review, the plan will notify you or your authorized representative in writing and include the reasons for the ineligibility.)

To apply for an external review, you must send your written request or the Appeal Request form to us at the following address:

By mail: Samaritan Choice Plans Appeals Team
PO Box 1310
Corvallis, OR 97339

By fax: 541-768-9765

By email: SHPOappealsteam@samhealth.org

External review decisions are made by randomly assigned Independent Review Organizations who are not associated with Samaritan Health Services.

Please note: When you request an external review, the plan will send you or your authorized representative a waiver that allows the IRO access to your medical records pertaining to the internal appeal adverse decision. It is important for you to know that the plan can only continue to process your request if the signed waiver is returned.

The plan, upon receiving notification of the assigned IRO, will forward your request within five business days. You will receive a letter from the IRO informing you that your request for external review has been received. You will have 10 business days to submit additional information directly to the IRO.

The IRO will return a written decision to you or your authorized representative and to the plan within the following timeframes:

- **Expedited** external review – **72 hours** after receipt of the request.
- **Standard** external review – **45 days** after receipt of the request.

IRO decisions are final and we are bound by their decisions. If you want more information regarding external review, please refer to the "Member resources" section to contact Customer Service.

Expedited appeals

Urgent is determined when the member's life or health would be in serious jeopardy or the member's ability to regain maximum function would be impaired or the member would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

If you believe your appeal is urgent, you, your authorized representative or your treating provider may request an expedited appeal. If the appeal request meets the definition of urgent; meaning, 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 three days after receipt of the request).

For urgent appeals, your treating provider may act as your authorized representative without a signed Authorized Representative form.

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.

When applicable, you may **simultaneously** request an expedited external review, in addition to an expedited internal review.

An expedited external review may be filed verbally or in writing within 120 days of our initial or final adverse determination.

An expedited internal review may be filed verbally or in writing within 180 days after you receive notice of the initial adverse determination.

The expedited appeal request must include the following:

- Be based on a pre-service adverse determination.
- State the reason for the appeal request.
- State the reason an expedited decision is needed.
- Include supporting documentation necessary for the plan to make a decision.

The internal expedited review decision will be determined by an appropriate health care 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 three days after receipt of the request. A written notice will be mailed within one working day following the verbal notification.

For an expedited external review, the randomly assigned IRO will have three days to make their decision from the time they receive the appeal information from the plan.

To apply for an internal or external expedited review, send your written request along with a completed Authorization to Release Health Plan Records for External Review form to:

By mail: Samaritan Choice Plans Appeals Team
PO Box 1310
Corvallis, OR 97339

By fax: 541-768-9765

By email: SHPOappealsteam@samhealth.org

By phone: Customer Service: **541-768-4550**; toll free **800-832-4580** (TTY **800-735-2900**).

Appeal timelines

Samaritan Choice Plans adheres to the following timeframes for making decisions for an internal appeal:

- Three days for urgent.
- 30 days for pre-service.
- 60 days for post-service.

SCP may take an extension of up to 14 days for pre-service appeals. You will be notified in writing if an extension is necessary.

Forms

You may obtain the following forms for your appeal by contacting Customer Service at **541-768-4550**; toll free **800-832-4580** (TTY **800-735-2900**) or online at **samhealthplans.org/Choice**:

- Authorized Representative.
- Appeal Request.

Your appeal rights

You have the right to:

- File a grievance about and appeal any decision we make regarding availability, delivery or quality of health care services, including claims payment, handling or reimbursement for health care services or matters pertaining to the contractual relationship between the member and the plan.
- Contact us when you:
    - Do not understand the reason for the denial.
    - Do not understand why the health care service or treatment was not fully covered.
    - Do not understand why a request for coverage of a health care service or treatment was not approved.
    - Cannot find the applicable provision in your plan document.
    - Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision.
- A full and fair internal review of your appeal by individuals associated with us but who were not involved in the adverse decision.
- Provide us with additional information that relates to your appeal.
- Appear in person to talk about your internal appeal.
- An internal review decision within 30 days for pre-service appeals, 60 days for post-service appeals and three days for an expedited appeal.
- File an external review (at no cost to you) if applicable.
- An external review decision within 45 days of the IRO receiving your standard request and three days for an expedited request.
- Send additional information, in writing, directly to the IRO.
- An expedited review if you, your authorized representative or your treating provider believes that waiting the standard 30-day timeframe would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed. (Urgent is determined when the member's life or health would be in serious jeopardy or the member's ability to regain maximum function would be impaired, or the member would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.)
- A simultaneous expedited internal and external review, if applicable.

For information about our grievance and appeal processes, contact Customer Service:

By phone: **541-768-4550**; toll free **800-832-4580** (TTY **800-735-2900**).

By mail: Samaritan Choice Plans Appeals Team
PO Box 1310
Corvallis, OR 97339

By fax: 541-768-9765

By email: SHPOappealsteam@samhealth.org

You also have the right to file a complaint and seek further assistance if you are unsatisfied with how your appeal or grievance was handled by SHP or if you remain unsatisfied with the outcome of your appeal or grievance:

By mail: U.S. Department of Labor, Seattle District Office
300 Fifth Avenue, Ste. 1110
Seattle, WA 98104-2397

By phone: **206-757-6781**

By fax: 206-757-6662

Your member rights and responsibilities

Your rights as a member:

- You have a right to receive information about SCP, our services, our providers and your rights and responsibilities.
- You have a right to be treated with respect and recognition of your dignity and right to privacy.
- You have a right to participate with your health care provider in decision-making regarding your health care.
- You have a right to honest discussion of appropriate or medically necessary treatment options.
- You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this plan.
- You have a right to the confidential protection of your medical information and records.
- You have a right to voice complaints about SCP or the care you receive and to appeal decisions you believe are wrong.
- You have a right to make recommendations regarding the organization's member rights and responsibilities policy.

Your responsibilities as a member:

- You are responsible for providing SCP and our providers with the information we need to care for you.
- You are responsible for following treatment plans or instructions agreed on by you and your health care providers.
- You are responsible for payment of copays at the time of service.
- You are responsible for reading and understanding all materials about your health plan benefits and for making sure that family members covered under this plan also understand them.
- You are responsible for making sure services are prior authorized when required by this plan before receiving medical care.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon treatment goals to the degree possible.

Claims information

When a claim is submitted for payment, every attempt will be made to process it promptly and accurately. Claims must be submitted within one year (365 days) of the time the covered person receives the service or supply to be eligible for payment.

Within 30 days of receipt of a clean claim, the claims administrator will report to you on the action it has taken. The term clean claim, means a claim that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Samaritan Choice Plans disclosures

The following are federal laws and plan notices that apply to your health benefits coverage and are found in appropriate sections of this document. You may access your plan documents online at **samhealthplans.org/Choice**.

Family and Medical Leave Act of 1993

Employees are eligible for leave if they have at least 12-months of service and have worked at least 1,250 hours during the previous 12-month period. Eligible employees are entitled to request the Family Medical Leave Act, also called, FMLA, leave for up to a maximum of 12 work-weeks within a 12-month period for the following reasons:

- To care for a child following a birth or placement of a child with the employee for adoption or foster care.
- To care for the spouse, child or parent of the employee who has a serious health condition or the employee is unable to perform the essential functions of his or her own job because of the employee's own serious health condition.
- For any qualifying exigency arising out of the fact that a spouse, son, daughter or parent is a military member on covered active duty or call to covered active duty status.
- An eligible employee may also take up to 26 workweeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness when the employee is the spouse, son, daughter, parent or next of kin of the service member.

If both parents work for the employer, they are entitled to a total of 12 weeks of leave for the birth of a newborn or the placement of an adopted or foster child and they may decide how to divide the leave. An entitled family and medical leave (FMLA) is NOT considered a COBRA qualifying event unless coverage is reinstated at the end of the leave (please refer to the "Continuation coverage" section).

If the employee chooses to continue coverage while on an approved FMLA leave, they may do so by continuing to pay their required premium contributions. If the employee is on leave without sufficient paycheck earnings to pay those premiums, unpaid premiums will go into arrears. Missed employee premiums are due by payment of arrears through payroll or by payment of a check to SHS. Employees may contact Human Resources for further details of this process.

If the employee choses to drop coverage during an approved FMLA leave and returns to active employment after an entitled FMLA leave, group coverage will be reinstated. Waiting periods satisfied prior to an employee's approved leave would be reinstated when an employee returns to work. This is true even if coverage was terminated due to lapse of contribution payments on the employee's part. Reinstated benefits will be equivalent to those the employee would have had if leave had not been taken and contribution payments had not been missed.

If the employee chooses not to participate while on a FMLA leave, they may do so by continuing to pay their required premium contributions. If the employee is on leave without sufficient paycheck earnings to pay those premiums, unpaid premiums will go into arrears. Missed employee premiums are due by payment of arrears through payroll or by payment of a check to SHS. Employees may contact Human Resources for further details of this process.

If the employee fails to return from leave (except because of your own or a relative's serious health condition or another circumstance beyond your control), SHS has the right to recover contributions it paid during the leave. If the employee does not return from a FMLA leave, health coverage will cease and a COBRA qualifying event will occur on the earlier of either of the:

- End of the leave period.
- Day the employer learns the employee does not plan to return.

State Family and Medical Leave and Paid Family and Medical Leave Insurance

Oregon has a family and medical leave law, the Oregon Family Leave Act (OFLA), that is substantially parallel to the federal FMLA law, although some provisions differ between OFLA and FMLA. An OFLA covered employer (25 or more employees) that provides a group health plan must continue to offer an employee the same coverage under the same terms as if they had continued to work while on leave under OFLA. If family member coverage is provided to the employee, family member coverage must be maintained during the period of family leave. The employee must continue to make any normal contributions to the cost of the health insurance premiums.

Effective in 2023, Oregon has a paid family and medical leave insurance program, Paid Leave Oregon (PLO), which also specifies continuation of the same health benefits coverage while an employee is on leave as if they had continued to work, if they meet the required length of employment.

For covered employees working for SHS remotely from outside the state of Oregon, other state leave laws that protect benefits coverage may apply.

Notices of federal and state leave laws are posted to the SHS intranet and may be found through the SHS Insider Employees link. Contact Human Resources for details of the policies and procedures pertaining to these laws and to obtain the required leave request forms.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Coverage will terminate if you are called to active duty by any of the U.S. armed forces. However, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if you request to continue coverage and pay any required contributions toward the cost of the coverage during the leave. If the leave is less than 30 days, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If you do not elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day you return to active employment with the group if you are released under honorable conditions, but only if you return to active employment:

- On the first full business day following completion of your military service for a leave of 30 days or less.
- Within 14 days of completing your military service for a leave of 31 to 180 days.
- Within 90 days of completing your military service for a leave of more than 180 days.

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury, determined by the Veteran's Administration (VA) to be service connected, will be allowed.

When coverage under this plan is reinstated, all provisions and limitations of this plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this plan. There will be no additional deductible owed for the year as if you had been continuously covered under this plan from your original effective date. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your employer.)

Enforcement: The U.S. Department of Labor Veterans' Employment and Training Service, also known as VETS, is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **866-4-USA-DOL** or visit its website at **dol.gov/agencies/vets/programs/userra**. An interactive online USERRA advisor can be viewed at **webapps.dol.gov/elaws/vets/userra/**.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

Strike or lockout

If you are covered by a collective bargaining agreement and are involved in a strike or lockout, coverage for you and your family may be able to be continued. You must pay the full cost of coverage directly to the union or organization that represents you.

Premium assistance under Medicaid and the Children's Health Insurance Program

If you or your children are eligible for Medicaid or the Children's Health Insurance Program, also known as CHIP, and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Oregon, you can contact your state Medicaid or CHIP office to find out if premium assistance is available. Go online at: **healthcare.oregon.gov** or call **800-699-9075**.

If you or your dependents are **not** currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **877-KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a special enrollment opportunity and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **866-444-EBSA (3272)**.

Genetic Information Nondiscrimination Act of 2008 (H.R. 493 (110th))

The Genetic Information Nondiscrimination Act, also known as GINA, expands the genetic information nondiscrimination protections included in Title I of the Health Insurance Portability and Accountability Act of 1996. Under GINA, group health plans cannot base premiums for a plan or a group of similarly situated individuals on genetic information. GINA generally prohibits plans from requesting or requiring an individual to undergo genetic tests and prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment or for underwriting purposes.

GINA applies generally to group health plans. Unlike the provision under Title I of HIPAA, there is no exception for very small health plans with less than two participants who are current employees.

SCP coverage and benefit provisions will comply with the Genetic Information Nondiscrimination Act of 2008; therefore, SCP members will not be discriminated against based on genetic information.

Notice of opportunity to enroll in connection with extension of dependent coverage to age 26 (section 2714, Patient Protection and Affordable Care Act of 2010)

Individuals whose coverage ended or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26, are eligible to enroll with SCP. Individuals may request enrollment for such children for 30 days from the date of notice. For more information, please refer to the "Member resources" section to contact Customer Service.

Statement of ERISA rights

As a participant in SCP, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive information about your plan and benefits

- Examine, without charge at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. Copies must be furnished no later than 30 days after a written request. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue group health plan coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage, if applicable.

Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan called fiduciaries of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file a suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

This document provides only essential guidance as required by federal guidelines and may not include all rules and requirements. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Certificate of creditable coverage

A covered person who ceases to be covered under the plan will be provided a certificate that evidences the covered person's creditable coverage and the period of that creditable coverage. The time as of which the certificate will be provided and the contents of the certificate are explained below.

Rights to receive certificates

A certificate of creditable coverage will automatically be provided to a covered person upon the occurrence of certain events. In certain cases, a covered person or someone on behalf of the covered person, may also request a certificate.

Automatic provision of certificate

A covered person whose coverage under the plan is to end (or which would end but for the right to elect COBRA continuation coverage) will automatically be provided a creditable coverage certificate. In that event, the certificate will be provided at the time the covered person will lose coverage under the plan or within a reasonable time after such date.

In the case of a covered person who has elected COBRA continuation coverage, a certificate of creditable coverage will be provided upon request.

A certificate automatically provided to a covered person will disclose the last period of the covered person's continuous coverage under the plan.

Provision of certificate upon request

A covered person or someone on behalf of a covered person, may request a certificate of creditable coverage at any time within 24 months of the date that coverage under the plan ended. A request for a certificate can be made even if a certificate was previously provided, including upon a prior request.

A certificate, provided upon request, will disclose each period of continuous coverage that ceased during the 24-month period ending on the date of the request or which was continuing on the date of the request. A separate certificate may be provided for each period of continuous coverage.

Specification of benefits

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

Nondiscrimination notice

Discrimination is against the law

Samaritan Health Plans must follow federal civil rights laws. SHP does not single out people based on their race, color, national origin, age, disability or sex. SHP does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

SHP:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact the SHP compliance officer.

If you believe that SHP has failed to provide these services or treated you differently because of race, color, national origin, age, disability or sex, you can file a grievance with:

By mail: SHP Compliance Officer
PO Box 1310
Corvallis, OR 97339

By phone: **541-768-4550**, **800-832-4580** (TTY **800-735-2900**)

By fax: 541-768-9791

Email: SHPOCompliance@samhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the SHP compliance 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, online through the Office for Civil Rights Complaint Portal, available at **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 **hhs.gov/ocr/office/file**.

Plan administration

Other authorities and responsibilities

Samaritan Health Services (SHS) has the discretionary authority to interpret the plan, in order to make eligibility and benefit determinations, as it may determine in its sole discretion. SHS also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the plan.

SHS, as the plan administrator, may give other decision-makers the authority to interpret the plan, to resolve and interpret any ambiguities that exist, and to make factual determinations on behalf of Samaritan Choice Plans.

The plan is administered by Samaritan Health Plans, a division of SHS, the plan administrator and the named fiduciary for all purposes except deciding benefit claims. The Human Resources vice president of SHS is the person who acts on behalf of the plan administrator. SHS has agreed to indemnify the Human Resources vice president for any liability that incurs as a result of acting on behalf of the plan administrator, unless such liability is due to gross negligence or misconduct. SHS and SHP share a responsibility for administering the plan as discussed in this document.

Compliance with state and federal mandates

To the extent applicable, the plan will provide benefits in accordance with the requirements of all applicable laws and as described in this document, including the Employee Retirement Income Security Act of 1974, the Uniformed Services Employment and Reemployment Rights Act of 1994, the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Health Insurance Portability and Accountability Act of 1996. These laws have been amended from time to time. In the event of any conflict between these provisions and the current provisions of the law, the current provisions of the law shall govern.

Definitions

Affordable Care Act or ACA: The ACA is the comprehensive health care reform law enacted in March 2010. It includes tax provisions that affect individuals, families, businesses, insurers, tax-exempt organizations and government entities. These tax provisions change how individuals and families file their taxes. The law also contains benefits and responsibilities for other organizations and employers.

Allowed amount: Maximum amount on which payment is based for covered health care services. This is the amount that is payable to the provider of service for medically necessary covered services. This may be called, eligible expenses, payment allowance or negotiated rate. This amount is the combination of the SCP payment and any deductible, coinsurance or copayment owed by the member. Amounts allocated to these cost shares are so indicated by the explanation of benefits (EOB). Contracted providers must write off, or not charge, the Samaritan Choice Plans' member for balances other than the deductible, coinsurance or copayment. Providers may collect, from members, for services that are not covered services under the SCP policy. If your provider charges more than the allowed amount, you may have to pay the difference. See the "Balance billing" section.)

Annual enrollment: A period of time, each year (usually held during October or November), when eligible employees can enroll in the plan or make plan changes as appropriate for themselves and their dependents.

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

Balance billing: When a provider bills the member for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider may not balance bill you for covered services.

Bright Futures: A national health promotion and prevention initiative led by the American Academy of Pediatrics and supported, in part, by the US Department of Health and Human Services, Health Resources and Services Administration and the Maternal and Child Health Bureau. The Bright Futures Guidelines provide theory-based and evidence-driven guidance for all preventive care and screenings and well-child visits.

Calendar year: The period starting on Jan. 1 and ending on Dec. 31 each year.

Claim: A request for a benefit (including reimbursement of a health care expense), made by you or your health care provider to your health insurer or plan, for items or services you think are covered.

Claims administrator: SHS serves as the claims administrator with respect to claims made under this plan.

Clean claim: A claim that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Consolidated Omnibus Budget Reconciliation Act or COBRA: COBRA allows for coverage to continue when a qualifying event occurs causing the loss of plan coverage. The group health plan must offer the qualified beneficiary an opportunity to elect the same group health plan coverage in effect on the day before the qualifying event.

Coinsurance: This amount is one type of cost share for which a member is responsible. Coinsurance is defined as a percentage of the allowed amount. It applies after the deductible and any applicable copays have been met. Coinsurance amounts vary between network utilization and service. Your share of the costs of a covered health care service, calculated as a percent (for example, 30%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 30% would be $30. The health insurance or plan pays the rest of the allowed amount.

Coordination of benefits: A method for determining the amount that each plan should pay when a covered person is covered under two or more health care plans. The coordination of benefit rules determine which plan is primary and which plan is secondary, thus coordinating benefits between the two plans. Please refer to the "General provisions" section for more information.

Copayment or copay: This type of cost share is a fixed amount (for example, $25) that you pay for a covered health care service, in place of or before the application of coinsurance. Members are responsible for copays and/or coinsurance at the time of service, after the deductible has been met, when a deductible applies. The amount can vary by the type of covered health care service.

Cost sharing: In health care, cost sharing occurs when members pay for a portion of health care costs for covered services, which are eligible for reimbursement by the health insurance plan. This term generally includes deductibles, coinsurance and copayments or similar charges. These charges may or may not apply to your out-of-pocket limit as designated by your plan.

Covered person: A covered employee, a covered dependent or a COBRA member who has completed the enrollment requirements and for whom applicable contribution or payroll deduction for premium has been made in the current month, in accordance to applicable rules and regulations.

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

Employer: SHS and any other affiliated entity that adopts the plan. Participants and beneficiaries may receive from the plan administrator, upon written request, a complete list of affiliated entities adopting the plan.

Excluded services: Health care services that your health insurance or plan does not pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Health insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a policy or plan.

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: A personal bodily injury to a covered person caused solely by external, violent, and/or accidental means and resulting directly or indirectly of all other causes in an eligible expense.

In-network: A provider or facility who has a contract with SHP and who has agreed to provide services to members of the plan. You generally will have a reduced out-of-pocket expense if you see a provider in the network.

In-network coinsurance: This cost share is a 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 costs you less than out-of-network coinsurance.

In-network copayment or copay: This cost share is 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.

In-network provider: A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called, preferred provider, participating provider or contracted provider. Be aware, your in-network provider might use an out-of-network provider for some services (such as lab work). Out-of-network services will have increased cost shares. Check with your provider before you receive services.

Maximum plan allowable or MPA: The MPA amount that we use to calculate what we pay for services and medical supplies provided by an out-of-network provider. MPA may be less than the amount billed for those services and medical 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.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Open enrollment period: The time each year during which eligible employees may change elections regarding coverage and add dependents who may not have been previously enrolled.

Ophthalmologist: A medical provider who specializes in eye and vision care. Services are covered by your medical plan.

Optometrist: A doctor of optometry that provides eye and vision care, including exams to detect vision problems and prescribes corrective lenses.

Out-of-network: A provider or facility who does not have a contract with SHP or its network vendor partners.

Out-of-network coinsurance: This cost share is the percent (for example, 30%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network copayment: This cost share is a fixed amount (for example $35) you pay for covered health care services from providers who do not contract with the plan. Out-of-network copayments are usually higher than in-network copayments.

Out-of-network provider: A provider who does not have a contract with the plan to provide services to you. You'll pay more to see an out-of-network provider. Also called non-preferred provider, nonparticipating provider or non-contracted provider.

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

Plan: Samaritan Choice Plans (SCP), which is described in this document. A benefit SHS provides to you, to help pay for your health care services.

Premium: The amount that must be paid for your health insurance or plan. You and/or your employer pay a portion every pay period. COBRA members will pay their premium monthly.

Prior authorization: A determination by your health insurer or plan that a health care service, treatment plan, prescription drug, medical equipment or medical supplies are medically necessary. Sometimes called preauthorization, prior approval or precertification. Your health insurer or plan may require prior authorization for certain services before you receive them, except in an emergency. Prior authorization isn't a promise your health insurer or plan will cover the cost as all services submitted must meet all plan provisions as outlined in this document. There are different prior authorization requirements for the medical and pharmacy plans.

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

Provider: A health care professional or health care facility licensed, registered or accredited as required by state law.

Screening: A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs or prevailing medical history or a disease or condition.

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

Summary plan description

General information: Name of plan	Samaritan Health Services benefit plan Plan no. 505
Name and address of plan sponsor/employer	Samaritan Health Services 3600 NW Samaritan Drive Corvallis, OR 97330 You may obtain a current list of employers that have adopted the plan by writing to the administrator.
Employer tax ID number	93-0951989
Type of plans	Group medical plan/preferred provider organization
Type of administration	Self-funded plan administered according to this document and agreement with the claims administrator, SHS.
Name of plan administration	Samaritan Health Plans, a division of Samaritan Health Services PO Box 1310 Corvallis, OR 97339-0336 Phone: **541-768-4550** or **800-832-4580** (TTY **800-735-2900**)
Agent for service of legal process	Tyler Jacobsen, vice president and general counsel 3600 NW Samaritan Drive Corvallis, OR 97330 Phone: **541-768-4550** Legal process may also be served on the administrator.
Contributions	Employer and employee contributions. Contribution rates are reviewed and determined by the plan sponsor in its sole discretion.
Plan year	Jan. 1 through Dec. 31
Plan continuation	The employer intends to continue the plan indefinitely, but it reserves the right to discontinue or change the plan at any time, without the consent of any participant or beneficiary.
Modifications or termination of the plan	The plan may be amended from time to time by SHS to make any changes that it believes are appropriate, including, but not limited to, changes in benefits or eligibility requirements. The plan may also be suspended or terminated at any time by SHS.
No guarantee of employment	Your participation in this plan does not guarantee your continued employment with SHS. If you quit, are discharged or laid off, this plan does not give you a right to any benefit or interest in the plan except as specifically provided in this document.

2300 NW Walnut Blvd., Corvallis, OR 97330
800-832-4580 (TTY 800-735-2900)

samhealthplans.org/Choice

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