Samaritan Health Plans

Samaritan Choice Plans

Medical and pharmacy benefits

Your Samaritan employee health plan
medical and pharmacy benefits handbook.

2025

Introduction

This Member Handbook contains important information about the health plan coverage offered to Samaritan Health Services' (SHS) employees. It is important to read this Member Handbook carefully as it explains your benefits and member responsibilities. If you do not understand a term that is used, please refer to the definitions section. Should you require additional information concerning this plan or any other topic related to medical insurance, please contact the plan administrator at the number below. It serves as both the plan document and the summary plan description and is designed to explain your plan as of Jan. 1, 2024. Throughout the document, plan refers to all Samaritan Choice Medical and Pharmacy Plan options, unless otherwise stated.

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

Customer Service Department
Monday through Friday, 8 a.m. to 8 p.m.
541-768-4550 or 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: HealthPlanResponse@samhealth.org.

By mail: PO Box 1310, Corvallis, OR 97339

Member website offers 24/7 access to plan details:

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

- **Find care:** search in-network for doctors and specialties near you.
- **Search drug list:** search for your drug coverage and costs.
- **Member materials:** look at the plan materials.

Member portal offers 24/7 access to claims information:

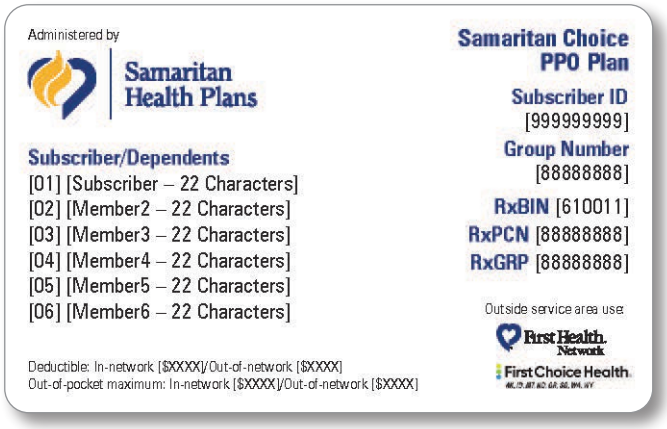
Go to **MyHealthPlan.samhealth.org** to take advantage of the following online tools:

- 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:



Out-of-pocket limits and deductibles

Please refer to the "Schedule of Benefits" and additional information throughout this document for further explanations of your benefits, including limitations and exclusions.

Your annual out-of-pocket limit

This plan has an out-of-pocket limit to protect you from excessive medical expenses. If you incur covered expenses over that amount, this plan will pay 100% of eligible charges for the rest of the calendar year. Those services that do not apply to your out-of-pocket limit will not be covered at 100% after your out-of-pocket limit has been met. Regular cost sharing will apply to these benefits.

Samaritan Choice PPO Plan: Integrated medical and pharmacy out-of-pocket limit

- In-network providers: $7,200 per person/$14,400 per family, per calendar year.
- Out-of-network providers: unlimited.
- Once the applicable in-network out-of-pocket limit has been met, this plan will pay 100% of the allowed amount for covered services at the applicable in-network benefit level, for the rest of that calendar year.
- The pharmacy benefit has an integrated out-of-pocket limit with the medical plan.

Samaritan Choice High-Deductible Health Plan with HSA:
Integrated medical and pharmacy out-of-pocket limit

- In-network providers: $5,000 per person/$10,000 per family, per calendar year.
- Out-of-network providers: unlimited.
- Once the applicable in-network out-of-pocket limit has been met, this plan will pay 100% of the allowed amount for covered services at the applicable in-network benefit level, for the rest of that calendar year.
- The pharmacy benefit has an integrated out-of-pocket limit with the medical plan.

Expenses for the following DO NOT count toward your out-of-pocket limit

Samaritan Choice PPO Plan:

- Bariatric surgery copays.
- Benefits paid in full by the plan (for example, vision hardware).
- Charges in excess of the maximum plan allowable (MPA).
- Incurred charges that exceed allowed amounts under this plan.
- Non-covered services, including those where a third party is responsible (COB, settlements, motor vehicle claims).
- Non-medically necessary services, such as excluded services or those deemed to be not medically necessary by the plan.
- Panniculectomies.
- Fertility benefits.

Samaritan Choice High-Deductible Health Plan with HSA:

- Benefits paid in full by the plan (for example, vision hardware).
- Charges in excess of the maximum plan allowable (MPA).
- Incurred charges that exceed allowed amounts under this plan.
- Non-covered services, including those where a third party is responsible (COB, settlements, motor vehicle claims).
- Non-medically necessary services, such as excluded services or those deemed to be not medically necessary by the plan.
- Other services that are specifically called out in this document.

Information about your deductible

The deductible amount for individuals and families is listed in the Schedule of Benefits. No family will have to satisfy more than the annual family deductible each calendar year.

The following DO NOT count toward the deductible

Samaritan Choice PPO Plan:

- **Some** preventive services do not apply to your deductible obligation.
- Bariatric surgery copays.
- Panniculectomies.
- Other services outlined in this document.

Samaritan Choice High-Deductible Health Plan with HSA:

- **Some** preventive services do not apply to your deductible obligation.

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 Samaritan Health Plans 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 for evaluation. 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.
- Services rendered.
- Date of service.
- Provider name.
- Charged amount by service received.
- Where you received services.
- Diagnosis.
- 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.

SCP does not cover services for the sole purpose of travel, school, work or occupation (for example, immunizations, routine physicals or laboratory services). SCP will **only** cover drugs up to a ninety (90) day supply, even when drugs are needed for vacations, travel, school or work for long periods of time.

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.

Medical plan benefits

* May require prior authorization. Please refer to the "Prior authorization" section for more information.

This plan provides benefits for the following services and supplies. These services and supplies may have additional **cost shares** and may be subject to additional limitations and exclusions. Please refer to the Schedule of Benefits and the "Benefit exclusions" section of this document for more information.

Acupuncture: Treatment and services for acupuncture by a licensed acupuncturist are covered.

Ambulance: Services of a state-certified ambulance are covered. Air transportation is also covered, but only to the nearest hospital capable of treatment when ground transportation is inappropriate, and when medically necessary. An out-of-network ground ambulance may bill more than the plan allows. The difference between the plan allowable and billed amount may be the responsibility of the member.

Bariatric surgery*: Roux-en-Y laparoscopic adjustable gastric banding, laparoscopic vertical sleeve gastrectomy and other types of bariatric surgery may be covered when the following criteria are met:

1. Body mass index (BMI) greater than or equal to 40 kg/m2.

OR

2. BMI greater than or equal to 35 kg/m2 with **one** of the following co-morbid conditions, which are expected to be improved with surgery:
   - Hypertension.
   - Diabetes.
   - Hyperlipidemia.
   - Sleep apnea.
   - Coronary artery disease.
   - Documented weight loss of greater than 5% after entering SHS Bariatric Surgery Program.
3. Psychological evaluation by psychologist or psychiatrist, approved by the SHS Bariatric Surgery Program, documenting absence of psychopathology that would interfere with understanding or compliance with surgical program. Examples: personality disorder, uncontrolled substance use disorder, uncontrolled major mood or thought disorder.

OR

   Same evaluation demonstrates presence of psychological issues that are controlled and will not compromise surgical outcome.

   Please note: Medical insurance will pay for evaluation only. Mental health treatment is covered under the mental health benefit, whether or not it is related to obesity.

4. Documentation of previous compliance with medical care and willingness to comply with preoperative and postoperative treatment plans.
5. No medical condition that would make the surgery unusually risky.
6. Age 18 or older.
7. Covered only at Good Samaritan Regional Medical Center (GSRMC) through the SHS Bariatric Surgery Program and subject to its policies and surgical criteria.

Inpatient hospital copay of $5,000, which does not include program educational fees or copays for professional services (for example, office visits and/or surgery). For the PPO Plan, the inpatient hospital **copay of $5,000 does not apply to the member's annual out-of-pocket limit or deductible**.

Biofeedback*: Services for biofeedback are covered when medically necessary. Covered services are paid based on place of service, provider type and provider billing.

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

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

1. Have a heart condition where exercise is standard treatment.
2. Need medical monitoring and supervision to exercise with safety.
3. The exercise program is ordered by a physician, physician assistant (PA) or nurse practitioner (NP).

This plan covers cardiac rehabilitation for phase I when provided in an inpatient setting and phase II when provided in a short-term outpatient setting.

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

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

Chemotherapy: Chemotherapy is covered and paid based on the type of chemotherapy you receive and where services are rendered. There may be cost sharing for drugs used. Please refer to the "Prescription Drug Services" section of this document.

Chiropractic: Coverage is provided for chiropractic manipulation as stated in the Schedule of Benefits. To be eligible for coverage, all chiropractic manipulation services must be medically necessary and within the provider's scope of license.

Circumcision*: Circumcision for a newborn/infant is covered. For the purposes of this benefit, a newborn/infant is defined as any child being 3 months of age or younger. Medically necessary circumcision for a non-newborn is also covered.

Clinical trial*: Clinical trial services will be covered in accordance with the Affordable Care Act (ACA). The ACA mandates coverage of all medically necessary charges associated with the clinical trial, such as physician charges, labs, X-rays, professional fees and other routine medical costs which meet a standard of care. The coverage does not include charges for the actual device, equipment or drug(s) that are typically given to participating patients free of charge by the medical device or pharmaceutical company sponsoring the trial. Services will be covered under the applicable benefits and in accordance with the provisions outlined by the services billed by the provider and will follow all provisions of this document.

Colonoscopy (non-preventive)*: Non-preventive colonoscopy services (non-preventive is a service being done with a predetermined diagnosis or presenting with a health problem) will be paid the same as an outpatient surgery. Colorectal screening is covered under the preventive benefit.

Complete Health Improvement Program (CHIP): A lifestyle medicine program scientifically proven to help people improve their blood pressure, cholesterol, triglycerides, blood sugar, body mass index (BMI), sleep, resilience and depression. The program integrates optimal nutrition, exercise and behavioral psychology principles and tools to help participants achieve their health goals. Program materials will be reimbursed up to $150. Services outside of program materials will be covered if they meet all plan provisions and are directly billed by a provider. All plan provisions apply for services billed and will be reimbursed in accordance to the benefit that is applied.

Cosmetic and/or reconstructive surgery*: Covered services are paid according to the plan, under the following circumstances, when medically necessary:

- Reconstructive surgery to primarily correct a functional disorder, which may or may not result from the initial surgery.
- Breast reconstruction following medically necessary mastectomy, including reconstruction of the opposite breast to achieve cosmetic symmetry.
- Reconstructive surgery necessitated by an accidental injury or that is medically approved by the plan.
- Surgery to correct a facial scar or defect, resulting from medically necessary surgery, that was covered or would have been covered under this plan.
- Surgery to correct a scar or defect resulting from surgery for cancer.
- Surgery to correct a congenital defect.

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

- Only one (1) attempt at reconstruction is covered following the initial injury or surgery.
- The reconstruction must be undertaken within 18 months of the original injury or surgery. This limit does not apply to children who sustain injury prior to their full physical developmental age or who are born with congenital defects requiring reconstructive surgery.

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

Dental hospitalization*: Dental hospitalization is covered under certain circumstances. Hospitalization because of the patient's apprehension or convenience is not covered. Only charges for the hospital, anesthesiologist and physician assistant are covered. Situations that may qualify for this benefit include:

- When a major dental procedure is necessary, such as multiple extraction or removal of impacted teeth or oral tumors.
- When the patient has another serious medical condition that may complicate the dental procedure.
- When pediatric dental care is required. The plan pays for outpatient care, general anesthesia and special supplies.

Dental medical*: Services of a dentist or physician, to medically treat injury of the jaw or natural teeth, are covered within the provisions of this plan. Generally, these services are not covered under your dental plan. When it is uncertain if a dental service meets the medical criteria, we may request you submit to the dental carrier first, to coordinate coverage. Services include restoring broken teeth to a state of functional acceptability determined by the plan and must be provided within 180 days of the injury.

Treatment and services for temporomandibular joint (TMJ) are not covered. Dental medical services are covered for, but not limited to, tumors, leukoplakia and premalignant lesions, trauma to jaw, acute damage to teeth, jaw fracture, lacerations in the mouth, infection beyond tooth or gum (facial cellulites, infection beyond tonsillar pillar, systemic disease manifestations in the mouth such as, lichen planus and Sjogren's syndrome). The plan pays for outpatient care, general anesthesia and special supplies. Emergency room visits, as a result of tooth or mouth pain of an unknown origin, are covered if the member is not presenting with an already determined dental issue.

Diabetic education: Services of a certified diabetes educator (CDE), for diabetes self-management education programs, are covered. This means outpatient instruction for diabetics about the disease and its control, taught by a CDE. For the PPO Plan, covered expenses are paid at 100% if received through a Samaritan Health Services provider. For the High-Deductible Health Plan with HSA, covered expenses are paid at 100%, after the deductible has been met, if received through a Samaritan Health Services provider.

Diabetic supplies: Diabetic supplies are covered. Eligible supplies are defined as continuous glucose monitors, gauzes, syringes, needles, lancets, alcohol and alcohol swabs, and betadine swabs. Some items can be purchased at a pharmacy. When diabetic supplies are purchased at a pharmacy, refer to the "Prescription drug benefits" section. Please refer to benefit schedule for cost shares.

Dialysis: Dialysis is covered.

Durable medical equipment (DME), prosthetics, orthotics and medical supplies*: The purchase or rental of DME (including crutches, wheelchairs, orthopedic braces, glucometers and equipment for administering oxygen), prosthetics, orthotics and medical supplies are covered. DME, prosthetics, orthotics and medical supplies must be prescribed in writing by a licensed MD, DO, DDS, DMD, DPM, physician assistant or nurse practitioner acting within the scope of their license. DME, prosthetics and orthotics must be purchased or rented through a licensed supplier. Medical supplies obtained from a licensed supplier or retailer may be covered with a written prescription. Please refer to the "Benefit exclusions" section for more information on items not covered.

- **Artificial limbs and eyes:** Prosthetics that are not power assisted are covered. Power assisted prosthetics are excluded and not covered. Repairs to existing prosthetics (even if acquired by non-Samaritan providers or before SCP coverage) are also covered up to the cost of replacement.
- **Bras:** Following a mastectomy, bras are covered under Samaritan Choice Plans DME, prosthetics, orthotics and medical supplies benefit without a limit to the number of bras allowed per year. Swimwear is not covered for any reason under the plan.
- **Breast prosthesis:** Both internal or external breast prosthesis, as a result of a mastectomy are covered, regardless where the original service took place. Removal or replacement of breast prosthesis is covered only according to certain criteria. For more information, please refer to the "Member Resources" section to contact Customer Service. The Women's Health and Cancer Rights Act (WHCRA) requires SCP to cover services that support rehabilitation and reconstruction services, in the instance that a member receives these services due to cancer and related treatment.
- **Breast pumps and supplies:** Breast pumps and supplies are covered under the preventive benefit, no prescription is required. When purchased at an out-of-network provider, this benefit will be considered out-of-network and a higher coinsurance will apply.
- **Diabetic equipment:** Eligible equipment is covered. Diabetic equipment is defined as: diabetic pumps, glucose monitors, test strips, diabetic shoes and inserts, and diabetic shoe fitting. Diabetic supplies are considered a separate benefit from diabetic equipment. Please refer to the diabetic supplies benefit for more information.
- **Maxillofacial prosthetic services:** Services to restore and manage head and facial structures, that cannot be replaced with living tissue, are covered. The treatment must be necessary to control or eliminate infection or pain. Treatment is only covered when the damage results from disease, trauma or birth and developmental deformities. Cosmetic procedures are not covered.
- **Orthotics:** Eligible devices are covered if medically necessary to restore or maintain the ability to complete activities of daily living. This can include custom made or fitted foot orthotics. A licensed physician or podiatrist must prescribe the device. There is a $500 lifetime limit for members 18 years and older, members 17 years and under do not have a lifetime limit.
- **Prosthetics:** Eligible devices are covered if medically necessary to restore or maintain the ability to complete activities of daily living. Power-assisted prosthetics are not covered. Repairs to existing prosthetics (even if acquired before the member's coverage under the plan) are also covered up to the cost of replacement.
- **Vision hardware:** Services after cataract surgery or due to medical needs, are covered under the DME, prosthetics, orthotics and medical supplies benefit. Hardware needed after cataract surgery is a one-time, per eye benefit.

Emergency services: Services are covered in accordance to applicable rules and regulations. When feasible, emergency care/emergency service should be obtained at a Samaritan Health Services (SHS) facility.

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

Education services: This benefit is for education service office visits performed by an in-network provider. Regular cost sharing remains for out-of-network providers. Please refer to the Schedule of Benefits for cost share information.

Fertility services: The PPO Plan covers fertility services, up to a $20,000 annual, $60,000 lifetime maximum, including:

- 20% coinsurance, not subject to deductible and does not apply to OOPM.
- Assistance Reproductive Technology Services (ARTs) and artificial insemination up to the annual benefit maximum including:
  - i. IVF – in-vitro fertilization.
  - ii. ZIFT – zygote intra-fallopian transfer.
  - iii. GIFT – gamete intra-fallopian transfer.
  - iv. PGSD – pre-implantation genetic diagnosis.
  - v. ICSI – intracytoplasmic sperm injection.
  - vi. ovum microsurgery.
  - vii. related prescription medications.
  - viii. artificial insemination (including Intrauterine insemination (IUI)), limited to a lifetime maximum of six cycles and sperm wash.

Other fertility services include:

- 50% coinsurance, not subject to deductible and does not apply to OOPM.
  - a. Diagnostic testing and related office visits to determine the cause of infertility.
  - b. Examination, related laboratory testing, and medical and surgical procedures to treat infertility.
  - c. Acquisition cost for semen.
  - d. Infertility-related medications or injectables.
  - e. Covered infertility-related supplies.
  - f. Egg/ovum/embryo cryopreservation and storage

The PPO Plan does not cover donor semen from donor banks or other providers, harvesting and storage of semen other than for immediate use, services for unenrolled surrogate mothers, reversals of voluntary sterilization and procedures determined to be experimental or investigational.

Please refer to the Schedule of Benefits for cost-share information and annual limits regarding fertility services.

Annual maximum	Lifetime limit
$20,000 does not apply to deductible or out-of-pocket limit	$60,000 does not apply to deductible or out-of-pocket limit

Genetic testing*: Covered services are paid according to the plan. Standard prenatal testing does not require prior authorization.

Hearing aids: Covered up to $3,000 every three (3) years, after deductible, for members 21 years of age and over. There is no limit for children ages 20 and under. Repairs and accessories to hearing aids will be paid through the annual limit. Fittings and medically appropriate services for cochlear implants are covered. Batteries are not covered.

Home health: Covered services are paid according to the plan. Services provided during your home health visit may apply to other benefits and other cost shares may apply. For example, if physical therapy is done in your home, this service will be paid under the physical therapy benefit.

Hospice: Covered services are paid according to the plan.

Infusion*: Infusion is covered and is paid by the plan based on the type of infusion you receive and where you receive it. You may have pharmacy costs for the drugs used during your infusion services. Please refer to the "Prescription drug benefits" section for more information.

Injections*: Injections done in an office by your primary care or specialist provider will apply an office visit and an injectable cost share. If you are receiving an injection drug at a pharmacy, only your pharmacy benefit will be applied. Please refer to the "Prescription drug services" section of this document for more information.

Inpatient hospital*: Medically necessary hospital inpatient services are covered. SHP must be notified of an emergency admit within 48 hours or as soon as reasonably possible. Charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit or private room for septicemic-caused isolation or when a private room is medically necessary. Covered inpatient hospital services may include (but are not limited to):

- Semi-private room.
- Cardiac care unit.
- Operating room.
- Anesthesia and post-anesthesia recovery.
- Respiratory care.
- Inpatient drugs.
- Lab and radiology services.
- Dressings, equipment and other necessary supplies.

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

Inpatient rehabilitative services*: Medically necessary inpatient rehabilitative services to restore and improve lost body functions after illness or injury are covered. The services must be consistent with the condition being treated and must be part of a formal written treatment program prescribed by a physician.

Laboratory services*: Laboratory services provided by a physician or prescribed by a physician and provided by a lab are covered. Please see the Schedule of Benefits for your cost share description for these services; not all laboratory services will have the same cost share.

Mastectomy services*: Either an internal or external breast prosthesis, as a result of a mastectomy, regardless where the original service took place, is covered. Removal or replacement of breast prosthesis is covered only according to certain criteria. Bras following a mastectomy are covered under Samaritan Choice Plans DME, prosthetics, orthotics and medical supplies benefit. No authorization is needed and there is no limit to the number of bras allowed per year. Swimwear is not covered for any reason under the plan. For more information, please refer to the "Member resources" section to contact Customer Service.

The Women's Health and Cancer Rights Act (WHCRA) requires SCP to cover services that support rehabilitation and reconstruction services, in the instance that a member receives these services due to cancer and related treatment.

Maternity care*: Services of a physician or certified nurse midwife (CNM) for maternity care are covered when done in an appropriate facility. Planned births in the home are not covered. Services are subject to the same payment amounts, conditions and limitations that apply to similar expenses for illness. Under federal law, the plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery (less than 96 hours following a caesarean section) or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods.

Medical foods*: Covered services are paid according to the plan under the DME, prosthetics, orthotics and medical supplies benefit. Services for a non-prescription elemental enteral formula for home use is covered if:

- The formula is medically necessary for the treatment of severe intestinal malabsorption.
- A provider has issued a written order for the formula.
- The formula comprises the sole source or an essential source of nutrition.

If a non-prescription elemental enteral formula is ordered by a provider, the provider must write a prescription for the item and the member will need to submit a member reimbursement form with supporting documentation, including a copy of the prescription.

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

Mental health*: The plan complies with Federal Mental Health Parity.

Benefits are provided for mental health services at the same level as and subject to limitations no more restrictive than those imposed on coverage or reimbursement for medically necessary treatment for other medical conditions.

Covered services include diagnostic evaluation, individual and group therapy, inpatient hospitalization, residential, day, intensive outpatient, or partial hospitalization Services.

All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be prior authorized. In an emergency situation, go directly to a hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Samaritan Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, for coverage to continue.

Nursery care*: Routine nursery care of eligible newborns while the mother is hospitalized and eligible for maternity benefits under this plan are covered. Planned births in the home are not covered. Please refer to the "How and when to enroll" section to ensure that your newborn is properly enrolled to receive benefits.

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

Nutritional therapy and/or counseling: Nutritional counseling services of a registered and licensed dietician for the treatment of celiac sprue, hyperlipidemia, eating disorders, obesity or otherwise stated as medically necessary by a physician referral, will be paid based on place of service, provider type and provider billing. Registered and licensed dieticians are considered specialists.

Occupational therapy: Occupational therapy is covered. Services must be performed by an occupational therapist and prescribed by a licensed MD, DO, DDS, DMD or DPM. The written prescription must include site, modality, duration and frequency of treatment.

Osteopathic manipulation: Osteopathic manipulation is covered. This service will be paid based on place of service, provider type and provider billing. Any accumulators or limits will apply.

Outpatient surgery*: Medically necessary services meeting a standard of care are covered based on all plan provisions. Outpatient settings include hospital outpatient departments, ambulatory surgical facilities and clinics. Outpatient surgery may be subject to professional and facility fee copays. Services will be paid based on place of service, provider type and provider billing.

Pain management*: Services provided as part of a pain management treatment plan or done within a pain management clinic are covered based on the provisions of the plan. Services are paid based on place of service, provider type and provider billing.

Panniculectomy*: This service must be provided at an in-network provider facility and will only be allowed after bariatric surgery has been authorized and performed by an in-network/designated facility. Charges submitted by an out-of-network provider for this service will not be paid by the plan. For the PPO Plan, cost shares for panniculectomy services will not apply to your deductible or out-of-pocket limit.

Physical therapy: Services of licensed physical therapists for physical therapy are covered. This service does not require a physician referral, also known as direct access. Services will be paid based on place of service, provider type and provider billing.

- **SamFit/SAM Elite conditioning and training option:** When a Samaritan physical therapist refers a member for SamFit/SAM conditioning and training in accordance to the criteria below, the member may have up to three months of a SamFit gym membership paid at one time or three months of a Samaritan Athletic Medicine (SAM) membership paid at one time.
    - Member must benefit from physical conditioning to support the member's recovery of the condition treated, while reducing the risk of reoccurrence.
    - The member must require additional assistance in performing specific rehabilitative exercises, so that further injuries can be avoided.

  Additional conditioning and training services may be reimbursed through an additional review and referral of a Samaritan physical therapist supporting that the member meets the criteria above. Services will only be reimbursed if the member is eligible under the plan at the time services are rendered and only when provided at a SamFit location or at the SAM with appropriate staff where required.

  The SamFit/SAM conditioning and training option benefit is specific to SCP and is not a benefit that can be coordinated between multiple plan coverages. This benefit applies to all members on a SCP plan. For the SCP PPO Plan, the SamFit/SAM conditioning and training option benefit does not apply to deductible. For the High-Deductible Health Plan with HSA, the SamFit/SAM conditioning and training option benefit applies to deductible.

Preventive care services: Preventive care services, as defined by the Affordable Care Act (ACA), do not require cost sharing when received by an in-network provider. Out-of-network services will have cost sharing applied. Health care reform preventive service requirements are developed through the guidelines provided by the US Preventive Task Force (USPTF), Advisory Committee on Immunizations Practices of the Centers of Disease Control and Health Resources and Services Administration.

This plan allows for reasonable charges of a covered provider for preventive care services as medically appropriate. If you have a question(s) as to whether a service is preventive, please contact Customer Service.

The preventive services listed below are only **recommendations and do not represent a full list**:

- **Preventive colorectal screenings:** Services for routine colorectal cancer screenings are covered as defined by rule and regulation. Additionally, SCP will also consider screenings for any individual at high risk as part of the individual's routine preventive care.

  For the purposes of this plan, members that are at high risk for colorectal cancer are:
    - Individuals who have a family history of colorectal cancer.
    - A prior occurrence of cancer or precursor neoplastic polyps.
    - A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, chronic disease or ulcerative colitis.
- **Preventive gynecological exams:** These services are covered.
- **Preventive immunizations:** We cover immunizations recommended by the Center for Disease Control and Prevention as medically appropriate. Human papilloma virus (HPV) vaccine is covered as medically appropriate as determined by the member's physician. Covered services do not include immunizations for the sole purpose of travel, school, work/occupation or residence in a foreign country. Please refer to the "Benefit exclusions" section.

- **Preventive prostate screening:** Preventive prostate screening exams are covered each calendar year for men age 50 and over.
- **Preventive routine physical exams:** Preventive routine physical exams can include related lab and radiology services and bone density screening for patients considered at risk per Medicare guidelines.
- **Preventive screening mammograms:** Preventive screening mammograms are covered.
- **Preventive well baby care:** Preventive well baby care is covered.
- **Preventive women's care services:** Preventive women's care services are covered.

Primary care provider (PCP) services: Medically necessary services of a PCP are covered, as determined by the plan.

Provider services: Services of a provider are covered, as determined by the plan, for diagnosis or medically appropriate treatment of illness or injury and for preventive services. Not all provider services will assess the same copayment. Please review your Schedule of Benefits or call Customer Service to determine cost share.

Radiology services*: Radiology services provided by a physician, or prescribed by a provider and provided by a lab or radiology facility, are covered. Covered services include (but are not limited to) diagnostic and therapeutic services, fluoroscopy, X-rays, MRIs and CT scans. Please see your Schedule of Benefits for your cost share description for these services; not all radiology services will have the same cost share. Please ensure you are aware of your cost sharing for these benefits. Some of these services will have a different cost share based on what benefit they fall under. For example, if they are preventive, they may not have a cost share to the member.

Skilled nursing facility (SNF)*: Services of a SNF are covered for up to 60 days per calendar year. Custodial care is not a covered service.

Sleep lab: Sleep lab services are covered when done in a home or hospital setting.

Smoking cessation: SCP offer ways to help you stop using tobacco, including nicotine replacement therapy (NRT), as well as various classes offered through SHS. For more information about this and other options, please refer to the "Member resources" section to contact Customer Service. If your doctor feels that you need a prescription to help you quit tobacco, SCP will pay for nicotine replacement therapy (NRT).

Specialist provider services: Services provided by a provider who is not defined as a primary care provider. A primary care provider is defined as a pediatric, family medicine, internal medicine, naturopath or OB-GYN provider. Please refer to the Schedule of Benefits for appropriate cost sharing.

Speech therapy: Services of a certified speech therapist are covered. Benefits are limited to speech delay in children ages seven or younger, cleft palate or to restore speech after brain trauma or stroke or after injury to or removal of neoplasm from the larynx. For restoration of speech after brain trauma or stroke or after injury to or removal of neoplasm from the larynx, speech therapy must begin within 12 months of the injury or illness. Speech therapy for the treatment of autism is covered.

Substance use disorder*: Benefits are provided for substance use disorder services at the same level as and subject to limitations no more restrictive than those imposed on coverage or reimbursement for medically necessary treatment for other medical conditions.

Covered services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 5.4, residential, day, intensive outpatient, or partial hospitalization Services when they are medically necessary. Prior authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment services. Treatments involving the use of methadone are a covered service only when such treatment is part of a medically supervised treatment program that has been prior authorized. In an emergency situation, go directly to a hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Samaritan Health Plans must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, for coverage to continue.

Termination of pregnancy: Covered services include those done because pregnancy would cause the mother hardship, endanger the life or health or because prenatal testing has shown that the fetus will be born with severe abnormalities, as determined by the plan.

Transplant services*: This plan covers medically necessary organ and tissue transplants. This plan also covers the medical and hospital expenses of the donor when the transplant recipient is insured by SCP.

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

- Kidney.
- Kidney-pancreas. (under certain conditions).
- Heart.
- Heart-lung.
- Lung.
- Liver (under certain criteria).
- Corneal (no prior authorization required).
- Bone marrow and peripheral blood stem cell (under certain criteria).

This plan only covers transplant of human body organs and tissues. Transplants of artificial or animal organs and tissues are not covered. Benefits are limited to one transplant per organ or tissue.

For detailed transplant criteria, please refer to the "Member resources" section for information on how to contact Customer Service.

Transplant reimbursement: The following will address how transplant services are reimbursed under SCP:

- **Facility services; in-network:** Covered services for hospitals and other facilities are reimbursed in full of the allowed amount less applicable copays, coinsurance and deductible.
- **Facility services; out-of-network:**
  - SCP will coordinate with in-network hospitals and other facilities to provide transplant services wherever possible. When an in-network hospital or facility is not available to provide the facility services, covered services will be reimbursed in full of the allowed amount less applicable copays, coinsurance and deductibles.
  - If transplant services are available through a contractual agreement with an in-network hospital or facility and you have the services performed at an out-of-network hospital or facility, this plan will reimburse covered services at 50% of the billed amount less any applicable copays, coinsurance and deductibles, up to a limit of $100,000. The remaining balance is your responsibility and does not accumulate toward the plan's out-of-pocket limit or deductible limits.
- **Professional transplant services; in-network:** Covered services provided by in-network physicians or other providers of care, are paid according to the service reflected for in-network providers in the Schedule of Benefits for the applicable plan option less applicable copays, coinsurance and deductibles.
- **Professional transplant services; out-of-network:** Covered services, provided by out-of-network physicians or other providers of care, are paid according to the percentages shown on the Schedule of Benefits for the applicable plan option less any applicable copays, coinsurance and deductibles.

Sterilization: Tubal ligation and vasectomy procedures are covered.

Urgent care services: Urgent care services provided by a provider are covered. Please refer to the "Definitions" section for a description of urgent care services.

Wigs: One synthetic wig every calendar year will be covered for members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced alopecia. Please refer to your Schedule of Benefits for cost sharing. Wigs may be purchased from any wig supplier. Wig suppliers may require members to pay for items and submit the paid receipt to Samaritan Health Plans for reimbursement.

Prior authorization

Coverage of certain medical services, procedures, supplies and equipment require SCP written authorization before being performed or supplied. Your provider may request prior authorization by phone, fax or mail. If for any reason your provider will not or does not, request prior authorization for you, you must contact SCP yourself. This requirement applies to both in-network and out-of-network providers. In some cases, SCP may require you to provide additional information or seek a second opinion before authorizing coverage.

SCP reserves the right to review or otherwise deny services that are not found to be medically necessary. Failure to obtain a prior authorization may result in your claim being denied, either in whole or in part. Prior authorization is not a guarantee of payment. Please refer to the Prior Authorization List to see a list of services and drugs billed to the medical plan that require prior authorization.

Prior authorization determination timeframes

SCP will decide and notify you of your authorization determination in accordance with reasonable timeframes, as required by the Employee Retirement Income Security Act (ERISA).

Type of claim	Authorization determination
Expedited requests	As your health status requires but no later than 72 hours of request
Pre-service requests	Within 15 days

Pharmacy plan benefits

Important notes:

- No over-the-counter (OTC) drugs will be covered by SCP without a prescription. Some OTC drugs are covered with a prescription. Reference the formulary for more specific drug coverage.
- All drugs covered by SCP are subject to the Pharmacy and Therapeutics Committee and are approved to be on the formulary list of covered drugs. Reference the formulary for more specific drug coverage information.

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

SCP uses a formulary, which lists the covered prescription drugs. Some covered drugs may have additional requirements or limits on coverage. These requirements may include:

- **Prior authorization:** SCP requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from SCP before SCP will pay for your prescriptions.
- **Quantity limits:** For certain drugs, SCP limits the amount or quantity of the drug that is covered.
- **Step therapy:** In some cases, SCP requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You can find out more about additional requirements or limits on covered drugs by contacting Customer Service or your physician.

The SCP Formulary is made available to you on the Samaritan Choice Plan's website at **samhealthplans.org/Find-a-Drug**. A printed copy of the SCP formulary may be mailed to you upon request.

Prescription drug services

Pharmacies: When you choose one of the Samaritan Choice medical plans, you will automatically have prescription drug coverage. To take advantage of the prescription drug coverage, you must fill your prescription at an in-network pharmacy.

In-area network: For Choice subscribers who reside in Benton, Lane, Lincoln, Linn, Marion, and Polk counties in Oregon, in-network pharmacies include:

- Elm Street Pharmacy – Albany.
- Geary Street Pharmacy – Albany.
- Samaritan Pharmacy – Corvallis.
- Samaritan Pharmacy – Lebanon.
- Samaritan Pacific Communities Hospital Pharmacy – Newport.
- Samaritan North Lincoln Hospital Pharmacy. (urgent needs only) – Lincoln City.
- Any Walgreens Pharmacy nationwide.

Out-of-area network: For Choice subscribers who reside outside of Benton, Lane, Lincoln, Linn, Marion, and Polk counties in Oregon, in-network pharmacies includes Samaritan Health Services and Walgreens pharmacies as well as all major retail pharmacy chains, such as Walmart, CVS, Kroger and many others.

Samaritan Choice In-area network and out-of- area network pharmacy directory documents provide a full list of in-network pharmacies and are available at **samhealthplans.org/Find-a-Drug**

Your most cost-effective option is to use generic drugs whenever available. Name brands are covered, but you most often will pay more for them. How much you pay depends in which tier a specific drug is categorized. SCP maintains the right to direct where your prescriptions and related services are provided.

Covered prescriptions must be medically necessary for diagnosis and/or treatment of an illness or injury. Most compounded drugs are covered with an approved prior authorization.

Prescription formulary: The drugs listed in the formulary are subject to change. The presence of a drug in the formulary does not guarantee that you, as a plan member, will be prescribed that drug by your primary care provider or in-network provider for a particular medical condition. The drugs may be subject to prior authorization. As new generics become available, the corresponding brand name drug will no longer be considered a preferred agent.

The Samaritan Choice formulary

Your prescription drug plan provides coverage for drugs listed on the Samaritan Choice formulary found at **samhealthplans.org/Find-a-Drug**. Developed in collaboration with SCP physicians and pharmacists, the formulary includes FDA-approved prescription generic, brand name and specialty drugs. The formulary can help you and your physician choose effective quality drugs that minimize your out-of-pocket expense.

Formulary updates

The formulary is updated at minimum on a quarterly basis. SCP's Pharmacy and Therapeutics Committee (comprised of doctors and pharmacists who practice in the communities we serve) continuously reviews the latest evidence to identify opportunities to promote safe, effective and affordable drug therapy. Generally, the formulary status of a drug covered by your Samaritan Choice Plans' prescription drug coverage will not change during the year unless:

- The drug becomes available in generic form.
- There are safety or effectiveness concerns raised about the prescription drug.
- The Pharmacy and Therapeutics Committee determines that changes to the formulary would be in the best overall interest of SCP's members.

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

- **Tier 1: preventive** offers select preventive drugs.
- **Tier 2: low-cost generic therapeutic** offers select therapeutic drugs at a low cost.
- **Tier 3: preferred** provides the same high quality medicinal and therapeutic benefit without the high cost (mostly generics, some brand name drugs).
- **Tier 4: high-cost preferred** consists of medium cost prescription drugs that provide high quality, effective benefits to SCP members and are less costly than other alternative drugs not included on the preferred drug list (both brand name and generic drugs).
- **Tier 5: non-preferred** are drugs that are non-preferred by the plan (mostly brand name, some generic drugs). You may choose to receive non-preferred drugs rather than the therapeutic equivalent, which may be on a lower cost sharing tier. If your drug is categorized as a Tier 5 drug on the formulary and does not have an equivalent preferred drug available, you may request a tier exception for your drug to be paid at Tier 4.
- **Tier 6: high-cost specialty** includes high-cost brand and generic specialty drugs, which may require special handling and/or close monitoring. You may be charged a high-cost specialty coinsurance if the drug is received in another setting (for example, infusion).

Please note: If a generic drug is released for a brand name drug, the plan automatically adds the generic equivalent to the formulary and removes the brand name drug. Drugs on the formulary are subject to change throughout the year, upon review by the SCP Pharmacy and Therapeutics Committee.

Prescription drugs are covered for up to a 90-day supply. Birth control pills are covered for up to a 12-month supply. **Please note:** SCP will only cover drugs up to a 90-day supply (12-month supply for birth control), even when drugs are needed for vacations, travel, school or work for long periods of time.

To find out which tier a specific drug is covered in or if there are any specific limits or authorization requirements, go online to **samhealthplans.org/Find-a-Drug** or refer to the "Member resources" section to contact Customer Service.

Prescription medication exception: You can ask us to make a medication exception to our coverage rules. This includes exceptions for:

- Covering your drug even if it is not on the formulary.
- Waiving coverage restrictions or limits on your drug.
- Providing a higher level of coverage for your drug. **Please note:** If we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for that drug.

Prescription exceptions: Generally, we will only approve your request for an exception if the alternative drug is included on the plan's formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your medication exception request.

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

Drugs that are not on the formulary require prior authorization. Exception approvals for standard non-formulary medications will process at the highest non-specialty copay. Exception approvals for non-formulary specialty drugs will process at the highest specialty copay.

Allow for a 90-day transition period on selected non-formulary mental health and behavioral drugs. For more information, please refer to the "Member resources" section to contact Customer Service, as this list is regularly updated as new drugs and generics become available.

Prescription urgent and emergent: Prescription drugs can be filled at any in-network pharmacy. The definition of in-network is determined by the subscriber's county of residence. Refer to the In area network or out-of-area network pharmacy directory, as applicable. If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask the plan to reimburse you for our share of the cost. If you utilize an out-of-network pharmacy during an urgent or emergent situation, the plan may cover prescription drugs received from that pharmacy. You or a family member must first pay the total cost of the prescription out-of-pocket and then submit the receipt and completed Prescription Reimbursement Claim form to the claims administrator for payment consideration. Forms for submitting these claims are available at any SHS retail pharmacy and online at **samhealthplans.org/ChoiceForms**.

Each claim is reviewed by the claims administrator and evaluated to determine whether it qualifies for reimbursement based upon emergent-based usage criteria. You will either be reimbursed as specified above or notified if the request has been denied. If the claims administrator makes a decision to approve your reimbursement request, the plan will reimburse the plan's contracted rate for the requested drug less any copay or coinsurance that is member responsibility. The member is responsible to pay any difference between the plan's contracted rate and the out-of-network pharmacy's retail charge. The difference in the plan's contracted rate and the out-of-network pharmacy's retail charge will not apply to member's deductible or maximum out-of-pocket expenses. Payments made with flexible spending account (FSA) will not be reimbursed.

Direct member reimbursement: In some situations, you or a family member must first pay the total cost of the prescription out-of-pocket and then submit the receipt and completed Prescription Reimbursement Claim form to the claims administrator for payment. Forms for submitting these claims are available at any SHS retail pharmacy and online at **samhealthplans.org/ChoiceForms**.

Each claim is reviewed by the administrator and evaluated to determine whether it qualifies for reimbursement based upon emergent-based usage criteria or if it meets exception criteria. You will either be reimbursed as specified above or notified if the request has been denied. If the claims administrator makes a decision to approve your reimbursement request, the plan will reimburse the plan's contracted rate for the requested drugs less any copay or coinsurance that is member responsibility. The member is responsible to pay any difference between the plan's contracted rate and the out-of-network pharmacy's retail charge. The difference in the plan's contracted rate and the out-of-network pharmacy's retail charge will not apply to the member's deductible or maximum out-of-pocket expenses.

Prescription out-of-pocket limit: The out-of-pocket limit on prescription drugs is integrated between the Medical and Pharmacy plan. For the PPO Plan, the out-of-pocket limit is $7,200 for individuals and $14,400 for families. For the High-Deductible Health Plan with HSA, the out-of-pocket limit is $5,000 for individuals and $10,000 for families. If you incur covered expenses in excess of the out-of-pocket limit, this plan will pay 100% of eligible charges for the rest of the calendar year. Those services that do not apply to your out-of-pocket limit will not be covered at 100% after your out-of-pocket limit has been met. Regular cost sharing will apply to those benefits.

Benefit exclusions

Samaritan Choice Plans reserves the right to review or otherwise deny services that are not found to be medically necessary. The following are limitations that apply to the plan:

Least costly setting for services

Covered services must be performed in the least costly setting where they can be provided safely. For example, if a procedure is performed in a hospital inpatient setting when it could have been performed on an outpatient basis, this plan will not pay any more than it would have paid had the procedure been performed on an outpatient basis. Services performed in an inappropriate setting may result in higher out-of-pocket expenses.

Excluded services

This is only a summary of excluded (not reimbursable) services and supplies.

This plan does not cover the following surgeries and procedures:

- Any treatment or services provided by licensed direct entry midwives.
- Massage therapist services.
- Routine foot care, such as treatment for corns and calluses, toenail conditions, hypertrophy or hyperplasia of the skin and nails, is not covered unless the patient has diabetes, peripheral vascular disease or recurrent infections.
- Abdominoplasty.
- Cosmetic services including supplies and drugs.
- Eye surgeries to improve vision, such as lasik.
- Surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia or astigmatism.
- Surgery to reverse sterilization.
- Treatment to augment or reduce the upper or lower jaw, except when necessary due to an injury.
- Temporomandibular joint (tmj) or myofascial pain treatment, advice or appliances.
- Services for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants or improving placement of dentures.
- Transplants, except as specified in this document.
- Myeloablative high-dose chemotherapy is not covered, except when related to a transplant.
- Planned births in the home.

This plan does not cover the following drugs (medications):

- Prescription drugs used primarily for weight control or obesity, regardless of the diagnosis (including, but not limited to, amphetamines).
- Drugs with no proven therapeutic indication or not medically necessary.
- Drugs or devices used for impotence and sexual dysfunction.
- Drugs or devices used for cosmetic reasons.
- Drugs for which claims are submitted 12 months or more after the date of purchase.
- Any drugs not specifically described as benefits under the prescription drug coverage offered by this plan.
- Off-label use. Medications prescribed for or used for non-FDA approved indications, unless approved by Oregon's Health Evidence Review Commission or the SCP Pharmacy Therapeutics and Review Committee.

- Non-prescription drugs: Drugs which, by law, do not require a prescription order, except for insulin and certain over-the-counter (OTC) drugs specifically covered by this prescription drug coverage. Those drugs covered by SCP, considered preventive OTC, require a written prescription from a physician to be covered under the plan.

Please note: You or your physician may submit a medication exception request for OTC drugs not listed in the formulary.

- Vitamins except those which by law require a prescription order.
- Immunizations or services for purposes of school, travel or work.

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

- Eyeglasses or contact lenses, vision therapy, orthoptics and visual appliances (colored lenses, prisms and special glasses) for reading, learning or behavioral disabilities or dyslexia. These services may be covered under your Samaritan Choice Vision Plan when enrolled and eligible.
- Hearing aid batteries.
- Power-assisted prosthetics.
- Routine supplies and equipment used for comfort, convenience, cosmetic purposes or environmental control. This includes appliances like air conditioners, air filters, whirlpools, hot tubs, heat lamps or tanning lights. It also includes personal items like telephones, radios and televisions or for guest meals and other personal items, maintenance supplies or equipment commonly used for purposes other than medical care.

This plan does not cover the following services:

- Educational programs, including court-ordered programs.
- Counseling in the absence of illness.
- Long-term psychiatric care, which includes the following:
  - State hospital care.
  - Secure children's inpatient (SCIP) care.
  - Secure adolescent inpatient (SAIP) care.
- Marital, family, career or personal growth counseling, unless it is part of an individual's treatment plan and billed specifically for the individual.
- Mental or psychological evaluation for sexual dysfunction or inadequacy.
- Psychological testing that is not medically necessary.
- Treatment of dementia (such as Alzheimer's disease), including any organic psychotic manifestations.
- Treatment that is experimental, investigational or unproven to treat a disorder.
- Treatment provided at wilderness therapy programs or camps.

This plan does not cover the following health related conditions, services or supplies:

- Experimental or unproven. A treatment, procedure, device, drug or medicine which meets any of the following:
  - Cannot be lawfully marketed without approval by the U.S. Food and Drug Administration (FDA) and approval for marketing for the condition treated has not been given at the time the device, drug or medicine is furnished.
  - Safety and effectiveness have not been proven by peer-reviewed, published, well-designed, controlled studies of sufficient statistical power.
  - Does not improve measurable health outcomes.
  - Does not compare favorably to existing treatments (effectiveness, cost, toxicity). Any treatments, services, supplies or related expenses that are educational or provided primarily for research unless otherwise addressed in this document.
  - Treatments, procedures, devices, drugs, medicines or other expenses relating to the transplant of non-human organs.
  - Does not meet standards of care.
- Homeopathic treatment.
- Hypnosis.
- Massage or massage therapy, even if it is part of a physical therapy program.
- Treatment that is not medically necessary for the treatment of an illness or injury as determined by the plan.

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

- Charges or other amounts in excess of the allowable charge for services or supplies.
- Charges or other amounts in excess of any specified limitation.
- Hospital, skilled nursing facility or other facility services that began before the covered person's coverage began, including services and supplies.
- Treatment incurred prior to enrollment and coverage under this plan or after coverage terminates. The only exception is that if this plan is replaced by a group health policy while you are hospitalized, SCP will continue paying covered hospital expenses until you are released or your benefits are exhausted, whichever occurs first.
- Any illness or injury resulting from an illegal activity or committing or attempting to commit a felony and any treatment received while incarcerated.
- Services or supplies for which the covered person could receive partial or complete payment had the covered person applied under any city, county, state or federal law.
- Services or supplies the covered person could have received in a hospital or program operated by a government agency or authority.
- Services provided by an immediate family member, including a husband or wife; birth or adoptive parent, child or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law; grandparent or grandchild and spouse of a grandparent or grandchild.
- Services or supplies for which you have no legal responsibility to pay or for which a charge would not ordinarily be made in the absence of coverage under the plan.
- Services or supplies for which the covered person is not charged or cannot be held liable because of an agreement between the provider rendering the service and another third-party payer that has already paid for the service.
- Services or supplies with no charge or which your employer would have paid for if you had applied.
- Charges that are the responsibility of a third party, such as worker's compensation insurance, personal injury protection insurance, motor vehicle liability insurance, uninsured or underinsured motorists or by contract services that are covered by other payment.

- Motor vehicle coverage and other insurance liability; expenses for services and supplies that are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage or similar contract or insurance. This applies when the contract or insurance is either issued to or makes benefits available to a claimant, whether or not the claimant makes a claim under such coverage. Further, the claimant is responsible for any cost sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, benefits will be provided according to this document.
- Third-party liability services and supplies for treatment of illness or injury for which a third-party is or may be responsible.
- Fees and expenses: Neither the plan nor the claims administrator are liable for any expenses or fees incurred by you in connection with obtaining a recovery. However, you may request that a proportional share of the attorney's fees and costs be paid at the time of any settlement or recovery, to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid under the plan. The claims administrator has the discretion whether to grant such requests.
- Future medical expense: Benefits for otherwise covered services may be excluded when you have received a recovery from another source relating to an illness or injury, for which benefits would normally be provided. However, the amount of any covered services excluded under this provision will not exceed the amount of your recovery.
- Charges for services or supplies, if you are not willing to release medical information to SCP needed to determine eligibility for payment. Failure to respond to requests from SCP may delay or deny payment of service.
- Treatment of any condition caused by a war, armed invasion or act of aggression, terrorism or while serving in the armed forces.
- Work-related illness or injury: Expenses for services and supplies incurred as a result of any work-related injury or illness, including any claims that are resolved related to a disputed claim settlement. The claims administrator may require the claimant to file a claim for worker's compensation benefits before providing any benefits under the plan. The plan does not cover services and supplies received for work-related injuries or illnesses, even if the service or supply is not a covered worker's compensation benefit. The only exception is if a participant is exempt from state or federal worker's compensation law.
- Charges for travel or work-related expenses, telephone consultations, missed appointments, get acquainted visits, completion of claim forms or completion of reports requested by the claims administrator in order to process claims.
- Custodial care, including routine nursing care and rest cures and hospitalization for environmental change.
- Care designed mainly to help with daily activities such as walking, getting out of bed, bathing, dressing, eating and preparing meals.
- Swimwear.
- Services and supplies not specifically described as covered services under this plan.

Who is eligible

Employees: All non-temporary employees of Samaritan Health Services (SHS) who are assigned as .50 full-time equivalent (FTE) or greater are eligible under the plan. Additionally, employees who meet the statutory definition of full-time employee under the Affordable Care Act (ACA) may be eligible for coverage.

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 (IRS) 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 (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 (QMCSO).
- 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 Qualified Medical Child Support Order (QMCSO), under Employee Retirement Income Security Act (ERISA). 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. Employees who qualify for coverage under the Affordable Care Act (ACA) are eligible for a period as defined under ACA regulations.

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 as a result of 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, either based on assigned FTE or if you are no longer a full-time employee as defined under the Affordable Care Act (ACA), 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 (COBRA)

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.

This document addresses the plan options under medical, pharmacy and health flexible spending account (FSA) components. 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 (COBRA) of 1985 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 (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 plan of a disability or a second qualifying event in order 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 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 some time 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 as a result of 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 their 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 18th 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 their 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 loses 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 that 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 by submitting the COBRA Address Notification form.

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 (FSA)

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 the COBRA plan administrator'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 their 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 section "Notice procedures" section below.

To add dependents or change coverage options (i.e., PPO to High-Deductible Health Plan with HSA) during open enrollment periods, please contact the plan 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 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 SHP.

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 above.

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 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, so 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 the address timely, an address change may be reported to the plan by contacting SHP Customer Service.

How, when and where to send notices

You must mail or hand-deliver your notice to:

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.

However, if a different address, email or fax 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 8:00 a.m. to 5:00 p.m., Monday through Friday, Central Time.Additional information required for notice of qualifying event

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 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 that 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 all the following:

1. The names and addresses of those that 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 all 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 that 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 mail or hand-deliver 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 mail or hand-deliver your monthly premium payments to TASC.	By the end of the 30-day grace period
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.

Continuity of care:

- If provider contract is terminated, a "continuing patient" can continue for either 90 days or the date when no longer a continuing patient, whichever is earlier.
- The provider must continue under same terms and conditions.
- This provision does not apply to for-cause terminations (provider fails to meet quality standards or commits fraud).

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 their 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 their 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 their guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the covered person (or their 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 theirself (or their 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 their 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 their 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 their 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 their 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 their 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 their 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 (COB)" 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 (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

   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 maximum plan allowable 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 on the basis of 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 (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:

            - The plan covering the custodial parent, first.
            - The plan covering the spouse of the custodial parent, second.
            - The plan covering the non-custodial parent, third.
            - The plan covering the dependent spouse of the non-custodial parent, last.

      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.

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 (ESRD), 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 the 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).

Right of Recovery

Samaritan Health Plans, on behalf of the plan, has the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this plan. This right of recovery applies to any excess benefit, including (but not limited to) benefits obtained through fraud, error or duplicate coverage relating to any member. If timely repayment is not made to the plan, Samaritan Health Plans is authorized by PEBB to deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected members under this plan. Samaritan Health Plans, on behalf of the plan, has the right to recover pharmacy overpayment directly from you or your family member.

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 Plans (SCP). 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 health care 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 or 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 by one of the following:

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 (IRO) 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: **Three days** 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:

- 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:

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

By fax: 541-768-9765

By email: SHPOappealsteam@samhealth.org

Call Customer Service at **541-768-4550**; toll free **800-832-4580** (TTY **800-735-2900**).

Appeal timelines

Samaritan Choice Plans (SCP) 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/ChoiceForms**:

- Authorized Representative.
- Appeal Request.

Your grievance and appeal rights

If you disagree with Samaritan Health Plans' decision about your medical bills or health care services, you have the right to an internal review. You may request a review if you have received an Adverse Benefit Determination. You may also file a quality of care or general compliant or grievance with Samaritan Health Plans. You may appoint an authorized representative to act on your behalf during your grievance or appeal. Please include as much information as possible including the date of the incident, name of individuals involved, and the specific circumstances.

In filing a grievance or appeal:

You can submit written comments, documents, records and other information relating to your grievance or appeal and Samaritan Health Plans will consider that information in the review process. You can be represented by anyone of your choice at all level of appeals.

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 Samaritan Health Plans or if you remain unsatisfied with the outcome of your appeal or grievance:

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

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

By fax: 541-768-9765

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 (FMLA)

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 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 their 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 called to covered active duty status.
- An eligible employee may also take up to 26 work-weeks 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 repayment 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 chooses 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 a 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 but subsequently returns to active working status on or before the expiration of the leave, the employee and all eligible dependents will immediately become covered under the plan without being required to give evidence of insurability.

If the employee fails to return from leave (except because of their 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 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 armed forces of the United States of America. 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 (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 **dol.gov/agencies/vets/programs/userra/USERRA-Pocket-Guide**.

- 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.

Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

MHPAEA, as amended by the Patient Protection and Affordable Care Act (ACA), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans and group and individual health insurance issuers that provide coverage for mental health or substance use disorder and benefits in addition to medical/surgical benefits.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or 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 (GINA) (H.R. 493 (110th))

GINA expands the genetic information nondiscrimination protections included in Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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.

WHCRA full annual notice

The Women's Health and Cancer Rights Act of 1998 provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and patient.

The required coverage includes:

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

Under WHCRA, mastectomy benefits may be subject to an annual deductible and coinsurance consistent with those established for other benefits under the plan or coverage. Please refer to the Schedule of Benefits for details.

Keep this notice for your records and call your plan administrator, SCP, for more information.

The Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 (PPACA))

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.

Lifetime limit no longer applies and enrollment opportunity notice (PPACA, 2010)

The lifetime limit on the dollar value of benefits under SCP no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, please refer to the "Member resources" section to contact Customer Service.

Patient protections notice (PPACA, 2010)

SCP generally allows the designation of a primary care provider*. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider and for a list of the participating primary care providers, please refer to the "Member resources" section to contact Customer Service.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from SCP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network, who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please refer to the "Member resources" section to contact Customer Service.

* Primary care provider is defined under SCP's provisions as a pediatric, family medicine and internal medicine or OB-GYN provider.

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). 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 in 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 (SHP) 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.

Samaritan Health Plans:

- Provide 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).
- Provide free language services to people whose main 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:

SHP Compliance Officer
PO Box 1310
Corvallis, OR 97339

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

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**.

Important notice from Samaritan Health Services about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with SCP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Samaritan Health Services has determined that the prescription drug coverage offered by SCP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 through Dec. 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month special enrollment period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current SCP coverage may be affected Samaritan Choice Plans' Prescription Drug Coverage includes the following:.

1. Samaritan Choice PPO Pharmacy Plan:

Tier 1: Preventive with no charge, deductible does not apply.
Tier 2: Low-cost therapeutic 30-day supply $3 copay, 90-day supply $9 copay, deductible does not apply.
Tier 3: Preferred with 30-day supply $15 copay, 90-day supply $45 copay, deductible does not apply.
Tier 4: High-cost preferred with $25 copay or 25% coinsurance (whichever is less), deductible does not apply.
Tier 5: Non-preferred with $250 copay or 50% coinsurance (whichever is less), deductible does not apply.
Tier 6: High-cost specialty with 15% coinsurance, deductible does not apply.

2. Samaritan Choice High-Deductible Health Plan with HSA Pharmacy Plan

Tier 1: Preventive with no charge, deductible does not apply.
Tier 2: Low-cost therapeutic 30-day supply $3 copay, 90-day supply $9 copay, deductible applies.
Tier 3: Preferred with 30-day supply $15 copay, 90-day supply $45 copay, deductible applies.
Tier 4: High-cost preferred with $65 copay or 25% coinsurance (whichever is less), deductible applies.
Tier 5: Non-preferred with $250 copay or $50 coinsurance (whichever is less), deductible applies.
Tier 6: High-cost specialty with 15% coinsurance, deductible applies.

In addition to prescription drugs, your current coverage pays for other health expenses. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current Samaritan Choice Plans coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Samaritan Choice Plans and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month, for every month that you did not have coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty), as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage

Please call Samaritan Choice Plans at **541-768-4550**, toll free **800-832-4580** (TTY **800-735-2900**).

Please note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through SCP changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare and You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **Medicare.gov**.
- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare and You" handbook for their telephone number) for personalized help.
- Call **800-MEDICARE (800-633-4227)** (TTY **877-486-2048**).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **socialsecurity.gov** or call them at **800-772-1213** (TTY **800-325-0778**).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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 he or she incurs as a result of acting on behalf of the plan administrator, unless such liability is due to their 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 (ERISA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) and the Women's Health and Cancer Rights Act of 1998 (WHCRA).

These laws have been amended from time to time. In the event of any conflict between these provisions and the current provisions of the law, the current provisions of the law shall govern.

Wellness program disclosure

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

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

Medical definitions

Accident: An unexpected event or circumstance without deliberate intent.

Affordable Care Act (ACA): 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, SCPs' 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 "Balance billing" section.)

Alternative Care Provider: A naturopath, chiropractor or acupuncturist who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides covered services within the scope of that license.

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

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.

Applied behavior analysis: Benefits are provided for applied behavior analysis for the treatment of autism spectrum disorders, subject to the following limitations:

- Services must be medically necessary.
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training in the diagnosis of autism spectrum disorder.
- Prior authorization is received by SCP.
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualized treatment plan.
- Treatment must be provided by a health care professional licensed to provide applied behavior analysis services.
- Treatment may be provided in the member's home or in a licensed health care facility.

Exclusions to applied behavior analysis services:

- Services provided by a family or household member.
- Services that are custodial in nature or that constitute marital, family or training services.
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an education or training program.
- Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, chelation or hyperbaric chamber.

- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act.
- Services provided through community or social programs.
- Services provided by the Department of Human Services or the Oregon Health Authority (or other state equivalent), other than employee benefit plans offered by the department and the authority.

An approved applied behavior analysis treatment plan is subject to review by SCP and may be modified or discontinued if review shows that the member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan.

Authorized representative: An individual who by law or by the consent of a person can act on behalf of the person. The authorization must be made by the completion of an authorized representative form that is available online at **samhealthplans.org/ChoiceForms**.

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.

Benefit year: The period starting on the date coverage begins and ending after 12 months.

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

Care coordination services: Care coordination services can include health coaching, case management and care management by the involved provider team.

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.

COBRA (Consolidated Omnibus Budget Reconciliation Act): This act 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 allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 30% would be $30. The plan pays the rest of the allowed amount.

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

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 (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.

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

Cost 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 covered service is:

1. Listed as a benefit in the Schedule of Benefits and in the covered services section of this member handbook.
2. Medically necessary.
3. Not listed as an exclusion or limitation in the Schedule of Benefits or in the relevant sections of this member handbook.
4. Provided to you while you are a participant and eligible for the service under this plan.

Custodial care: Non-medical care that helps individuals with their activities of daily living, preparation of special diets and self-administration of prescription drugs not requiring constant attention of medical personnel.

Deductible: This cost share is the portion of covered health care services each member is obligated to pay before Samaritan Choice Plans begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. Please refer to the "Out-of-pocket limits and deductibles" section for more information.

Diagnostic test: Test that is used to identify what your health problem is. For example, an X-ray can be a diagnostic test to see if you have a broken bone.

Disease: An illness or sickness characterized by specific signs and symptoms which negatively affect the structure or function of an individual.

Durable medical equipment (DME): Is equipment that must:

1. Be able to withstand repeated use.
2. Be primarily and customarily used to serve a medical purpose.
3. Not be generally useful to a person except for the treatment of an injury or illness.

Electrocardiogram: A test that measures the electrical activity of the heartbeat.

Eligible expense or charge: The allowed amount assessed on an itemized bill for medically necessary medical treatment as provided and addressed by this plan.

Emergency medical condition: An illness, injury, symptom (including severe pain) or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following:

1. Your health would be put in serious danger.
2. You would have serious problems with your bodily functions.
3. You would have serious damage to any part or organ of your body.

Emergency medical transportation: Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land or sea. The plan may not cover all types of emergency medical transportation or may pay less for certain types.

Emergency room care/emergency services: Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Employer: SHS. 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 the plan does not pay for or cover.

Experimental/investigational: Experimental/investigational means services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the service for treating or diagnosing the condition or illness for which its use is proposed. In determining whether services are experimental/investigational, the plan considers a variety of criteria, which include, but are not limited to, whether the services are:

- Approved by the appropriate governmental regulatory body.
- Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial.
- Offered through an accredited and proficient provider in the United States.
- Reviewed and supported by national professional medical societies.
- Address the condition, injury or complaint of the Member and show a demonstrable benefit for a particular illness or disease.
- Proven to be safe and efficacious.
- Pose a significant risk to the health and safety of the member.

The experimental/investigational status of a Service may be determined on a case-by-case basis. Samaritan Health Plans will retain documentation of the criteria used to define a Service as experimental/investigational and will make this available for review upon request.

Family deductible: The family deductible is the amount shown in the Schedule of Benefits that applies when two or more family members are enrolled in this plan and is the maximum deductible that enrolled family members must pay. All amounts paid by family members toward their individual deductibles apply toward the family deductible. When the family deductible is met, no further individual deductibles will need to be met by any enrolled family members. **Note:** No member will ever pay more than an individual deductible before the plan begins paying for services for that member.

Full-time employee: As defined for the purposes of the Affordable Care Act (ACA), an employee employed on average at least 30 hours of service per week or 130 hours per month.

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

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

Health savings account (HSA): A tax-advantaged individually-owned savings account that you can use to pay for eligible health care expenses. You must be enrolled in a qualified High-Deductible Health Plan (HDHP) in order to open and participate in an HSA. Please contact Human Resources (HR) for more information.

Home health care: Health care services and supplies you get in your home under doctor's orders. Services may be provided by nurses, therapists, social workers or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning or driving.

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

Hospital: An institution that provides diagnostic and treatment facilities if you are injured or ill. It is licensed as a general hospital, is under the supervision of a staff of physicians and is staffed 24 hours a day by registered nurses. Rest, old age or convalescent homes are not considered hospitals, nor are most facilities operated by agencies of the federal government. Hospitalization must be authorized by a physician and must be medically necessary for acute care treatment of illness or injury.

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

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

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.

Individual deductible: An Individual deductible is the amount shown in the Schedule of Benefits that must be paid by the member before the plan provides benefits for covered services for that member.

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 (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.

Mastectomy: The surgical removal of all or part of the breast or a breast tumor suspected to be malignant.

Maxillofacial prosthetic services: Services to restore and manage head and facial structures that cannot be replaced with living tissue.

Maximum plan allowable (MPA): The amount that we use to calculate what we pay for 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 set forth in your copayment and coinsurance schedule.

The MPA for out-of-network emergency care will be the greatest of:

1. The amount negotiated with in-network providers for the emergency service provided, excluding any in-network copayment or coinsurance.
2. The amount calculated using the same method we generally use to determine payments for out-of-network provider, excluding any in-network copayment or coinsurance.
3. The amount paid under Medicare Part A or B, excluding any in-network copayment or coinsurance.
   - The MPA for covered outpatient pharmaceuticals (including but not limited to injectable medications) dispensed and administered to the patient by an out-of-network provider, in an outpatient setting, including, but not limited to: physician office, outpatient hospital facilities and services in the patient's home, will be the lesser of billed charges or the average wholesale price for the drug or medication. Average wholesale price is the amount listed in a national pharmaceutical pricing publication and accepted as the standard price for that drug by SHP.
   - The MPA for covered services and medical supplies, excluding emergency medical care and outpatient pharmaceuticals, received from an out-of-network provider is a percentage of what Medicare would pay (known as the Medicare allowable amount). Medicare pays 100% of the Medicare allowable amount.
   - The MPA for facility services, including but not limited to hospital, skilled nursing facility and outpatient surgery, is determined by applying 165% of the Medicare allowable amount.
   - The MPA for physician and all other types of services and supplies is the lesser of the billed charge or 165% of the Medicare allowable amount.
   - In the event that the billed charges for covered services and medical supplies received from an out-of-network provider are more than the MPA, you are responsible for any amounts charged in excess of the MPA, in addition to applicable deductibles, copayments or coinsurance.

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

- Bleeding that does not stop.
- Sudden abdominal or chest pains.
- Suspected heart attacks.
- Broken bones.
- Serious burns.
- Onset of delivery.
- Severe pain.

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

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

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

The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply medically necessary or covered under the plan.

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

Medical supplies: Disposable items that may be essential to effectively carry out the care a physician has ordered for treatment or diagnosis of an illness, injury or disease.

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.

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 the 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 your health insurance or Plan. Out-of-network copayments are usually more than in-network copayments.

Out-of-network provider: A provider who does not have a contract with your health insurer or 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. When services are performed by or received from an out-of-network provider, your expenses include a calendar year deductible (if any), fixed dollar amounts for certain services and the amount by which billed charges exceed the maximum plan allowable (MPA) for other services. The definition of MPA is set forth in the "Definitions" section of this document. The MPA for covered services and supplies may not be the same as what an out-of-network provider bills.

Out-of-pocket maximum: The most you pay during a benefit plan year (Jan. 1 through Dec. 31), before the plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance billed charges or services the plan doesn't cover. Some services do not apply your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses towards this limit.

Outpatient intensive services: Services targeted to individuals who require more intensive services than outpatient counseling services. These services are provided in a concentrated manner and generally involve multiple outpatient visits per week, over a period of time. They include both individual and group therapy, for individuals requiring stabilization.

Partial hospitalization: Partial hospitalization provides outpatient behavioral and substance use disorder services as an alternative to inpatient care. It's a time limited, structured program of multiple and intensive psychotherapy and other therapeutic services provided by a multidisciplinary team. This treatment is provided during the day and doesn't require an overnight stay.

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 coverage under the plan. You and/or your employer pay a portion every pay period. COBRA members will pay their premium monthly.

Prescription drugs: Drugs that by law require a prescription. For medical prescription drug authorization requirements, please refer to the "Prior authorization" section. For information about prescription drug coverage, please refer to the "Prescription plan benefits" section.

Preventive care (preventive service): Routine health care, including screenings, check-ups and patient counseling, to prevent or discover illness, disease or other health problems.

Primary care provider (PCP): A provider, as allowed under state law and the terms of the plan, who provides, coordinates or helps you access a range of health care services. A primary care provider visit is defined as services provided by a pediatrics, family medicine, internal medicine, naturopath or OB-GYN.

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. The plan may require prior authorization for certain services before you receive them, except in an emergency. Prior authorization isn't a promise the 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.

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

Provider: A physician, women's health care provider, nurse practitioner, clinical social worker, physician assistant, psychologist, dentist, podiatrist, acupuncturist, naturopath, chiropractor, audiologist or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides covered services within the scope of that license.

Reconstructive: Services, procedures and surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, disease or for treatment of gender dysphoria. It is generally performed to improve function but can also be done to approximate a normal appearance. It also includes follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, transgender services or medical conditions.

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

Residential services: Care in a residential facility, which provides an organized full-day or part-day program of treatment and is licensed or approved for the particular level of care for which reimbursement is being sought.

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.

Services: A health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a participant by a provider.

SHS designated facilities: Facilities wholly or partially owned or otherwise designated by Samaritan Health Services.

Skilled nursing care: Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as skilled care services, which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

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

Substance use disorder: An addictive relationship a person has with any drug or alcohol agent. Substance use disorder may be physical, psychological or both and interferes with a person's social, psychological or physical adjustment. substance use disorder does not include dependence on tobacco products or food.

Termination of pregnancy: An abortion induced when pregnancy constitutes a threat to the physical or mental health of the mother and/or the fetus.

Urgent care services: Services for an unforeseen illness or injury, that requires treatment within 24 hours to prevent serious deterioration of a patient's health. Urgent conditions are normally less severe than true medical emergencies. Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care. Examples of conditions that could need urgent care are sprains and strains, vomiting, cuts and severe headaches.

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

Women's Health Care Provider: An obstetrician or gynecologist, some primary care providers and naturopaths (if they are licensed to provide obstetrical services), or physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health, certified nurse midwife or licensed direct entry midwife practicing within the applicable lawful scope of practice.

Pharmacy definitions

Brand name drugs (medication): A drug marketed under a proprietary, trademark-protected name.

Formulary: A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

The drugs listed in the formulary are subject to change. The presence of a drug in the formulary does not guarantee that you will be prescribed that drug by your primary care provider for a particular medical condition. Drugs can be subject to prior authorization. As new generic drugs become available, the corresponding brand name drug will no longer be considered a preferred agent.

Generic drug (medication): An equivalent brand name drug, with the same ingredients, safety profile and method of administration.

Pharmacist: An individual licensed to dispense prescription drugs and who must act within the scope of a valid license for benefits to be payable.

Pharmacy: An establishment which is registered as a pharmacy with the appropriate state licensing agency and in which prescription drugs are regularly compounded and dispensed by a pharmacist.

Prescription drugs (medication): Drugs, biologicals and compounded prescriptions approved by the FDA which can be dispensed only pursuant to a prescription order and which by law must bear the Rx legend: Caution — federal law prohibits dispensing without a prescription or which are specifically designated by SCP.

Prescription order: A written or verbal request for prescription drugs issued by a licensed provider.

Preventive tier: The preventive tier offers select preventive drugs.

Prior authorization: The plan requires that you or your physician get prior authorization from SHP for certain drugs. This means that you will need to get approval from us before we will pay for your prescriptions.

Quantity limits: certain drugs have quantity limits, where the plan will not pay for quantities above the FDA approved maximum dosing without an approved prescription medication exception.

Step therapy: In some cases, the plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

Usual and customary charges: Charges that the claims administrator determines fall within a range of those most frequently made for prescription drugs and insulin.

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 Telephone: 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 Telephone: 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

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